



Editor: David Lubel

# B G S

n e w s l e t t e r

## Clinical governance



**T**he Society recently initiated a draft position paper on the subject of clinical governance.

The concept of clinical governance was initiated by the White Paper, *The New NHS, Modern, Dependable*,<sup>1</sup> December 1997. "The new NHS will have quality at its heart... Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality."

The concept was further developed in the second White Paper, *A First Class Service - Quality in the New NHS*,<sup>2</sup> July 1998, which defined it as "a framework through which the NHS organisations are accountable for continuously improving the quality of their services and safeguarding high

*standards of care by creating an environment in which excellence in clinical care will flourish."*

It is against this background that the BGS initiated a draft position paper for geriatric medicine leading to the document prepared by its working group, chaired by Prof Cameron Swift and reproduced below.

Prof Swift described its principles as generic so that it could be adopted by the Royal Colleges in England and Scotland, and adapted to Northern Ireland and Wales, to reflect the different health structures, within existing and future regional political frameworks.

### Clinical governance in Scotland - steps ahead!

There already exists a Scottish Clinical Governance Group (SCGG) which, since this Newsletter went to press, has already provided addenda to Prof Swift's document to reflect the different legal and organisational structures in Scotland. Unfortunately, we could not incorporate these amendments in this issue of the Newsletter, but will report them in the July issue.

The aim is to achieve common standards across the UK.

### General introduction

This position paper has been prepared by a joint working group of the BGS (see Appendix, page 11 for membership). The concept of

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FOR HEALTH IN OLD AGE

'Clinical governance' continued from page 1

clinical governance is, in many respects, built into the heart of the specialty of geriatric medicine. In the UK this has been reflected particularly in:

- 1 the commitment of specialists in this branch of medicine to assume accountable leadership in the delivery of comprehensive services to a patient population historically vulnerable to sub-optimal standards of provision; and
- 2 the degree to which progress in the field (in the British Isles and beyond) has been regularly achieved through internal and external scrutiny of successful and cost-effective models of care.

The move towards a more formal recognition and scrutiny of standards - in professional practice, patient care and service organisation -

**A MORE FORMAL RECOGNITION AND SCRUTINY OF STANDARDS IS WARMLY WELCOMED BY THE SOCIETY**

is, therefore, warmly welcomed by both the BGS and the Royal Colleges of Physicians of the UK (respectively

the representative specialty society and the institution responsible for the training and recognition of specialists). It has provided an opportunity to prepare a strategic and organised approach to the measurement and maintenance of standards, in which we believe the specialty is well placed by virtue of its background and evolution to take a creative lead role.

## 1 Policy background

- 1.1 The first White Paper<sup>1</sup> introduced the concept of clinical governance requiring practitioners to accept the responsibility for developing and maintaining standards within their local NHS organisation.
- 1.2 The second White paper<sup>2</sup> developed this topic in some depth. Paragraph 3.11 states that a clinical governance framework will:
- ◆ modernise and strengthen professional self regulation and build on the principles of performance review; and
  - ◆ strengthen existing systems for quality control, based on clinical standards, evidence based practice and learning lessons of poor performance.
- 1.3 The British Association of Medical Managers, states<sup>3</sup> that clinical governance sets

out to ensure that:

- ◆ systems to monitor the quality of clinical practice are in place and functioning properly;
- ◆ clinical practice is reviewed and improved as a result; and
- ◆ clinical practitioners meet standards, such as those set by national professional regulatory bodies.

1.4 In July 1998, the RCP London published a discussion document<sup>4</sup> 'Self Regulation in clinical governance' and encouraged all fellows and members to participate fully in local mechanisms to achieve it. The Colleges have indicated their wish to work in close collaboration with specialist societies.

1.5 In February 1999, the RCP<sup>5</sup> set out the key components of clinical governance for physicians as:

- ◆ appraisal;
- ◆ continuing professional development (CPD) (the term within this paper will be understood to incorporate continuing medical education (CME));
- ◆ participation in national audit; and
- ◆ peer led service review.

