Educational Implications of the National Service Framework for Older People: Developing Education for Quality Services to Older People

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1. Executive Summary

The National Service Framework for Older People represents a re-affirmation of the principles of equity upon which the NHS was founded. The authors of this report argue that a coherent approach to the educational agenda arising from the NSF is likely to bring forward and enhance the benefits arising from the NSF itself.

Interviews with twenty-seven stakeholders representing a wide range of opinion from the general public through voluntary organisations to different health and social care providers and educational experts tended to confirm this view. At the time of the study the NSF was still in its early days. Whilst widely welcomed, there were some reservations about how far it was likely to be implemented. Knowledge of examples of good practice was not widespread. A common problem in many agencies was finding time and money to release staff for educational activities. Whilst staff working in specialist elderly services recognised their need for specialist education, uptake of existing courses was not good from areas that did not specialise in care of older people but nevertheless had an elderly clientele. There was a particular deficit in expertise when it came to managing older people with mental health problems in the general hospital and other settings.

Skills were also needed in partnership working to help bridge organisational gaps and there was a perceived need for multi-disciplinary and inter-agency training. Education needed to be pervasive, perhaps starting in schools with respect to issues like ageism and working with existing staff to continually update as well as with staff in training. Learning by association (for example by having mental health liaison nurses working on general wards and mentoring) was seen as important alongside formal courses. Commissioners and managers as well as practitioners needed to be educated if “institutional” ageism was to be eradicated. Leadership, co-ordination and persistence were also seen as vital.

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.

Particular areas of activity and need were seen in each of the agencies and groups studied and these are detailed in the report. Limitations in the research methodology are discussed. 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.

2. Introduction

Background to National Service Frameworks

In order to understand the significance of National Service Frameworks (NSFs), it is necessary to understand something of the history of the National Health Service (NHS). This brief account is summarised and modified from a more extensive account elsewhere [1]. Established in 1948, the NHS built on a broad consensus that medical care should be delivered equitably, according to need and not according to ability to pay. The NHS, as then set up, was tripartite. Primary care services - general practitioners, opticians, dentists and pharmacists - were answerable to local executive committees. They were the “local shopkeepers” of the NHS. Maternity, child welfare, health visiting, health education, immunisation and ambulances remained the responsibility of the local authority (the “public health” function) and Regional Hospital Boards administered hospitals. When the NHS was set up, some assumed that increasing health in the population would cause health expenditure to level off. This optimistic prediction did not allow for demographic changes and technological progress. Financial pressures resulted. A pressing need for capital investment was addressed in the Hospital Plan of 1962.

At about the same time the 1959 Mental Health Act marked a move away from Asylum care to District General Hospital Mental Health Units and “Care in the Community.” The large institutions were, in any case, rocked by a series of scandals about the mistreatment of patients resulting in the establishment of the Hospital Advisory Service (later the Health Advisory Service), effectively an inspectorate to monitor standards and spread good practice. In some ways, though more limited in scope, this was the forerunner of the Commission for Health Improvement introduced in the most recent reforms.

Twenty-six years after its inception, in 1974, the NHS went through its first major reorganisation. The chief elements of this reorganisation were the separation of health and social care functions, the integration of all health functions under one management and the establishment of area health authorities, generally co-terminous with local authorities (which remained responsible for social services), to facilitate joint planning. The reformed service did not work well. There were too many layers of responsibility and decisions were delayed whilst information and responsibility were passed up and down the tree. Not for the last time, there was an increase in clerical and administrative staff without a corresponding increase in managerial efficiency. During this period important government reports were produced including Better Services for the Mentally Ill [2] and A Happier Old Age[3].

In 1982 the Area Health Authorities were abolished and new district health authorities combined the functions of the old areas and districts. In some areas, co-terminosity with local government was lost. A new government was determined to cut public expenditure and the rate of growth of the NHS slowed. Following the Griffiths report[4], a general management structure was established within the NHS and Family Practitioner Committees became independent. Government payment for continuing care was channeled to the private sector and social services and hospital provision for this group of patients/residents was either reduced or failed to keep pace with demographic changes[5]. During this period, Psychiatric services were coping with the implementation of the 1983 Mental Health Act.

The next major upheaval was in 1990, sixteen years after the first. This was a reform not just of the service but a rejection of the ethos of "service" in favour of an "internal market". The new health authorities became planners and purchasers of health care

at "arm's length" from the providers, which became semi-independent Trusts. The health authorities were provided with a budget for the local population and placed contracts for care with Trusts or the private and voluntary sector in order to obtain the best "value for money". Quality was, at least in theory, specified in the contract and monitored. Competition and other features of business life were "introduced" into the NHS, not least by setting up groups of “fundholding” general practitioners who were enabled to make their own contracts for some aspects of secondary care. The bottom line was very clearly financial and in many cases clinical services were sacrificed to balance the books.

