

Educational implications of the National Service Framework for older people: A brief report

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Abstract

This paper gives a short account of qualitative research undertaken with a large variety of stakeholders in the early days of the National Service Framework (NSF) for Older People. The aim of the work was to explore the educational needs arising from the NSF and to inform developments in education designed to address these needs. The study identified generally positive views on the NSF but few relevant training activities. There was a strong opinion that the elimination of age discrimination should be a major target and that cross agency and multidisciplinary training would be particularly helpful. The size of the staff groups involved, the need to address those who did not specialize in older people's care (but nevertheless spent a lot of time with older people), the generally fragmentary knowledge of the whole care system possessed by those working in parts of it and service pressures were seen as obstacles to training. A number of key areas for further progress were identified including the following:

- Mental health, palliative care and intermediate care
- Addressing the needs of staff not specializing in care of older people
- Increasing the health awareness of older people themselves
- Identifying leaders for developing specific education in each service area
- Developing guidelines and milestones to measure progress
- The need for an ongoing educational "campaign"
- Pervasive education to eradicate ageism, starting in schools.

Introduction

National Service Frameworks (NSFs) are an attempt to introduce equity of provision into the NHS and to encourage clinical excellence. They are based on clinical evidence and expert opinion and depend for their implementation on managerial effectiveness and educational initiatives. This is a brief summary of a project that examined the educational implications of the NSF for older people. It will be used locally to inform a workshop involving University, Social Services and NHS staff responsible for education. More widely, it will be of interest to anybody wrestling with the educational imperatives of turning the standards of the NSF into clinical reality. A full version of the report is available on the Ageing and Mental Health research Group Website at the University of Huddersfield <http://www.hud.ac.uk/hhs/research/amh/index.htm>. This includes a fuller report of the findings including a more detailed breakdown standard by standard and an analysis of views expressed by different stakeholders or stakeholder groups.

Background to National Service Frameworks

In 1997 a radical reforming Labour government came to power. A range of reforms and programme of modernisation were introduced in both health and social care. In December 1997 a White Paper "The new NHS: Modern, Dependable" (Department of Health 1997) outlined a comprehensive new vision for the NHS. Priorities guidance on modernising health and social service (Department of Health, 1998a) extended parallel reforms to social services. Much of this emphasis on social services modernisation and the subsequent injection of funding addressed the needs of older people

At the same time that vision and values were being laid down, performance management techniques were introduced across the range of health and social provision. The quality framework involved a three-layer approach (Department of Health 1998b). National Service Frameworks (NSFs) and a National Institute for Clinical Excellence (NICE) were to set clear standards for services, technology and treatments. The NHS was to make local delivery of services dependable by professional self-regulation, lifelong learning and clinical governance (Department of Health 1999). Clinical governance placed obligations on NHS Trusts to monitor and continuously improve the quality of health care that they provided. Wattis and McGinnis (1999a) emphasized the strong link between clinical governance and continuing professional development. A National Performance Framework, an inspectorate (the Commission for Health Improvement, now the Healthcare Commission) and a National Patient and User Survey underpinned Clinical Governance. This ambitious vision for change and its detailed prescribed implementation set a massive agenda for change and demanded radical shifts in the management and clinical cultures of the NHS (Wattis and McGinnis 1999b). This is the background against which the NSF for older people, the third NSF to be introduced, was developed and released. It was intended to promote high standards for the care of older people throughout the NHS.

Do we need an educational strategy?

The NSF is so hedged about with targets and administrative deadlines, that it is tempting to question the need for an educational strategy. It might be argued that the detailed targets by themselves are sufficient to generate the required change. Our local experience with the implementations of the educational recommendations arising from the "Forget-me-not" audit of older people's mental health services suggested that even when specific areas for action were identified by District Audit, little happened without a conscious strategy to make it do so. This was in accordance with modern management theory that the best results are to be obtained not only by setting objectives but also by paying attention to process and people (Johnson and Broms 2000). It seemed reasonable to assume that the absence of a specific educational strategy and processes would at least reduce the speed of change in areas such as staff and management attitudes, knowledge and skills, and present an obstacle to implementing the NSF. This would delay or reduce the benefit to older people.

The rationale for the study and methods used

We were left with the question of what a strategy should contain. It would have been easy simply to turn to the "educational" experts but we wanted also to consider other points of view. With the aid of a grant from School of Human and Health Science's Innovation Fund at the University of Huddersfield we systematically sought the views of a wide variety of stakeholders to develop a robust view of what needed to be done. We planned to identify areas of progress and good practice and areas that needed special attention as a first step towards developing an educational strategy

Choice of qualitative methodology

We chose qualitative methods in order to:

- be open to a variety of views, reducing the effect of pre-conceived ideas
- examine the issue from a number of different viewpoints to see whether any consensus emerged
- draw upon the experience of people who had grappled with the real-life implementation of NHS policy in the past
- ensure that what emerged would provide new ideas as well as perhaps confirming or refuting some pre-conceptions.

Twenty-seven people were interviewed. These included the following:

- representatives of social services (including a training manager)
- a representative of the housing department
- representatives of intermediate care
- representatives of NHS Trusts
- nursing and residential home providers
- university educators
- a representative of the voluntary sector
- carers
- members of the general public

All interviews were conducted by one of the authors (MM), trained and experienced in this type of work, in late 2001 to early 2002. Where necessary interviewees were provided with a summary of the NSF before the interview. We sought to discover general views about the NSF and for each standard to determine what educational activities were currently available, what gaps there were and what was needed to deliver on the standards. Interviews were recorded and transcribed before being analysed using the computer programme “N-VIVO” (Gibbs, 2002). As detailed in the main report we used this programme to analyse the data, developing themes linked to nodes by an iterative process. These could then be explored in a variety of different ways, for example standard by standard or stakeholder by stakeholder.