1.6 The General Medical Council (GMC) has voted to accept the principle of revalidation, liable to involve personal portfolios of appraisal, CPD and audit.

1.7 This position paper has been developed as a collaboration between the RCP and the BGS.

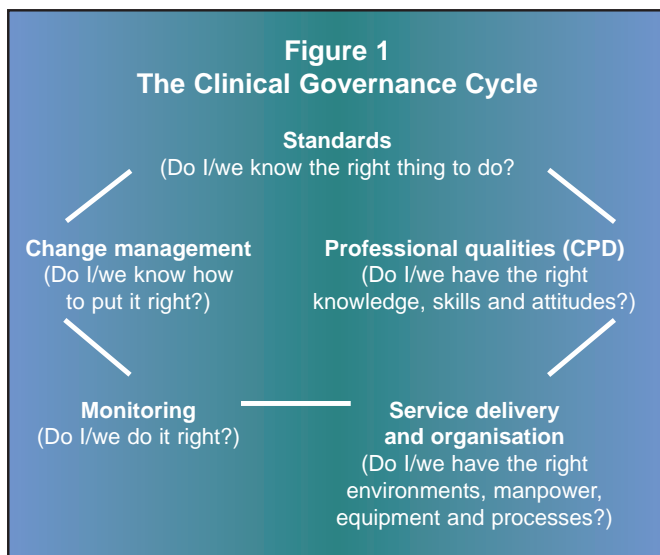
## 2 Basic concepts

- 2.1 Developing a framework to promote clinical governance presents an opportunity to integrate a range of important initiatives in the quality of patient care, professional practice and service provision.
- 2.2 These include (for example) clinical audit, service organisational audit, patient charter standards, benchmarking, peer review, clinical guidelines, and clinical pathways, all of which are currently disparate, and to all of which the profession exhibit variable commitment.
- 2.2 Clinical governance offers a distinctly positive focus on the quality of care of patients (both as individuals and groups) as the unifying *raison d'etre* for these policy initiatives.
- 2.3 A properly structured system will ensure clear lines of accountability and coordination within which the practising consultant will operate for clinical governance purposes. It will entail a degree of mutual responsibility encom-

passing the individual specialist and the organisational context of his or her professional practice. Thus, clinical governance procedures are anticipated to be widely represented at departmental, trust, local district (e.g. Commissioning Authority/PCG Commission) and national levels, with advisory input as required.

**2.4** This paper comprises four sections:

- 1 an integrated common scheme for clinical governance; and
- clinical governance recommendations for:



- 2 individual practitioners;
- 3 the service within an organisation; and
- 4 the services within a group of organisations (i.e. focused on a natural community as opposed to a single provider organisation).

**2.5** The emphasis is on the key principles and practice of clinical governance implementation that are broadly applicable to all settings within the UK. Details of procedure are expected to vary, particularly in Wales, Scotland and Northern Ireland.

**2.6** The recommendations are applicable to consultant practice in geriatric medicine. Further work will be required to clarify the requirements for specialists in non-training grades other than consultant.

### 3 Integrated common scheme for clinical governance

The following outline endeavours to integrate the components of clinical governance, and to incorporate the different strands of activity within those components.

**3.1** The purpose of this approach is to enable individual specialists and the organisations in which they work to utilise all of the elements of clinical governance effectively, and not add to a disparate list.

**3.2** Clinical governance can be viewed from three main perspectives, i.e.:

- ◆ the individual consultant;
- ◆ the service within an organisation; and
- ◆ the service within and between organisations (including non-NHS organisations, e.g. Social Services and the independent sector).

The recommendations in this paper have been separated for each level, even though, in practice, the division is less clear cut.

### 3.3 The clinical governance cycle

Each set of recommendations has been made with reference to the model in Figure 1. It should be noted that, unlike other cycles, the clinical governance cycle may be entered at any stage.