Then a radical reforming Labour government came to power. Whilst some principles of the previous government were nominally retained, concepts of partnership, quality and performance replaced the internal market and a range of new reforms and programme of modernisation were introduced in both health and social care. In December 1997 a White Paper “The new NHS: Modern, Dependable” [6] outlined a comprehensive new vision for the NHS. The frequency of radical reforms was increasing! Two of the main planks of the new policy were the setting up of Primary Care Groups (PCGs) to replace the fundholding / non-fundholding split and the introduction of comprehensive quality controls to ensure high standards and equity in access across the country. PCGs were local groupings of general practices involved in the commissioning of local community and secondary services. They were developed into Primary Care NHS Trusts (PCTs), providing community services and commissioning secondary services. District and regional health authorities were abolished and replaced by “strategic health authorities”. Many secondary care trusts were also re-organised, split or merged. Mental health was sometimes found in PCTs, sometimes in Mental Health Trusts. In many cases this produced a new managerial boundary between geriatric medicine and psychiatric services.

Within the social care field, the White Paper “Modernising Social Services” introduced a number of reforms aimed at promoting independence, improving protection and raising standards, much of this emphasis and subsequent injection of funding addressing the needs of older people. [7] This introduced priorities for the Government’s modernisation programme for both the NHS and Social Services and for the first time this indicated areas where there was to be a shared lead between health and social care. This indicated New Labour’s agenda to merge the health/social divide and place greater emphasis on inter-agency and inter-professional working, a direction which was reinforced in all subsequent policies, leading to the introduction of the legal basis in the Health and Social Care Act 2001 of the development of Care Trusts.

A further trend of this government was to introduce performance management techniques across the range of health and social provision. A quality framework involving a three-layer approach[8] matched the radical approach to NHS structures. Clear standards of service were set by National Service Frameworks (NSFs) and a National Institute for Clinical Excellence (NICE) that evaluated new treatments. The NHS was to make local delivery of services dependable by a combination of lifelong learning [9] linked to professional self-regulation and clinical governance. Clinical governance[10] placed obligations on Chief Executives of NHS Trusts to make arrangements to monitor and continuously improve the quality of health care that they provided. Finally, all this was underpinned by the national monitoring of standards involving a National Performance Framework, an inspectorate (the Commission for Health Improvement) and a National Patient and User Survey. This ambitious vision set a massive agenda for change and demanded radical shifts in the management and clinical cultures of the NHS[11].

This is the background to the NSF for older people. It was the third major NSF to be introduced, following an NSF for cardiovascular disease and one for mental health. It is intended to promote uniformly high standards for the care of older people throughout the NHS. The objectives of this NSF have been reinforced by a number of measures with a specific emphasis on the needs of older people, such as "No Secrets – Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" [12], and guidance on "Fair Access to Care Services" [13] which provided an equitable eligibility framework for adult social care. Other policies on benchmarking, such as "The Essence of Care"[14] have also had an impact on implementation of the NSF.

Making the NSF work

The NSF for older people was surrounded by a panoply of administrative mechanisms to make it work. These included joint commissioning boards and local implementation teams. There was also the full weight of the various inspection mechanisms to detect whether or not changes were being implemented. However, initially, there was no clear educational strategy for changing the "hearts and minds" of those involved in commissioning, managing and delivering health care for older people. Real, sustained change depends on changing people's attitudes, knowledge and skills. That, in turn, requires a consistent long-term strategic approach. This project aimed to help to fill the gap in educational strategy. We sought wide consultation amongst key stakeholders in and around Huddersfield to establish what were the important educational priorities, what was currently being done to meet them and to and consider how they might be met in the future.

Do we need an educational strategy?

When the framework is so hedged about with targets and administrative deadlines, it is tempting to question the need for an educational strategy. Will not the very act of "driving through" change push staff into any necessary educational activity? Acting in a certain way certainly can change attitudes and beliefs, but ingrained ageism, like most prejudices, takes a lot of rooting out.

Our own experience with the implementations of the educational recommendations arising from the "Forget-me-not" audit of older people's mental health services carried out in Kirklees suggested that even when specific areas for action had been identified by District Audit, little happened without a conscious strategy to make it do so. To be fair, this particular audit was carried out at a time of unprecedented change in local NHS structures. However, it seemed reasonable to assume that the absence of a specific educational strategy would at very least reduce the speed of change in areas such as staff and management attitudes, knowledge and skills and so present an obstacle to implementing the NSF. This in turn would delay or reduce the benefit from the framework to older people

3. Summary of the National Service Framework for Older People (NSF)

The following four themes run through the NSF:

- Respecting the individual
- Intermediate care
- Providing evidence-based specialist care and
- Promoting Healthy active life.

Each theme contains one or more standards with a varying degree of detail and time-limited targets within these standards. The standards are summarised below. This is the summary that was made available to interviewees.

Respecting the Individual

Standard 1: Rooting out age discrimination
NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Standard 2: Person-centred care
NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

A key to person centred care is the development and implementation of the single assessment process, an attempt to rationalise and manage skilled and sensitive assessment throughout any health or social care journey. Existing bureaucratic and technological barriers have been clearly demonstrated by the early development projects. The educational challenge is huge in terms of logistics, shared learning and common understanding.

Intermediate Care

Standard 3: Intermediate care
Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long term care.

Providing Evidence-based Specialist Care

Standard 4: General hospital care
Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Standard 5: Stroke
The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multi-disciplinary programme of secondary prevention and rehabilitation.

Standard 6: Falls
The NHS, working in partnership with councils, will take action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Old people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention, through a specialised falls service.

