Four years on: The impact of the National Service Framework for Older People on the experiences, expectations and views of older people

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Abstract

Aim evaluation of the impact of the National Service Framework for Older People (NSFOP) on the experiences and expectations of older people, 4 years into its 10 year programme.

Background the NSFOP is a comprehensive strategy designed to promote fair, high quality, integrated health and social care services for older people in England. It emphasises (i) the need for services to support independence and promote health, (ii) the specialisation of services for key conditions (stroke, falls and mental illness) and (iii) advocates a cultural change in services so that the older people and their carers are treated with respect, dignity and fairness. It has a 10-year timetable for implementation, starting in 2001.

Method a mixed methods approach to evaluation was taken in ten purposively selected localities in England. A portfolio of methods (listening events, nominal groups and interviews) was used with older people and carers to focus on processes as well as on outcomes and to allow for the possibility of conflicting or differing judgements about service quality.

Findings one thousand eight hundred and thirty-nine people participated in public listening events, 1,639 took part in nominal groups and 120 were interviewed individually. The existence of the NSFOP was not widely known beyond the NSFOP local implementation teams and voluntary sector activists. Many, but not all older people, identified themselves as members of a group that was subject to age prejudice that altered the quality and standard of their care. This identity included a role as carer for others, but there was less emphasis on the rights of older people. Positive changes in primary care services were offset by difficulties in accessing general practice and a sense that services were becoming impersonal. The quality of social care at home varied from sensitive and personal to fragmentary, hurried and impersonal. Hospitals treatment was perceived as improved in speed and quality in most places, but hospitals were also seen as risky and insufficiently caring, with discharge sometimes being unprepared, over-zealous and disorganised.

Conclusions if asked, older people do not perceive improvements as the result of a NSFOP, but nonetheless they do perceive improvements in systems. It is difficult to attribute any of the changes in experiences that we identified to the NSFOP itself, but we can see that other change processes run contrary to some aspects of the NSFOP whilst some trends are congruent with the aspirations of the NSFOP. Government initiatives face the difficulty of distinguishing experiences that may be attributable to multiple causes. They are influenced nonetheless by the outcome of public consultation since these provide relatively rapid means of feedback and commentary by citizens and regulators on the performance of services.

Keywords: public policy, ageing, patient satisfaction, quality assurance, elderly

Background

The National Service Framework for Older People (NSFOP) was introduced in England by the Department of Health in 2001 [1]. It is a comprehensive, evidence-based strategy aimed at ensuring fair, high quality, integrated health and social care services for older people, and outlines a 10-year
timetable for action. It emphasises the need for services to support independence and promote health, promotes specialisation of services for stroke, falls prevention and mental illness, and advocates a cultural change in service delivery so that older people and their carers are treated with respect, dignity and fairness. Although earlier policy announcements, such as the National Health Service (NHS) Plan [2] had delivered much of the resources underpinning the NSFOP, the NSFOP has been the ‘focus for many advances’ [3]. Like other National Service Frameworks, it provokes considerable debate within medicine, with opinions being divided about its potential for effecting real change [4–7].

In 2004, the Healthcare Commission began an evaluation of the National Service Framework for Older People, and commissioned an independent research team to answer the question: has the NSFOP produced improvements in the quality of health and social care services that are visible from the perspective of older people? The research task was to capture the complex reality of the implementation of the NSFOP by eliciting the views of older people. The principle underpinning the project was to accumulate experiences of health and social care from multiple perspectives, recognising the differences and diversity in the older population and engaging ‘hard to reach’ groups like older people from black and ethnic minority groups, older people with learning disabilities, older people living in rural areas and older people in contact with drug and alcohol services. The operational approach taken was to ensure that older people were involved in the research at all levels, from designing the study to carrying out the fieldwork.

The key challenges identified at the genesis of the project fell into three categories. Local issues for older people included possible consultation fatigue [8], interest in the topic, and worries about voicing criticism of services upon which they depended [9]. System issues included low or cautious responses from voluntary and community sector representatives because of fear of inspection and defensiveness, sensitivities around perceptions of appearing critical of commissioners, and consultation overload [10]. ‘Tick box’ responses and infectious lassitude were anticipated as possible unhelpful consequences of these system problems. Problems in the wider policy context included possible changes to the NSFOP, changes to public and patient involvement structures in the NHS, competition with other NSFOP evaluations, and the confusion of multiple policy imperatives [11].