Research Governance and ethical considerations

This study was designed and commenced before the research governance framework was implemented. At that stage it was not considered necessary to seek ethical approval for studies involving consenting members of staff. However, the research design was subject to peer review within the University. When it became evident that the new Research Governance Framework (Department of Health, 2001) required Local Research Ethics (LREC) approval, the study was halted. The study was then submitted to the LREC and, once approval was granted, was recommenced.

Findings

The findings were analysed under five headings and key findings are summarised in Box 1 with supporting quotes in Box 2.

A standard by standard analysis showed that rooting out ageism, and person centred care were seen to be fundamental tasks. Intermediate care was a new area but one where education for inter-agency working was particularly important. In the general hospital there was particular concern about lack of education for dealing with mental health problems and about interest in the NSF outside specialist older people’s services. Stroke and falls were areas where pre-existing initiatives had been strengthened by the authority of the NSF. Mental health was seen as an area where more knowledge and skills were needed not only in the general hospital but also in the community amongst home care and in residential and nursing care. Health promotion was a subject that needed to be tackled by all practitioners as part of their everyday work and education was needed to support them in this.

Box 1: Summary of emergent themes:

Views on the NSF generally

- The NSF was a good idea with much potential.
- Practical implementation was vital and required financial support
- It should address all staff and systems in health and social care.
- Those charged with implementation needed to be able to work with organisational complexity.

Current status of education and training for the NSF

- At the time of the study few relevant training strategies had been developed.
- Existing programmes might be adapted to this purpose.
- Training should arise as a result of immediate needs and should be focused.
- Cross-agency, interdisciplinary forums could improve mutual understanding.
- The elimination of age discrimination should be a major target

The gaps in and obstacles to education and training

- Target staff groups were large and consequently difficult to address.
- It was essential to reach those who did not specialise in older people's care.
- People tended not to be aware of all relevant aspects of the care system.
- The day to day operation of health care in general took priority over training.
- Joint learning, teamwork and attitude change were important targets.
- The care of older people should be promoted as an important field of study and development.
- There should be more training in areas specific to older people: e.g., dementia

Views on multi-disciplinary and inter-agency working

- There should be no 'grey areas' between separate health and social care organisations.
- We should acknowledge that these organisations worked in different ways.
- Existing rivalries must be overcome to promote integration.
- Separate budgets might be pulled together.
- Training must be related to the patients/clients needs.
- The biggest hindrance to development was claimed to be lack of coherence between health and social services.

Areas for further progress

- Mental health, palliative care and intermediate care required a special educational effort.
- Staff working in other areas needed knowledge about these areas in order to deal with the needs of older people that they cared for.
- Older people themselves need to be targeted, primarily by attempts to increase health awareness.
- Leaders ought to be identified and developed in each area of the service.
- Guidelines and milestones would help monitor progress.
- Senior staff needed an understanding of the "political" aspects of health and social care.
- Education and training should be ongoing.
- A cadre of specialist nurses could provide support and expertise as well as training.
- Education to eradicate ageism needed to start in schools and to be pervasive.

Box 2: Quotes to support emergent themes

General

"it cannot be done on the cheap and at the moment that does seem to be the way that it's expected to be delivered."

(Nurse consultant)

Current education and training

"...with the students that we take, we always ensure that they spend time with the district nurses and the therapists and the social workers, so it's very much done in-house - it's more of a shadowing rather than formal training, but that in itself has provided huge benefits because people have got a greater understanding of what each other's roles are..."

(Intermediate care provider)

Gaps and obstacles in education and training

"...I still get the feeling talking to my contacts that people who are specifically related to care services with older people see it as very relevant to them, but I am not convinced that other people or other practitioners where it really needs targeting, see it as being related to their care, because to me the Framework is talking about older people wherever they need care."

(University teacher)

Multi-disciplinary and inter-agency working

"...there is a sort of joint training and shared discussion because otherwise people don't understand the different assumptions that people from different professions and organisations are working to, and that's the only way to really resolve those."

(Voluntary organisation manager)

Areas for further progress

"I can't underestimate the value of front-line carers and equipping them to do a job that we are going to demand more and more in the future, so there has to be a recognition that it has to be as a career; they have to be trained and supported continually, and they have to be paid to do it."

(Intermediate care manager)

Conclusions

Particular areas of activity and need were seen in each of the agencies and groups studied and these are detailed in the full report. We concluded that to take forward the educational agenda for the NSF a strategic approach was needed that :

- Embraced different methods - personal agency and service design as well as courses.
- Included a variety of content - attitude-changing and technical.
- Crossed boundaries - health and social, mental and physical, caring and technical.
- Was co-ordinated - sharing resources and best practice.
- Was pervasive - starting in schools and involving all providers of health and social services.
- Was addressed to key groups - continually reminding commissioners, managers and providers of the needs of older people.
- Was persistent: - changing attitudes takes time, knowledge and skills need constant updating.
- Was well led - "champions" for the NSF in all relevant areas with support to facilitate delivery of the standards.

We plan a workshop in Huddersfield in autumn 2004 to consider the lessons to be learned from this study and from trying to develop education to implement the NSF. Our findings will be of interest more widely to those seeking to develop education to facilitate the shifts in attitudes, changes in organisations and gains in knowledge necessary to successful implementation of the NSF.

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