Standard 7: Mental health for older people
Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and their carers.

Promoting an active, healthy life

Standard 8: The promotion of health and active life in older age
The health and well being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

The medication management document adds to the eight standards, recognising the pivotal role which medication plays in the health and well-being of older people. There is a huge challenge in meeting the milestones, developing existing skills and facilitating new roles relating to medication management.

4. The rationale for the study and methods used

If we accept the need for a strategy, we are still left with the question of what it should contain. It would be easy simply to turn to the "educational" experts but other points of view need also to be considered. With the aid of a grant from the School of Human and Health Science's Innovation Fund we adopted a broad approach, systematically seeking the views of a wide variety of stakeholders in order to develop a robust view of what needed to be done. We hoped that this would reveal what were the key issues for people near to the clinical interface. We also hoped to identify areas of progress and good practice and areas that needed special attention. The result of this work would not be an educational strategy in itself but would be a fair indication of what such a strategy should contain. We recognised the primary responsibility for developing such a strategy lay with local workforce confederations but intended our work to inform development of such strategies. We recognised that the NSF was more than the sum of its standards. Issues about falls were likely to be important in intermediate care, mental health would be important in the general hospital setting, rooting out ageism would be vital in all the other areas. This complexity led us to adopt an open-minded approach to the work, interviewing a wide range of people and seeking to distil from their views the essential areas that needed attention.

Choice of qualitative methodology
We chose qualitative methods in order to:

- minimise 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 common pre-conceptions.

At the start of the study we did not apply for ethical approval because the research

governance framework[15] had not been published and it had not previously been necessary to obtain ethical approval before conducting research interviews with consenting NHS staff. However, with the advent of the research governance framework we had to seek ethical approval from the local research ethics committee. This delayed the project and production of this report.

Twenty-seven subjects were interviewed, including educators, practitioners and managers from a variety of settings in health and social services, carers and 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. 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".

Use of N-VIVO
N-VIVO is a computer program that facilitates the analysis of qualitative data by allowing the researcher to group together passages that reflect ideas from different interviewees. These passages can than be manipulated and linked, using "nodes", in a variety of ways that enables common themes to be identified. The analysis is an iterative process and the researcher can revise the emerging themes and their links. In this context, N-VIVO enabled general ideas about the NSF to be pulled together, these ideas could then be looked at under a variety of headings, including, standard by standard and agency by agency.

5. Findings

The findings are analysed under three headings as follows:

- General views on the NSF
- Current education and training
- Gaps and obstacles in education and training
- Multidisciplinary and inter agency working
- Areas for further progress
- Comments on standards
- Different viewpoints from stakeholders

General views on the NSF
This theme in the material captured the comments made by interviewees with regard to the NSF.

It was generally agreed that the NSF has much potential. As a nurse consultant (NHS Trust) put this, it is *"a complex and demanding framework and potentially very empowering for staff who deliver care, and empowering for patients."*

Nevertheless it was also asserted by many that implementation of the scheme would not be without its difficulties, both existing and potential. The practical implications of enforcing the measures were particularly an issue. As a senior lecturer stated:

> *"…there's a danger, I think, with this document; it becomes an intellectual piece, and with all due respect, it becomes an intellectual piece of property that people do research on and nothing fundamentally changes."*

Another aspect of concern was the amount of funding and the degree of commitment

involved. With regard to the former, a nurse consultant (NHS Trust) said *"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."* Adding that there is little funding available, this interviewee claimed that as a result of this, *"we can't [arrange] long term planning and provision".*

The importance of communicating the tenets of the framework to staff as a whole was another significant factor. A modern matron (NHS Trust) recognised that the NSF was a long-term plan but said:

> *"…it does need to work its way right to the very grass roots of education and training for new doctors, nurses, therapists and anybody within the health service."*

The head of a university nursing department claimed that apart from those specialising in care of older people, *"I am not convinced that other people, or other practitioners where it really needs targeting, see it as being relevant to their care"*. In short, it was asserted that all practitioners involved in any aspect of older people care need to be aware of the NSF.

Indeed the problem of integrating the framework with existing organisations was acknowledged. A modern matron (NHS Trust) suggested that reorganisation could become very complicated in certain circumstances - for example, with neighbouring primary care trusts, problems of liaising with multiple agencies were recognised.

On the whole, however, despite negative comments being issued by a social services training officer - *"It doesn't address the issues."* - and the assertion of a nursing and residential home manager that she had not read it, the NSF was greeted with cautious optimism and occasionally great expectations. The head of a university nursing department stated*, "I certainly welcomed the National Service Framework".* An older person's carer said, *"I think the NSF that you showed me looked good and it seems that the NHS is going the right way about things…we are happy."* After expressing scepticism about implementation, a senior lecturer claimed that *"on the positive side there's some good stuff - you can't deny it and its intentions";* and then, *"It's wonderfully researched, wonderfully referenced, beautiful stuff. I hope it really does have an impact."*

In summary, the views on the NSF were that it was a good idea with much potential. However, it could not be fully implemented without adequate financial support; it needed implementation at a practical level, and not merely as an abstract concept; it should address all staff and systems across the board in health and social care. Finally, those charged with implementation needed to be able to work with organisational complexity.