**Methods**

We adopted a rapid appraisal approach [12] to evaluate the impact of the NSFOP on local services. This involves communities in identifying their own needs, and is a common means internationally of evaluating improvements in health and well-being. It can provide timely, relevant information, contextualising such needs within local social structures and service cultures [13]. Although rapid appraisal methods can include quantitative data collection, the dominant approach is qualitative, to capture the perspectives and experiences of those using services [14]. Qualitative research produces knowledge of public relevance [15] and relies for its validity on its ability to accurately reflect the changeable and complex phenomena under study [16].

Through the involvement of Older People Researching Social Issues (OPRSI), a research co-operative, older people were involved in the design of the evaluation, in carrying it out, and in data analysis, following the research and development methodology advocated by Scott and colleagues [17]. A purposively selected sample of localities was identified by the Healthcare Commission to optimise the typicality of the services studied, and increase the transferability of the findings [18, 19]. The sample included urban and rural areas with diverse populations, covering 40 NHS trusts and 10 local authorities. Data collection took place between December 2004 and May 2005.

A portfolio of methods (public listening events, nominal groups and individual interviews) was used with older people and their carers to focus on processes of health and social care delivery as well as on the outcomes, and to allow for the possibility of conflicting or differing judgements [20]. Use of multiple methods of collecting data, and multiple investigators from different disciplines, permits triangulation of findings, which enhances their validity [21]. Researchers were tasked to ensure that all experiences recounted were recent (defined as in the last year) and personal, or reported the accounts of an older family member or close friend, to minimise the risk of hearsay evidence.

Since the consultation processes were part of a statutory inspection, approval was not sought from ethics committees, in line with the regulators’ practices. However, the research team sought informed consent from all participants.

**Public listening events**

Public consultation meetings can contribute to appraisal of citizens’ views, but only when part of a portfolio of methods and when organised to maximise attendance and participation [22]. Events were publicised through local organisations of older people, accessible venues and transports were arranged. A member of the research team took detailed notes of all the discussions, with a sample tape-recorded for quality control. Members of the Healthcare Commission observed these events to provide an independent view. Interpreters assisted with communication.

**Nominal groups**

Nominal groups were held with older people, using existing organisations (voluntary sector groups, community centres) as the source for and site of these groups as well as those at the listening events. Nominal groups are led by a facilitator who directs the discussion to consider a number of questions, and focuses attention on achieving a common understanding of these questions, and their answers [23]. A nominal group technique designed for complex problems was chosen, to
allow small groups of older people to debate the questions and to contribute from their own experiences [24]. Each group was facilitated with observers taking detailed notes and a sample recorded.

**Individual interviews**

Interviews were conducted with individuals who had personal experience of local services for falls, stroke and mental health in the previous year, since the Healthcare Commission had identified these topics as key developmental areas. Older people were identified in one of the three ways: (i) through contacts at listening events and nominal groups; (ii) from response to invitations for personal experiences issued through voluntary and community groups, patient participation networks, local media and (iii) snowballing methods. Individual interviews were chosen to gain inside perspectives, detailed understanding of how local services functioned, and frames of reference for the key conditions (stroke, mental health and falls) [25]. A sample of interviews was tape-recorded and transcribed.

**Quality assurance**

Quality assurance in the whole consultation process was ensured by: (i) training OPRSI members in the semi-standardised enquiry method; (ii) briefing and de-briefing following data collection (iii) observation by research team leaders; (iv) multi-disciplinary analysis of the findings.

**Data analysis**

In each locality, the data were reviewed by the multi-disciplinary research team and OPRSI. An analytic induction technique [26, 27] was used with initial hypotheses being checked against empirical data, particularly for falsifying evidence. A consensus approach [22] was taken to produce a local report that was submitted to the Healthcare Commission’s inspectors for comment. At the end of the study, the research team met in a consensus conference. Through a process of progressive focussing [28] on the research question, the research team identified the overarching themes arising from the consultation, and these are presented in this article.