#### A Standards

These include:

- 1 professional standards, as directed by the General Medical Council;
- 2 NHS clinical standards, as identified by the National Institute for Clinical Excellence;
- 3 legal standards, as directed by the law of the land;
- 4 procedural standards, as directed by external bodies e.g. the Clinical Negligence Scheme for Trusts;
- 5 Patient Charter standards; and
- 6 National Service Frameworks.

#### B Professional qualities

These are generic as well as specific to the service characteristics and needs, are developed by CME/CPD, and should be focused on a continual lifelong learning philosophy.

#### C Service delivery and organisation

This includes structures and processes of care, use of guidelines and protocols, routine procedures such as the use of assessment technology, and the systems for generating data for monitoring. It will involve identification both of the evidence-base underpinning practice and the relevant criteria and structures for performance monitoring e.g. peer review, external agency evaluation, benchmarking, national audit

programmes and patient satisfaction.

**D Monitoring**

Monitoring includes (amongst others):

- 1 clinical and service audit (local and national);
- 2 complaints;
- 3 Health Ombudsman reports;
- 4 risk assessment;
- 5 Caldicott Guardian reports;
- 6 national indicators' results;
- 7 critical incident reviews;
- 8 Royal College training visit reports;
- 9 national patient surveys;
- 10 service agreement performance;
- 11 health improvement plan performance; and
- 12 external body reviews (e.g. peer review/ Health Advisory Service (HAS) 2000 visits).

**E Change management**

This includes all those processes that can be utilised to improve the quality of care, which should initially be focused, where possible, on positive actions to improve the system of care rather than on negative actions to blame and discipline. Such actions may include improvements in service, operational policy, education, training, manpower, environment, equipment and funding. Approaches that include continuous quality improvement and total quality management should also be considered.

**4 Clinical governance recommendations for individual practitioners**

**4.1 Standards, professional qualities and service provision**

4.1.1 Central to maintaining and improving standards are the concepts of CPD (including

CME) and self-assessment. Consultant physicians will be required to demonstrate their state of knowledge

and organised and demonstrable CPD is expected to become mandatory. Innovative and interactive CPD programmes that incorporate self-assessment are currently being developed.

4.1.2 *A First Class Service*<sup>2</sup> states that personal development (CPD) plans should be developed for all staff by April 2000.

4.1.3 Each consultant should ensure and be able to demonstrate that part of his/her person-

al CPD portfolio is dedicated towards a 'departmental development plan' (DDP) (see 5.2).

**4.2 Monitoring and change management**

4.2.1 Appraisal can be defined as *"the use of systematic methods regularly to review the work of senior hospital doctors. It is an inclusive term whose use can only be justified if it includes both the clinical and non-clinical aspects of a consultant's work and focuses on both the performance of the individual and the performance of the units and departments in which they function"*.<sup>6</sup>

4.2.2 All consultants in geriatric medicine should have an annual appraisal, including an annual review of the job plan. This will include review of clinical activities, audit, CPD and information from all other monitoring arrangements. The process should involve at least one other consultant in geriatric medicine.

**4.3 Educational aspects of CPD**

4.3.1 Education should help to attract, motivate and retain high calibre staff.

4.3.2 Education includes the following:

- ◆ maintaining and increasing the knowledge base;
- ◆ honing and teaching professional skills e.g. teaching, learning, appraisal, interviewing, management, team work; and
- ◆ reassuring consultants on their clinical skills and professional abilities.

It also enables consultants to:

- ◆ keep up-to-date;
- ◆ identify their strengths and potential;
- ◆ identify their defects, and to correct them;
- ◆ learn new skills to meet service requirements or developments; and
- ◆ apply their knowledge and skills in the practice setting.