Current education and training

This theme in the material captured the comments made by interviewees with regard to educational activities currently available for different staff groups.

Interviewees generally conceded that since the NSF was a relatively new scheme, there had been few specific education and training activities put in place to deal with the framework's proposals. Nevertheless existing schemes and programmes were claimed by many to be compatible with the proposals of the new framework. There were, however, differences between several groups.

A representative of the social services claimed that person-centred and intermediate care did have resources, though training requirements needed to be identified.

Additionally it was suggested that guidelines of the social services would be consulted as often as those of the NSF. Nevertheless some schemes did map on to the proposed framework. For example:

> *"…our assessment has worked closely with the health trust, then we have pioneered, if you like, the NVQ - let me get this right, 'certificate in community mental health', and it's the first one in the authority to go through*."

Other factors mentioned by this social services officer were the need for training that resulted as and when problems emerged; such issues are often brought forward by managers, and programmes might have to rely on volunteers. A social services manager suggested that it was useful to train managers, so that knowledge *"cascades down"* to other team members, and that all training should *be "need-related"* as opposed to general. Another social services manager claimed that training should not be compulsory, but that everyone should possess a *"baseline"* of knowledge. It was conceded that not much had been done to establish such measures, a fact echoed by a housing manager.

The notion that full training should not be an expectation of all staff was repeated by an intermediate care provider. A ward manager in intermediate care explained how meetings of multi-disciplinary teams had proved to be a good way of sharing knowledge. On the whole, the same interviewee claimed, training was carried out in an informal manner:

> *"…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…"*

A health promotion specialist (NHS Trust) claimed that briefing sessions had been held across health and social services covering different standards for each of the professional groups. One specific project, reported by this interviewee, involved a pocket guide card that highlighted risk factors for falls; this had been developed and combined with briefing sessions to enable managers to try and improve recognition and the management of risk factors.

A mental health representative (NHS Trust) claimed that forums designed to identify areas of required training were a useful method, as was specific training analysis; nevertheless he added that no such measures had been taken. With regard to the NSF, however, it was claimed that person-centred care and rooting out age discrimination had generated a lot of ongoing research. Similarly a module had been developed for increasing stroke awareness. A falls group had been developed before the proposal of the NSF. Mental health awareness had been addressed by producing appropriate guidelines, and health and activity promotion was being tackled by initiatives.

A senior nurse (NHS Trust) discussed an 'essence of care' *programme "which is run three, four times a year".* Initially this had been designed for senior members of staff, though soon all were encouraged to attend, and although many often turned out for the meetings, some were regrettably missing, including representatives of portering and catering. Clearly the training/awareness of all staff is regarded as important in such teams.

The manager of nursing and residential homes team claimed that an NVQ system

was firmly in place; under 21 year-olds are sent to college for training, while those older were trained in-house. Her company was heavily involved in training, having its own syllabus, and there are no 'grey areas'. Most of the training areas come from care assistants who *"never stop asking questions".* Again, training areas are identified by people directly doing the work.

It was claimed by a manager of a primary care trust that although there are a range of NVQs dealing with older people, it wasn't clear how these related to the NSF. It was advised that there ought to be a focus on nursing staff with regard to training analysis, and some of this had been done already, though it needed implementing. Clinical governance forums were recommended as a good way of identifying needs.

A central concern of the manager of a voluntary organisation was age discrimination, and that this was being targeted by in-house training. Additionally, a general awareness of mental health for all staff was regarded as crucial. Finally, the promotion of an older person's guide to the NSF was hoped to be *"available shortly".*

A senior lecturer from a university claimed that she was using the NSF as part of a course on health promotion. Again, age discrimination was regarded as a significant factor to address, particularly that this issue didn't become 'intellectualised' rather than practised. Courses, which already contained a good deal that is covered by the NSF, were being modified to incorporate all elements of the framework.

The head of a university nursing department claimed to welcome the NSF and to teach it. Indeed discrimination was a crucial area, though not just with regard to older people, rather in every area of nursing. Person-centred care was central to the course, while all of the NSF standards were addressed by the course she taught.

In summary, the views on education and training at that stage were that few training strategies had been devised to tackle the NSF proposals directly. However, existing programmes might be adapted to this purpose. Realistically, training should arise as a result of immediate needs. It was regarded as unrealistic to train all staff to cover all areas of health care; rather meetings and forums might be used to pool resources and innovations could develop in the context of an overall informal approach. Finally, the elimination of age discrimination was identified as a major target of future training.

Gaps and obstacles in education and training

This theme in the material captured the comments made by interviewees with regard to the perceived gaps in and obstacles to education and training. There was a range of issues discussed by interviewees of different groups, many of which overlapped - particularly the issue of funding and resources - and others specific to certain divisions of the service.

A social services manager claimed that the sheer volume of staff for whom she was responsible made it difficult to attend to all:

> *"…they are a dispersed workforce because you tend to have between forty and sixty staff per full-time manager. That's a lot of people to get around when you're sort of organising the work as well…"*

One possible solution proposed by this interviewee was the prospect of a mentoring system whereby staff were allowed to shadow senior members, or receive direct instruction from them. Nevertheless it was concluded that setting up such a system would be 'very expensive', a factor echoed by a social services training and

developing officer.