**Findings**

A total of 1,839 people participated in public listening events, 1,639 took part in nominal groups and 120 were interviewed individually. Table 1 shows the distribution of participants across the study sites, and their demographic characteristics. The population profile of the study reflected area profiles with the exception that the great majority of those responding were community dwelling, were not severely cognitively impaired and were more likely to be from a minority ethnic group than overall older population profile of England. The results presented here do not include findings about falls, stroke and mental health services, which will be reported separately.

We identified three findings that encapsulated older people’s experiences of health and social services. These relate to knowledge, identity and personalisation.

1. **Knowledge**

The NSFOP was not widely known about, except amongst a small minority of older people who were involved in voluntary organisations and community politics, who had participated in public and patient involvement exercises, or who had been health or social care professionals themselves. This aspect was apparent not only in the narrative of participants, but also evident in their responses to direct questions. The term ‘intermediate care’, a specific service development promoted by the NSFOP, was also generally not known to older people. Whilst ‘rehabilitation’ was a term used to explain what was considered by older people to be the desirable professional goal in hospital care, many felt that the actual goal was to accelerate discharge. Aspects of health promotion were known but largely associated with other public services rather than joined up to health provision (Box 1).

### Box 1—Knowledge

‘It means just another management excuse to get rid of doctors and nurses and appoint managers to manage the few that are left.’ (IS8 NG3)

‘Yes (has heard of NSFOP). I’m on the LIT (local Implementation Team), it’s a lot of money for desk jobs. There is still much age discrimination and a long wait for hip replacements.’ (IS1 NG31)

‘My flat had to be adapted for a wheelchair—a large amount was done before I came out of hospital (following amputation of leg)—I had someone come along and assess me—they arranged for a ramp. I moved here to be near my family—they take up the slack—social services is very good.’ (IS6 NG1)

‘It all started (exercise classes organised by older people) because so many people who had heart problems wanted to continue exercise rehabilitation but could not. Most had tried other places. The leisure centre at the school seemed to be reluctant to take on people who had heart problems (there was talk of someone dying in the changing room). And the leisure centre costs more than we do.’ (IS6 Int7)

2. **Identity**

Older people responded in large numbers to an invitation to discuss services for older people as an explicit category, and many identified themselves as ‘older people’ and had differences in views that this made to their treatment and care. There was limited discussion about the rights that older people have, most evident but not confined to disabled people who had grown older. Some negative personal experiences of using services were attributed to staff attitudes towards ageing (Box 2). The concept of the role of carer was
widely understood and accepted, and many had expectations of support for themselves as carers and that this role should be recognised by health care practitioners.

Box 2—Identity

‘I do detect a difference between the physical disability team and the older persons’ team. They [i.e. former] will provide respite care for people under 65 at a specialist centre but it’s like pulling teeth to get someone over the age of 65 there for the first time.’ (IS8 NGMS)

‘I was admitted (to hospital), not able to breathe properly. They asked me a lot of questions and then assumed that I was confused because of my age.’ (IS3 LE)

‘[In local hospital], there is a distinct lack of recognition of carers. I now make a point of going in with my wife and it’s often as if I am not there. If I phone, they say they can’t talk to me [but] my participation is vital.’ (IS8 Int 2)

‘The wife had an operation in Hospital recently but there was no consultation with me, her carer. I was told she was being discharged on the day, no one bothered to talk to me to see if I felt it was the right time. I thought I was a bit early. There was nothing in the hospital records to identify that I’m her carer.’ (IS6 NG7)

3. Personalisation

Although the quality and range of treatment now available in primary care were appreciated, access to general practitioner (GP) services was seen as worsening. This change was perceived as recent, and was contained within a view that GP services were less personal and less tailored to the individual compared to the past. There was virtually no mention of older people waiting for outpatient appointments, inpatient care or on trolleys in A&E departments, but hospital treatment was seen as potentially risky (lack of cleanliness and infection), insufficiently caring (insufficient help with eating and drinking) and sometimes disorganised, unprepared or over-zealous around discharge. However, positive experiences offset negative ones, and there were expressions of surprise at the improvement in hospital treatment noted in all localities. Social care in the home was seen in diverse ways, by some as excellent, sensitive and personalised, but by others as fragmentary, hurried and impersonal (Box 3).

Discussion

The validity, applicability or transferability of qualitative research findings depend on the judgement of the reader, who can decide on the authenticity of the accountability and ideas presented [25]. No qualitative research can give assurances of representativeness, since research is unethical if coercive, but we believe that the findings reported here will be congruent with the experiences of many professionals providing services to older people.