4.3.3 Education is largely based and assessed locally. Each department will be required to ensure that:

- ◆ suitable facilities exist (5.8);
- ◆ a local CPD co-ordinator is appointed;
- ◆ a yearly appraisal of each individual occurs, identifying strengths and deficiencies (over the range in 4.3.2);
- ◆ the educational and training needs of the service are discussed with individuals;
- ◆ suitable educational opportunities are known to the individual and are present locally or nationally, taking into account different preferred ways of learning;

**INNOVATIVE CPD PROGRAMMES INCORPORATING SELF-ASSESSMENT ARE NOW BEING DEVELOPED**

- ◆ sufficient work time is protected for both internal and external education;
- ◆ methods of self-audit are available and confidential; and
- ◆ every consultant has a personal learning plan, derived from personal wants and needs, as directed by the national programme, DPP and remedying potential identified deficits.

**4.3.4** Education programmes will be developed nationally. This professional curriculum will be at several levels, with time intervals set for completion and repetition. It will outline the knowledge and expertise that:

- ◆ every consultant must possess and demonstrate as up-to-date (locally taught);
- ◆ are desirable for consultants in this specialty

**'DEPARTMENTAL DEVELOPMENT PLANS' SHOULD BE FORMALISED**

(locally taught and evidence-based); and

- ◆ are optional (acquired at national level, not necessarily evidence-based subjects requiring analysis and consensus, 'what's new' list, and courses to cover such subjects).

**4.3.5** Assessment of every consultant will be undertaken annually by:

- ◆ individuals using self-audit and distance learning programmes on national curriculum and core requirements;
- ◆ local appraisal by colleagues and managers, and attendance at courses and meetings; and
- ◆ national CME returns of attendance at meetings.

**4.3.6** The implementation of assessment in practice will include the following:

- ◆ Individual consultants will be required to demonstrate that they have undertaken self-audit activities and that, when necessary, specific measures to deal with unmet performance or CPD needs have been pursued.
- ◆ Clinical governance lead consultants at the departmental and Trust level will be required to provide evidence of the appropriate annual appraisals and the identification of personal learning/CPD plans.
- ◆ Colleges (in partnership with the BGS) will be able to produce, for every individual consultant and for organisational clinical governance lead consultants, a national CME return of attendance at CPD and related activities.
- ◆ RCP visits and Commission for Health Improvement (CHI)/HAS 2000 visits will require from each individual consultant an up-

to-date personal learning/CPD portfolio. (Such a personal portfolio will include the personal learning/CPD plan, the resultant activities that have taken place, and an evaluation of the impact of both on professional practice. If an activity was in response to an explicit need, evidence of the appropriate professional development will be required).

## **5 Clinical governance recommendations for the service within an organisation**

### **5.1 Standards**

**5.1.2** Each department of geriatric medicine should have a nominated lead consultant in organisational service quality.

**5.1.3** All consultants in geriatric medicine (especially the lead consultant in organisational service quality) should be able to demonstrate their knowledge and expertise with respect to each element of the clinical governance cycle for organisational service quality.

### **5.2 Professional qualities**

**5.2.1** Each department of geriatric medicine should draw up and formalise a DDP to overcome identified deficits and develop the quality of service provided.

**5.2.2** Each consultant should ensure and be able to demonstrate that part of his/her personal CPD portfolio is dedicated towards the DDP.

**5.2.3** Departments of geriatric medicine should have available to them a set of expert services to help improve the quality of their services. These services should be at the organisation or district level and include:

- 1 educational facilities in CPD, work-based learning, distance learning and the ability to access skills laboratories or skills training centres;
- 2 library resources including access to the medical and scientific knowledge and research base e.g. electronic libraries, literature search facilities, up-to-date internet technology resources;
- 3 'clinical effectiveness' resources;
- 4 information management and technology resources, to acquire and manipulate national data, especially benchmarking data; and
- 5 monitoring resources, especially in clinical audit.

### **5.3 Service delivery, organisation and monitoring**

**5.3.1** Each department of geriatric medicine should be able to demonstrate its application

and integration of the range of quality of care monitoring activities.