An issue specific to social services mentioned by this latter interviewee was the differences between health and social services:

> *"…there are grey areas, where each group does not want to take responsibility, i.e., that health might think, well, this is a social care problem, whereas in social care they are saying, no, this is a medical problem…"*

Other issues that emerged from social services included the fact that skills are unknown until they are practised (manager) and that it would be useful to get together the ideas of all staff (manager).

This focus on staff was also a central concern of a housing and health unit manager:

> *"The issue for us is keeping a handle on what is actually going on and whatever services are and who does what…so when our folks go out and sit in somebody's home, they've got an idea of what is available. So they don't necessarily need lots of training about particular skills, but they do need a really good awareness of what's going on."*

An intermediate care ward manager suggested that the priority was the patients. Although training was regarded as potentially useful, it was stated that due to a lack of funds, the day to day running of practice must come first. Issues such as rooting out discrimination and altering cultural perspectives were claimed by an intermediate care manager to be uppermost in training targets. A development manager suggested that staff should have *"wider skills and a deeper knowledge around the philosophy of Intermediate Care and the whole enabling culture".* Health promotion leaflets might be distributed to patients (ward manager), though it was also agreed that money and resources were limited for any training strategies (development manager).

Representatives of NHS Trusts also expressed a concern about a lack of funding and resources. There was a focus on teamwork, sharing good practice and role understanding. A nurse consultant said, *"there's definitely some gaps in terms of shared learning, joint learning"*, while a health promotion specialist indicated:

> *"I think there needs to be training around understanding the roles of other organisations…there's quite a lot of gaps in people's knowledge about what's going on elsewhere."*

She added that differing structures of separate organisations made this a difficult task.

Echoing comments made in Intermediate Care, it was stated by a modern matron that knowledge of Intermediate Care should be promoted among staff, while a senior nurse suggested that 'trendy courses' were less effective than approaches that covered the 'essence of care'. Another similarity was to the comments made by social services regarding artificial divisions, this time between physical and mental health. Greater understanding was needed by staff about different aspects of care (modern matron), although the priority ought to be practice (health promotion specialist). Finally there was a notion that teaching senior staff would ultimately benefit auxiliary members (senior nurse).

Older people's carers believed that nurses were rarely seen to have much time for

patients. This seemed to be due to a lack of understanding about mental health issues. As one carer put it, *"They didn't seem to understand the physical and mental needs he [patient] has."* This was a criticism extended to social services too. One possible solution was the provision of more information on such issues as dementia; training staff was regarded as a significant manner of achieving this.

University educators made some remarks that supported the notion that teaching awareness about older people was important not only for direct carers, but for the whole of the practice team. A head of a university nursing department said:

> *"…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…"*

This view was supported by a senior lecturer in health promotion, who also added that the care of older people was generally viewed as being less significant than other aspects of care (e.g., heart treatment). Focus groups set up to enable knowledge to be shared were often hampered by the fact that many attendants didn't see concerns about older people as relevant to their own work.

Specific concerns expressed by university educators were the fact that health promotion modules dealing with older people necessarily did not run if fewer than five students applied to study this part of the course. A senior lecturer also claimed that such material was difficult to teach on account of a paucity of research on older people on which to draw. In general, despite the NSF, there *"isn't a huge emphasis on health promotion for older people".*

Finally, representatives of voluntary organisations focused predominantly on the degree of ignorance about such issues as dementia among existing staff. A manager claimed that there was also a lack of awareness about *"the process and…the support that's available".* It was additionally suggested that there should *be "more scope for involving older people themselves"* in training development, principally finding out what they would like attending to by way of effective care. A manager proposed an assessment of risk and its management, the better to prevent falls, etc, or to treat victims effectively. A final aspect was a focus on rooting out discrimination and promoting cultural change.

In summary, the views on the gaps and obstacles in education and training were that 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 but nevertheless cared for large numbers of older people. People tended not to be aware of all relevant aspects of the care system: different providers of services needed to be more aware of each other's roles. The day to day operation of health care took priority over training in general. Joint learning, teamwork and attitude change were important targets for education. The care of older people specifically needed to be promoted as an important field of study and development, and staff should be made more aware of problems specific to older people: e.g., dementia.

Multi-disciplinary and inter-agency working

This theme in the material captured the comments made by interviewees with regard to the problems involved in different areas of care working together.

One central concern was the fact that different divisions of the care service functioned independently when it would more efficient to collaborate. For example, a training and development officer of the social services mentioned the "grey areas" that exist between health and social services. It was felt that *"we've absolutely got to get rid of the grey areas, and I think that's going to take a long, long time, we're never fully going to be working together*". It would, in short, be *"foolish not to identify or admit that there are different ways of working."* Indeed the *whole "culture of the health service is different to the culture of social services"*, and many feel *that "it's the health model versus the social care model".*

Clearly a way forward would be for staff of varying areas to put past differences behind them and focus on what's best for patients; this involves mutual trust, sharing and respect, while such staff need to mix and work together (training and development officer of the social services).