As a whole, older people consulted in the 10 inspection sites were not aware of a national policy initiative designed to improve health and social services provided to them, in terms of their both technical and experiential quality. This is despite the wide and extensive consultations that preceded the publication of the NSFOP [24]. This will be disappointing to the architects of the NSFOP, and may explain the perceived need for a relaunch [29]. However, older people are very conscious of changes in health and social services, as our findings demonstrate.

Four points are discussed in this paper. The first is that although the older people identify themselves as older citizens with similar interests, they can also have different or overlaid identities, which at present emphasise some roles (being carers) rather than others (being citizens with rights) (Box 2). The second is that the older people perceive the changes underway in health and social care as a mixture of losses and gains, appreciating the speed and efficiency of treatments in both primary and secondary care, whilst also lamenting the loss of the kinds of personalised support and relationships with which they had been familiar. These personalised relationships had in the past navigated the system on older people’s behalf, rather than encouraged
them to act as citizens with rights or even as consumers of services (Box 3).

**Box 3—Personalisation**

"There is a local health centre, and that, as far as I can see, is pretty efficient. My doctor’s surgery is there; I go there for blood tests, x-rays and that sort of thing. It seems pretty efficient; there is a built-in pharmacy, so I don’t even have to go to a chemist’s shop in the high street to get my prescriptions." (IS2 NG5)

‘What I find with the NHS, I have noticed and personal experiences of my elderly neighbours is: at one time the GP would regularly visit the elderly but not now. They are trying to educate the elderly now; if they don’t ring they won’t get a visit. They tend not to bother the GP. Their attitude is they should wait for doctor. One neighbour has Alzheimer’s and they suffer in silence. I offered to ring for them but they think they should get a visit.’ (IS4 Int4)

‘There’s enough people keep coming and going out. I don’t like that. I like a permanent person. If you come regular then you know where you are, but to have them coming in when they want to, and how they want to, and sometimes they were 2 or 3 hours late.’ (IS6 Int15)

‘. . . carers they’re not trained—just bodies that come to your house or flat. I had a girl—she could only have been 20—she couldn’t cook a bacon sandwich—she was only 20 or so—very pretty but she was no good—I had to get rid of her.’ (IS8 NG6)

‘There are not enough staff in hospital to see to different people’s needs. I didn’t feel safe when the woman in the bed opposite threw a jug of water at me in the night ‘cos she was scared. She was moved but they could have seen it coming and it would have been better for all concerned.’ (IS3 NG8)

‘I went to hospital and was dealt with immediately, no long wait, an improvement in the delivery of service’. . . ‘the local hospital was reported in the newspaper as one of the worst hospitals but as she (above) has reported the good treatment she had, it goes to show that you cannot believe everything you read.’ (IS8 NG2)

The third theme is that the specific mixture of losses and gains (less accessible but higher quality GP services, hurried but more flexible home care, faster but riskier hospital treatment) is altering expectations of health and social care. Older people complaining about the fragmentary nature of health and social care did not discuss their fears of being ‘put in a home’, for example, or of long waits for surgery, rather their concerns centred more around the changing expectations of nursing care, the inconsistent nature of social care and issues about recruitment and retention of social care and heath staff (Box 3). The noticeable absence in this discourse is any distinction between age-specific services and general services.

Finally, as Box 1 illustrates, participatory mechanisms designed to engage citizens in local service development in general, and the implementation of the NSFOP in particular, do not seem to reach many older people, but perhaps this is not surprising if older people do not see themselves as citizens with rights, and participation and communication mechanisms are under-developed. Or perhaps the real improvements that older people perceive and hear about make them modify their critical perceptions. Impersonal care, or even lack of cleanliness in hospitals, may be seen as a price worth paying for timely and effective treatment that enhances the quality of life following treatment (Box 3).