**5.3.2** External peer review should be welcomed and planned on a recurring basis. This can be undertaken:

- ◆ with reference to existing and developing mechanisms identified by the BGS/RCP; and
- ◆ as part of the CHI, as a statutory NHS process.

**5.3.3** Organised peer review has been a long-standing part of the culture of British geriatric medicine and its strengths and multidisciplinary

**EXTERNAL PEER REVIEW SHOULD BE WELCOMED AND PLANNED ON A RECURRING BASIS**

nature are represented in the recently reformulated HAS 2000 which, it is hoped, will become the statutory arm

of CHI for geriatric medicine services. In 1996-97, the BGS was instrumental, together with the Royal College of Nursing Research Unit, the Royal College of Psychiatrists and the Office for Public Management, in a successful initiative to re-establish the HAS as a new organisation. HAS 2000 has now developed as a new and effective organisation, actively involved in systematic service evaluation<sup>7</sup>. It recently produced a key report *Not Because They are Old*<sup>8</sup>, expected to have a major impact on the development of the new National Service Framework for the Care of Older People.

**5.4 Change management**

**5.4.1** Deficiencies in service provision in any setting (especially if they occur frequently or arise from differing monitoring methods) will be required to have an explicit, available, remedial action plan.

**5.4.2** The effectiveness of any action plan should be measurable by one or both of the following:

- ◆ the development of a new service; and
- ◆ improvement in the monitoring data which first identified the problem.

**5.4.3** Consultants in geriatric medicine should have available to them:

- ◆ organisational (e.g. Trust level) clinical governance arenas for the resolution of quality issues which cannot be resolved within their own departments; and
- ◆ district level clinical governance arenas for the resolution of quality issues, which cannot be solved without changes in other organisations.

**6.0 Inter-organisational service quality**

**6.1** Each natural community, e.g. a district health authority boundary, should have a clinical governance group which oversees the inter-organisational service quality issues and ensures the system of care for the patient is appropriately integrated. This should include the input from non-NHS agencies and the public, as well as local NHS organisations.

**6.2** The 'district' clinical governance group should consider district-wide quality initiatives, e.g. the health improvement plans, or district-wide concerns about the quality of a service due to inter-organisational factors.

**6.3** The reports and recommendations of the district group should be made available to the clinical governance lead for departments of geriatric medicine.

**6.4** The district group should act as an arena whereby quality of service issues, which cannot be solved through normal departmental and organisational routes, can be addressed if they meet the criteria identified in 6.2.

**6.5** The district group should have access to a similar set of expert services as the organisational groups (see section 5.2.3)

**6.6** Inter-organisational service quality will need external assessment by the CHI. As yet, HAS 2000 does not include these measures as part of its portfolio, but it is anticipated that these will be developed over the next one to two years.

**7.0 Summary of immediate recommendations**

**7.1** All consultants in geriatric medicine should welcome and introduce local appraisal mechanisms, including personal development plans, by April 2000

**7.2** All departments of geriatric medicine should identify a nominated lead consultant in organisational service quality and a CPD co-ordinator, and should set in place a DPP.

**7.3** The BGS and the Royal Colleges of Physicians will continue to collaborate in the development of the necessary innovative and interactive CME programmes.

**7.4** The BGS and the RCP will support work to enable HAS 2000 become the statutory arm of CHI for geriatric medicine services.

**7.5** The BGS will undertake and promote further work in the identification and evaluation of national and individual performance measures.

**References**

- 1 *NHS: Modern, Dependable*. DOH, 1997.
- 2 *A First Class Service, HSC 19991033*. DOH, 1998.
- 3 *Clinical Governance and the New NHS*. The British Association of Medical Managers, 1998.
- 4 *Role of the Royal College of Physicians in Regulation of Clinical Governance Consultation Government*. RCP, July 1998.
- 5 *Physicians Maintaining Good Medical Practice: Clinical Governance and Self-regulation*. RCP, February 1999.
- 6 *Appraisal for Senior Hospital Doctors: Statement from the Central Consultants and Specialists Committee*. BMA, London 1998.