A housing manager echoed this sentiment. Indeed a nurse consultant (NHS Trust) went on to suggest that the current system was *"in turmoil*", and that joint training was *"very slow in moving forward".* However it was felt that with strategies in place, this could improve. The problem should be addressed *"right across the board"* of all staff, so that "whole teams need to have an opportunity to learn how each other function and to learn together."

Another method of developing multi-disciplinary skills would be for the health and social budgets to be *"pulled together"*; this was recommended by a modern matron (NHS Trust) who, from the perspective of patients, went on to claim:

> "…*it must be totally intrusive into your home having all these people coming in and doing bits, and be wondering, well, who does this bit, who does that bit…"*

This interviewee concluded that the reality of the service is that it's *"all based on the service…and until we actually look at people's individual needs and put resources in together, you know it's not very customer focused whatsoever".*

One area of care that did seem to have developed a multi-disciplinary focus was intermediate care, of which a development manager claimed:

> "…*there is now a multi-disciplinary team meeting going on and that's input from any relevant social workers, from the district nurses, from therapists on the ward and from any relevant social workers who feel the need to attend*."

This arrangement appeared to be proving successful, and at the time of speaking, the interviewee hoped to have a GP present at future meetings, in order to complete the input of all areas of the system. Nevertheless, it was generally felt that more work was needed to achieve the cohesion required to provide an effective service. The head of a university nursing department suggested that problems ensue from simple issues, such as the fact that *"a social worker has their notes, the nurse has their notes, the doctor has their notes; although there has been a move towards one set of documents...".* Indeed a voluntary organisation manager concluded that it was essential that:

> *"…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."*

In summary, the views on multi-disciplinary and inter-agency components of existing health care were that there should be no 'grey areas' between health and social care. We should acknowledge that these organisations worked in different ways, and that existing rivalries must be overcome to promote integration. Separate budgets might be pulled together. Training must be related to the patients, and the biggest hindrance to development was claimed to be lack of coherence between health and social services.

Areas for further progress

This theme in the material captured the comments made by interviewees identifying training and education activities required to reflect the needs of the NSF.

Again there was a range of opinion, much of which overlapped, and other factors that were specific to certain divisions of the care system. One issue raised by a social services manager was the importance of a wide-ranging *"strategy"*, and *of "educating at all levels and stages."* Additionally, special staff was considered as important in key areas such as palliative and intermediate care, and especially mental health. These are areas in which a baseline of awareness in other staff was not regarded as sufficient.

Focusing on older people as well as staff was an issue brought up by a housing manager who suggested that *"I would like to see some stuff done with the target groups themselves, with the older people themselves."* This involved health promotion and raising awareness of accident avoidance, etc. Again it was stated that in order for the new framework to function effectively, it was important for teams to work well together. Nevertheless a concern specific to housing was that staff of other areas should know how their own system worked:

> *"…it's just as important for the people out there to understand how the housing role works because it wouldn't be unreasonable to say that people within health and social care…just think in terms of their own areas."*

However, it was considered to be the responsibility of housing to keep other staff informed of their activities.

A further urge to identify key members of staff and train them effectively was suggested by an intermediate care development manager:

> *"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."*

This sentiment was echoed by a ward manager in intermediate care (she focused particularly on health care assistants), who also suggested that such training wasn't just about expensive courses, but about *"basic awareness".* Additionally, in order to meet NSF proposals, there should be official "guidance" provided and "milestones" outlined.

However, the focus on various teams and their interaction was taken even further by another intermediate care development manager who claimed there should *be "multi-skilled staff where people can actually take on roles and responsibilities that have traditionally been those attached to other groups"*. Nevertheless, the other manager was less ambitious, suggesting that a *"baseline"* level of skills only was essential - for

example, with regard to dealing with dementia.

Representatives of NHS Trusts were keen to emphasise the need for good leadership. For instance, a nurse consultant proposed *that "in terms of effecting change, you've got to have effective leaders."* An existing programme, based on the NSF, was in place, which started:

> *"…with the directors and then [moved on to] the managerial level and operational staff, and the plan is within a year as many people as possible from those different hierarchies within the organisation will be going through that."*

According to the nurse consultant, leaders should have *"political awareness"* in order to understand *"what influences the designs of care that we have, and how we can influence change at national levels as well."* Staff genuinely want to meet needs, yet feel inadequate to do so, and require such training and funding with which to complete this.

The desire of staff to provide a good service was also expressed by a senior nurse. Nevertheless she also suggested that money was not the only or even the major issue. She claimed that *"a lot of people think it's always down to resources and money and it sometimes isn't, it's about changing the way we work".* She went on to suggest that a baseline of older people skills is important for all staff, that education should be *"an ongoing process and continuous",* and that guidelines and a coordinator are required in order that targets are clear. Staff wish to make the best of such documents as the NSF, though they need adequate support to do so. The NSF, it was asserted, was usefully *"very prescriptive".*

Another issue emerging from NHS Trusts was an emphasis on addressing discrimination in practice, as opposed to only in theory (ward manager). A mental health worker suggested that an assessment was vital with regard to what already exists and how to achieve the proposals of the NSF. He also addressed the issue of understanding the "mixed skills" of varying staff. A health promotion specialist claimed that health promotion ought not to be just an "add on", but part of the everyday work of all staff. Finally, a modern matron suggested that what was needed *was "a lot of education and challenging work, and a lot of it's around attitudes";* she added that she *"would hope that there will be a joint pooled budget between health and social services in relation to the NSF."*

An older person's carer suggested that older nurses *"need retraining",* while younger nurses are *"not trained enough".* A primary care development manager echoed this statement by claiming particularly that older *nurses "need updating in relation to the intermediate care agenda."* Preventative measures were suggested, particularly among home care staff, and with regard to fall avoidance, etc. A member of the general public suggested that all staff required "regular training courses".

