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Evaluating the impact of the National Service Framework for Older People; qualitative science or populist propaganda?

SIR—Harwood's editorial [1] challenges the readership to decide the worth of the qualitative research by Manthorpe *et al.* [2] regarding the impact of the National Service Framework for Older People (NSFOP).

The authors acknowledge the use of purposive sampling, which led to over-representation of ethnic minorities but we are not given any data about other 'hard-to reach' groups that were involved. A lack of data regarding socio-economic, health or educational status makes results harder to interpret. Only the 120 participants interviewed were identified as having specific contact with health care services. A significant number of participants were aged 50–59, a group I would suggest who do not usually identify themselves as 'older people.'

The authors make much of the fact that the majority of older people involved had not heard of the NSFOP or intermediate care. Yet they failed to build on this by questioning the research groups about their thoughts regarding a relaunch of the NSFOP or the need for policy change directed specifically at older people.

The themes identified are identity; losses and gains; expectations (specifically around inconsistencies in social care) and knowledge of the NSFOP. Although multi-disciplinary members were involved in analysing the data, it is not clear how themes were identified and there is no specific evidence of respondent validation. Many of the quotations used do not seem to complement the themes. For example, 'They asked me a lot of questions and then assumed that I was confused because of my age' is a poignant quote which reflects both age discrimination and the way that older people perceive that they are viewed by health care professionals. Yet it does not seem to fit into any of the themes. In a robust system with review of emerging themes this problem would have been addressed.

One quote from the article is 'many felt that the actual goal [of rehabilitation] was to accelerate discharge.' But how does this affect engagement with rehabilitation services? Are there differing views about hospital-based versus intermediate care versus home-based rehabilitation? Having this knowledge would be invaluable in improving rehabilitation services and is ideally investigated by qualitative research, but the opportunity was missed.

The research question was probably always unanswerable. Maybe it would have been better to have asked, 'How do older people feel that health policy affects them? Do older people perceive a need for health policy to outlaw age discrimination?' or even, 'Do older people feel that the existence of a NSFOP actually marginalises them and excludes them from 'mainstream' medical management?'

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Reply

SIR—Dr Powell raises important points about how health service evaluation is conducted, how rapid appraisal techniques differ from so-called rigorous investigation and how difficult it is to work with qualitative methods, especially in medicine. We have three responses to make to her. First, health service evaluation that is funded by a regulatory body means that the design is given, with the result that those aged 50–59 years are included in the category 'older people' even though clinicians might put the entry age nearer to 75 years. Similarly, socio-economic, health or educational status can be included or excluded, according to the regulators' need (in our view their exclusion was correct, since they would help most in assessing the representativeness of the data, an action that is meaningless in qualitative research). Health service evaluation conducted through, say, the Service Delivery and Organisation funding stream, might give the researchers more opportunity to shape the design, but it would still be highly focussed. Neither approach would encourage researchers to ask about a relaunch of the National Service Framework for Older People when most older people had never heard of its launch.

Second, rapid appraisal follows a policy timetable, not an academic one, and so is rapid. It accepts that fuzzy and messy information emerges from using multiple methods of acquisition and frames the methodological problem as that of making sense of imprecise data in ways that fit with the views of those 'on the ground'. The Healthcare

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