- 7 *HAS First Annual Report*. HAS 2000, 1998.
- 8 *Not Because They Are Old*. HAS 2000, 1998.

**Appendix**

Membership of the Joint BGS/RCP Clinical Governance Working Group:

- ◆ Prof C G Swift (Chairman) (BGS President Elect);
- ◆ Dr D Black (RCP Geriatrics Committee Chairman);
- ◆ Prof C M Castleden (BGS Director of CME/CPD);
- ◆ Dr F C Martin (BGS Policy Committee Chairman); and
- ◆ Prof M Severs (Professor of Health Services Research, University of Portsmouth).

# Performance Assessment Framework



**The NHS Performance Assessment Framework was launched in April 1999**

The Framework's accompanying *Health Service Circular (HSC 1999/078)* made clear that Health Authorities, Primary Care Groups and NHS Trusts working with local Social Services departments were to begin using the Framework from April 1999 to assess local performance, support the development of local Health Improvement Programmes and account to Ministers and the public for performance.

The Framework was outlined in The NHS White Paper, *'The New NHS, Modern Dependable'*. It covers six areas, namely: health improvement; fair access to services; effective delivery of appropriate healthcare; efficiency; the patient and carer experience; and the health outcomes of NHS care. It is accompanied by a set of High Level Performance Indicators (HLPIs) which are intended to flag up the need for further investigation and action. Last spring, details of both were published in a consultation document to which the BGS responded (see Newsletter May 1998). The present document, which is for action, is the outcome of this consultation exercise and road testing of the

Framework and HLPIs which involved all Health Authorities last summer.

The following points are worth emphasising.

**1 The revised Framework seems to be identical to the one put out for consultation.**

**I Health improvement**

**Aspects of performance** - The overall health of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies.

**II Fair access**

**Aspects of performance** - The fairness of provision of services in relation to need on various dimensions: geographical; socio-economic; demographic (age, ethnicity, sex); and care groups (e.g. people with learning difficulties).

**III Effective delivery of appropriate health care**

**Aspects of performance** - The extent to which services are: (1) clinically effective (interventions or care packages are evidence-based); (2) appropriate to need; (3) timely; (4) in line with agreed standards; (5) provided according to best practice service organisation; and (6) delivered by appropriately trained and educated staff.

**IV Efficiency**

**Aspects of performance** - The extent to which the NHS provides efficient services, e.g.: (1) cost per unit of care/outcome; (2) productivity of capital estate; and (3) labour productivity.

**V Patient/carer experience**

**Aspects of performance** - The patient/carer perceptions on the delivery of services, e.g.: (1) responsiveness to individual needs and

**IMPORTANT ISSUES RAISED BY THE BGS WERE NOT ADDRESSED IN THE REPORT**

preferences; (2) the skill, care and continuity of service provision; (3) patient

involvement, good information and choice; (4) waiting times and accessibility; and (5) physical environment, organisation and courtesy of administrative arrangements.

**VI Health outcomes of NHS care**

**Aspects of performance** - NHS success in using its resources to: reduce levels of risk factors; reduce levels of disease, impairment and complications of treatment; improve quality of life for patients and carers; and reduce premature deaths.

**2 There have been some changes to the HPLIs but the document only gives a summary of the revised HPLIs**

Two indicators about which the BGS had expressed concerns have been removed. These were district nurse contacts and avoidable diseases. **The High Level Indicator Set, 1999-2000**

**I Health improvement:**

- 1 *deaths from all causes (for people aged 15-64);*
- 2 *deaths from all causes (for people aged 65-74);*
- 3 *cancer registrations;*
- 4 deaths from malignant neoplasms;
- 5 deaths from all circulatory diseases;
- 6 suicide rates; and
- 7 deaths from accidents.