University educators also focused on the necessity of bringing people together as a group, principally because, in terms of education, it is easier to teach them this way. A senior lecturer in health promotion said:

> *"…it would have an immediate impact on teaching because…that would perhaps bring some of these ideas together and what the focus should be."*

A concern of the head of a university nursing department was that students tend to discriminate against training to treat older people, preferring to study *"high-tech"*

programmes. Changing such attitudes was regarded as the *"hardest thing of all".* This interviewee also suggested that the NSF required "long-term monitoring", and that issues appertaining to older people should be addressed to staff across all disciplines (e.g., social, health, mental health), since each area of the service always deals with such individuals, and such individuals often have multiple problems.

A senior lecturer recommended the following were needed:

- specialist older people's nurses to *provide "expertise, knowledge and advice as well as training";*
- inter/intra professional working in key areas such as intermediate care and rehabilitation *to "enhance the understanding of each unique contribution and the benefits and collaboration of teamwork";*
- clinics relating to falls, health promotion, and properly trained carers;
- targeting of schools, and media support, to eradicate ageism.

Altering attitudes to older people was a key factor in the opinion of a voluntary organisation manager. Additionally there should *be "really good mechanisms for telling people what's changing and how it all fits together."* Finally, it was stated that a *"better understanding of older people's behaviour and prejudices as well"* was a key component of any future training and education strategy.

In summary, the view on areas for further progress was that particular areas such as 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 in each area of the care service, and their abilities developed in order to pass on such expertise. 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.

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.*
- *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.*
- *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.*

Comments on Standards
Although we recognised the interdependence of the different standards, we thought it appropriate to highlight some of the specific comments made about individual standards. These issues have been mentioned intermittently in the foregoing analysis, though here we draw together the relevant material.

Standard 1: Rooting out age discrimination
A social services training and developmental officer regarded the rooting out of age discrimination as *"one of our key factors".* The problem was considered a difficult one. The manager of a nursing and residential home stated that age discrimination is found most when older people are admitted to hospital. This was echoed by a senior lecturer who claimed that the main difficulty was:

> *"…trying to get people to see how discrimination can be very silent. You don't know you're doing it, but it's there all the time: the way you address people, the facilities you offer…sometimes overtly…"*

A modern matron suggested that *"even physicians for older people who say they're rooting out age discrimination…in the next breath, you know, you're talking about over sixty-fives and over seventy-fives."*

One way of tackling this problem was by addressing age discrimination *"right from the outset within nurse training, medical training and across all health care professionals."* (modern matron, NHS Trust) It was added that this issue is perhaps a modern phenomenon, with greater respect having been accorded older people in the past. Clearly this trend needs addressing.

Nevertheless, moves to achieve this should take into account the distinction between a theoretical appreciation of the issue, and its application in practice (modern matron). This notion was emphasised by a senior lecturer:

> *"…there is a tendency to intellectualise; we can talk about discrimination until the cows come home; we can write wonderful essays…someone can do the course and get a wonderful mark at the end, and still go back totally bigoted."*

The head of a university nursing department suggested that discrimination was a problem that occurred in all areas of patient care, and that it should be addressed as a *"general part of the curriculum".* The manager of a voluntary organisation additionally stated that rooting out discrimination was *"fundamental to our values",* and that moves had already been made to address this concern.

Standard 2: Person-centred care
A social services training and development officer claimed that person-centred care is something *"we do very well on…we promote and project that at all times".* This was an issue that, like rooting out discrimination, involved the changing of attitudes and respecting the individual while ensuring *that "the person does have choice in what happens to them"* (modern matron, NHS Trust).

However, it was stated that one of the problems in developing such skills was the fact that orthodox education and training was insufficient to encourage staff to adopt the necessary attitudes. In fact it was in practice that the crucial factors lie - in the way, for example, that managers treat practitioners. A senior lecturer stated:

> *"…If people are treated like machines, work seven to nine, go home, management you know, if people are to deliver person-centred care, you*

need to be treated like a person."

This focus on person centred practice was reflected in education. The head of a university nursing department claimed *that "person-centred care is central to our philosophy and education, so that it is certainly included and spiraled throughout the curriculum."* One further suggestion, proposed by the manager of a voluntary organisation, was the importance of involving older people in the development of strategies for promoting such change.