**Limitations of the study**

Each of the consultation methods is limited but together their combined strengths, and the scale of the consultation process, allow us to draw transferable conclusions from this study about the perspectives of older people, unmodified by other stakeholder perspectives, feelings of obligation or gratitude, or by new policy considerations. The iterative exchanges within the research team and the sharing of detailed examples and individual narratives with the Healthcare Commission meant that all findings and local conclusions were open to scrutiny and challenge. The multidisciplinary nature of the research team helped contain and reduce professional and personal biases. The risk of the researchers importing their own views or interpretations was also minimised by the multidisciplinary background of the research team, the balance of lay and professional memberships, including older people who had experiences of service use and other members who had none, and the constant comparative checking with the Healthcare Commission. All qualitative analysis is a process of reduction and it is recognised that this can compromise the totality of the qualitative data [28]. However, in this study the risk of oversimplifying rich data was offset by the iterative processes described above.

**Conclusion**

Has the NSFOP had an impact, from the very different and varied perspectives of older people? If asked older people do not perceive improvements as the result of a NSFOP, but nonetheless they do perceive improvements in systems. It is difficult to attribute any of the changes in experience that we identified to the NSFOP itself, but we can see that some change processes run contrary to some aspects of the NSFOP whilst some trends are congruent with the aspirations of the NSFOP. For example, making practice more evidence-based and more efficient at the same time may weaken person-centredness and reinforce perceptions of ageism. We are not alone in identifying the benefits of policy exhortations and improvement plans as diffuse and complex, and some have argued that only very close attention to local detail or context will permit specific tracking of policy drivers [30]. Expectations are changing however and at the end of the 10 year implementation period of the NSFOP
it may be that these will affect the judgements about the balance or pattern of gains and losses that we have identified.

Key points
• The National Service Framework for Older People (NSFOP) gave new direction to older people’s healthcare and local government services in England by setting out a series of service targets and provided a continuing impetus for system review and change at local level.
• A multi-method study of older people’s views and experiences revealed that most are not aware of this policy designed to improve the quality of health and social services that they receive, some 4 years after its implementation.
• The timeliness and efficiency of primary care and hospital services have improved, but accessibility to general practitioners has worsened, social care is often described as fragmented and impersonal, and hospitals are perceived by some as risky, uncaring and disorganised around discharge.
• Older people understand the identity of carer and the need to support carers but are less likely to see themselves as having rights to good quality care.

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None

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Jill Manthorpe was the lead applicant on the proposal and was overall project manager. Roger Clough was a co-applicant on the proposal, facilitated groups and trained the researchers and analysed the data. Michelle Cornes was the project coordinator and collated and analysed all data. Les Bright was a co-applicant and facilitated groups and conducted interviews. Steve Liliffe was a co-applicant on the proposal, analysed the data and wrote up the project findings. Jo Moriarty conducted focus groups and interviews, analysed the data and wrote up the project findings. OPRSI conducted focus groups and interviews and commented on the study findings and local reports.

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Does vitamin D stop inpatients falling? A randomised controlled trial

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Abstract

Background vitamin D deficiency is common in older people and may increase risk of falls and fracture. Hospital inpatients are at particular risk of falling. Previous studies suggest that vitamin D improves neuromuscular function and reduces falls.

Objective to determine whether routine supplementation with vitamin D plus calcium reduces numbers of fallers and falls in a cohort of hospital admissions while they are inpatients.

Design randomised, double-blind, controlled study.

Participants two hundred and five acute admissions >65 years to a geriatric medical unit.

Methods patients were randomised to intervention of daily vitamin D 800 iu plus calcium 1,200 mg or control group of daily calcium 1,200 mg, until discharge or death.

Results baseline characteristics were similar in both groups with a median age 84 years and a median length of stay = 30 days (IQR 14.75–71.00). In a pre-selected sub-group (54/205 participants), median admission vitamin D level = 22.00 nmol/l (IQR 15.00–30.50). This did not significantly increase in the treatment versus control group. Median study drug adherence = 88%, with no significant difference between study groups (Mann–Whitney: \( P = 0.711 \)). Although there were fewer fallers in the vitamin D cohort, this did not reach statistical significance (vitamin D: calcium = 36:45 fallers; RR 0.82 (CI 0.59–1.16). Neither the mean number of falls (vitamin D: calcium = 1.040:1.155; Mann–Whitney \( P = 0.435 \)) or time to first fall (Log-rank test \( P = 0.377 \)) differed between groups.

Conclusions in a population of geriatric hospital inpatients, vitamin D did not reduce the number of fallers. Routine supplementation cannot be recommended to reduce falls in this group.

Keywords: vitamin D, accidental falls, elderly, hospitalisation, randomised controlled trial