**II Fair access:**

- 1 surgery rates;
- 2 size of inpatient waiting list per head of population (weighted);
- 3 adults registered with an NHS dentist;
- 4 children registered with an NHS dentist; and

- 5 early detection of cancer.

**III Effective delivery of appropriate health care:**

- 1 disease prevention and health promotion;
- 2 early detection of cancer;
- 3 inappropriately used surgery;
- 4 surgery rates;
- 5 acute care management;
- 6 chronic care management;
- 7 mental health in primary care;
- 8 *cost effective prescribing;* and
- 9 discharge from hospital\*.

**IV Efficiency:**

- 1 *day case rate;*
- 2 *length of stay in hospital (case-mix adjusted);*
- 3 unit cost of maternity (adjusted);
- 4 unit cost of caring for patients receiving specialist mental health services (adjusted); and
- 5 *generic prescribing.*

**V Patient/carer experience of the NHS:**

- 1 *patients who wait more than two hours for emergency admission (through A&E);*
- 2 *patients with operations cancelled for non-medical reasons;*
- 3 delayed discharge from hospital for people aged 75 or over\*;
- 4 *first out-patient appointments for which patients did not attend;*
- 5 out-patients seen within 13 weeks of GP referral; and
- 6 percentage of those on waiting list waiting 12 months or more.

**VI Health outcomes of NHS health care:**

- 1 conceptions below 16;
- 2 decayed, missing and filled teeth in five-year old children;
- 3 adverse events/complications of treatment;
- 4 emergency admissions to hospital for people aged 75 and over\*;
- 5 emergency psychiatric re-admission rate\*;
- 6 *infant deaths;*
- 7 survival rates for breast and cervical cancer;
- 8 *avoidable deaths;* and
- 9 in-hospital premature deaths.

Those in italics were in the draft list and have not been revised so presumably any reservations expressed by the BGS remain. Those marked ‘\*’ are now termed ‘interface indicators’ because

they relate to performance at the health/social care interface and will be included in the HPLI sets for the NHS Framework and the indicator set for the Personal Social Services Performance Assessment Framework. No details are given, so our concerns in these areas may not have been addressed. The other indicators have been amended or added from other sources such as the White Paper *'Our Healthier Nation'*. In the absence of more data no comment can be made. One suspects that important issues raised by the BGS, such as the need to look at outcome in terms of disability, have not been addressed.

### 3 The need to improve data quality must be given high priority

It was reassuring to read the acknowledgement *'that the information requirements of the Framework are beyond the scope of currently established information flows'*. Most of us do not have access to information systems that are clinically driven and know that much of the data collected routinely does not reflect clinical practice; therefore comparisons can be meaningless. *Information for Health* sets out the Government's intention to ensure that information is accessible, to help managers and clinicians assess their own performance, to support the identification of best practice, to compare one organisation with another and to improve performance. There is another way to go before this vision is realised.

### 4 Use of the Framework this year

The Government intends the Framework to be used: locally to review current performance across the six areas of the Framework and, thereby, to support decisions to secure improvements in local health and health care; by Health Authorities, Trusts and Primary Care Groups to inform performance and accountability arrangements and for monitoring progress across the six areas of the Framework; and by Ministers and the NHS Executive to account for the use of public funds to meet the Government objectives for the Department of Health (DOH).

It is clear that the Framework will become increasingly important: in Health Improvement Programmes; annual accountability

arrangements between a Health Authority and local Primary Care Groups; service agreements developed at clinical directorate level; the NHS/social care interface; and the annual performance agreement between each Health Authority and its regional office.

### 5 Development of Framework and HPLIs

In the short-term, the indicator set will be extended: to support the assessment of NHS Trust performance; to include quality indicators following the development of National Service Frameworks; and to support the development of the new NHS charter programme.

Work continues to develop a comprehensive, high quality indicator set capable of providing a basis for national and local assessment. This work is linked to that set out in the Information Strategy aimed at improving data quality and timeliness. It will be linked to other indicator sets and the results collated and published annually. To ensure the continued development of the Framework, a Performance Framework Reference Group will be established.

To aid comparison of performance, new units of account will be developed: 'a provider spell' to cover care provided from admission to discharge; and 'a programme spell' to cover all care delivered from beginning to end of treatment relating to a particular need. These are likely to be particularly relevant to the elderly.

### Key points

- 1 The NHS Performance Assessment Framework is Government policy. It will affect us increasingly in everyday clinical practice.
- 2 We need to work within our Trusts and local Primary Care Groups to ensure that information systems are clinically driven and that the data collected are relevant to the work we do.
- 3 The setting up of the National Service Framework for the elderly is timely as the need to set national standards and establish performance measures for our specialty is urgent.

**Rebecca Dunn**  
Hon Deputy Secretary

Copies of *The NHS Performance Assessment Framework*, can be obtained free from DOH, PO Box 410, Wetherby LS23 7LN, or telephone the NHS Staff Response Line on 0541 555 444.

**THE FRAMEWORK IS NOW GOVERNMENT POLICY AND WILL INCREASINGLY AFFECT CLINICAL PRACTICE**

# National Service Framework for Older People



## The BGS has participated in the National Service Framework (NSF) External Reference Group

### The aim of NSFs

The White Paper, *The New NHS*, set out a package of measures to drive up quality and reduce variations in service, including the introduction of NSFs. These will: set national standards and define service models for a defined service or care group; put in place strategies to support implementation; and establish performance measures against which progress within an agreed timescale will be measured.

### The use of External Reference Groups

The NSFs will adopt an inclusive process to engage the full range of views of health and social care professionals and managers, service users and carers, partner agencies, and other advocates. In this way, the NSF for Older People will focus on those parts of the NHS that are particularly important to older people. One of the key ways to gather these views is through the advice of an External Reference Group (ERG), whose members will be drawn from the groups of people mentioned above and from organisations who know how to access their views.

### Prof Ian Philp co-chairman

Frank Dobson appointed Prof Ian Philp, and Denise Platt, Chief Inspector, Social Services Inspectorate, as co-chairmen of the ERG, supporting the NSF for Older People. Amongst the other members of the ERG are Dr Chris Dunstan (see page 20), Prof Alistair Burns, Psychogeriatrician, Manchester, Prof Cameron Swift, and Theresa Harding from Help the Aged.

The ERG commenced work on 17 March 1999 with the task of advising the Department of Health (DOH) on the development of

‘generically applicable’ standards of health care and guidance on implementing the standards in relation to older people experiencing:

- ◆ stroke;
- ◆ injuries sustained as the result of accidents, especially falls, and organic and functional mental illness;
- ◆ care in acute hospitals, including palliative care;
- ◆ models of care in primary and community settings;
- ◆ transition to and from hospital;
- ◆ assessment and care management; and
- ◆ performance measures to monitor the standards.

### Task Groups

The NSF for Older People is in turn supported by several Task Groups, comprising between 10-12 members with an active interest in the particular subject. These include a group on Accidents (particularly falls), on which the Society is represented by Prof Sir John Grimley Evans and Prof Cameron Swift (chairman). Other Task Forces cover acute hospital care (including palliative care), models of primary and community care, transition to, from and within hospital, models of assessment and care management, mental illness and stroke. BGS members involved in these groups are Dr David Black, Dr Finbarr Martin, and Dr John Young (Bradford).

### Timetable

‘Emerging findings’ will be published this autumn and the final framework by April 2000. Speaking to the first meeting of the ERG in March, John Hutton, Health Minister, said *‘This is an opportunity to make a real difference to the lives of older people ... It is an ambitious remit, but timely. In this United Nation’s Year of Older People, I am determined that we shall prepare to enter the new millennium with health and social services working together to deliver standards of care in which we can all take pride’.*

**Richard Lynham**