Standard 3: Intermediate care

Some moves had already been made with regard to the development of intermediate care resource centres, etc. A social services manager claimed that such measures have *"been established for a couple of years now and we're still identifying some training needs."*

However, one specific concern about intermediate care was expressed by a modern matron (NHS Trust) who claimed that this was:

> *"…a relatively new concept, I think, really for a lot of people, though it has existed not necessarily under that title as it were, so in terms of educational aspects on things, a lot of education about what intermediate care is and does [is required]…"*

Indeed the head of a university nursing department claimed that the term intermediate care, although referring to an issue already covered by existing modules, might fall between other terms (for example*, "rehabilitation in hospital and rehabilitation at home"*). In short, a *"lot of work [needed] to be done including it in education."*

Standard 4: General hospital care

One major issue with regard to older people and general hospital care was that of mental health. A modern matron (NHS Trust) asserted that staff generally lacked the necessary skills to recognise specific problems relating to mental health in older people. One proposal was for there to be *a "mental health liaison person who worked with patients and staff in the general sphere who could offer support and education around mental health".* It was felt by this interviewee that the divisions of the health service were artificial, that:

> *"…the reality is we, in health, have separated them out. We've got mental health, we've got general nursing, and the reality is neither are very well equipped to cater for this kind of patient."*

A further concern was the lack of interest in courses that specifically addressed older people in health care. A senior lecturer stated*, "if people can realise that a lot of these standards are related to general hospital care"* as well as to older people, then such modules might be better attended. The head of a university nursing department emphasised that there were differences in dealing with older people:

> *"…we teach the difference between nursing an older person in hospital for whatever reason, and between sort of nursing a younger adult. So we look at the commonalities, we look at the differences…"*

In order to move between patients of differing ages, *"everyone must have these skills."*

Finally a nurse consultant (NHS Trust) suggested that *"spiritual care in its broadest sense"* was being addressed with regard to general hospital care.

Standard 5: Stroke
This was regarded as an area in which effective practice was already well-developed, partly because of the existence of a good evidence base. For example, a modern matron (NHS Trust) stated:

> *"There's the Royal College of Physicians' report in 2000 which has sort of driven the stroke agenda, particularly in the NSF, and there's an awful lot of up-to-date research around the evidence of stroke units and evidence-based stroke care."*

Nevertheless there was a concern that the educational message must get through to all staff who are concerned with stroke management, and that this must be continually updated:

> *"…the message has to get right across the board into the casualty, right to the ambulance service who first pick the patient up, right the way through, and then looking at developing stroke co-ordinators who will see the patient through."*

This interviewee concluded that because a lot of this work is "quite new", then a lot of effort is needed to establish awareness. The head of a university nursing department claimed that this was something that was being addressed by university courses.

A senior nurse in a stroke unit discussed a major programme that was being developed between The University of Huddersfield and the Calderdale and Huddersfield NHS Trust. This was designed to develop a stroke neurological and rehabilitation module that was now generally available. A further course called 'Essence of Care' was another attempt to develop knowledge and skills; this ran three or four times a year, and was attended by qualified and unqualified staff on a stroke unit. Although efforts had been made to involve other disciplines, with some success, not all groups had been represented. Optimism was expressed about the future of such programmes.

Standard 6: Falls
This was also an area in which a great deal of progress was being made. A health promotion officer claimed *that "there are quite a lot of different training activities available."* Much of this could not be regarded as "formal training", rather as the provision of information about the issue to staff. Nevertheless this interviewee additionally suggested that there remained gaps in the promotion of fall awareness:

> *"I think there are some missed opportunities in terms of induction courses…At the moment I don't think there's an awful lot that's covered around falls or the risk of falls on induction courses, so then that's an opportunity when new staff are coming through, to raise their awareness really. "*

This sentiment was echoed by a modern matron (NHS Trust):

> *"There's been pockets of good work around falls and it's been in isolation; it's not been coordinated, and it's not been linked together."*

This interviewee concluded that *"there needs to be an awareness at all levels".* Additionally, she stated that there ought to be a *"falls risk management protocol"*

which is administered to every patient in order to estimate their risk of falling.

Finally, the manager of a voluntary organisation claimed that it is important to make the development of training to avoid falls *"attractive to people*", since there *was "a huge shortage of exercise tutors who can take it further."*

Standard 7: Mental health

The division between physical and mental health was considered to be creating problems in the management of mental health issues. It was recognised that mental health problems were encountered not only in the mental health services, but also in the community and on general wards. It is in these latter areas that insufficient training was claimed to be most noticeable. For example, an intermediate care development officer claimed:

> *"I think that particularly mental health in older people, the fact that we are dealing with older people who live longer, who therefore have probably a greater propensity to some sort of dementia, we need to make sure everybody, everyone has got some knowledge, not great in-depth training, but some knowledge of dealing with mental health and how it affects older people and the carers."*

Arguably the biggest problem was *"the general level of understanding about the process and the support that's available"* (manager of a voluntary organisation). One possible solution to existing shortcoming was suggested by a modern matron (NHS Trust):

> *"I mean, within general nurse training, you have mental health allocation, as it were, but I don't think it fully equips people to cater for the needs of older people, and again some specific training around that would be useful. I think also potentially the role of a mental health liaison person who worked with patients and staff in the general sphere, who could offer support and education around mental health…"*

Some provisions had been made for staff. A lead person for mental health claimed that members could shadow colleagues involved in mental health, several times a week. Additionally, a training assessment was being conducted, while many aspects of mental health (bereavement, memory impairment, etc) were being identified.

On the whole, however, it was considered that much work must be done to meet the problems presented by mental health concerns in older people.

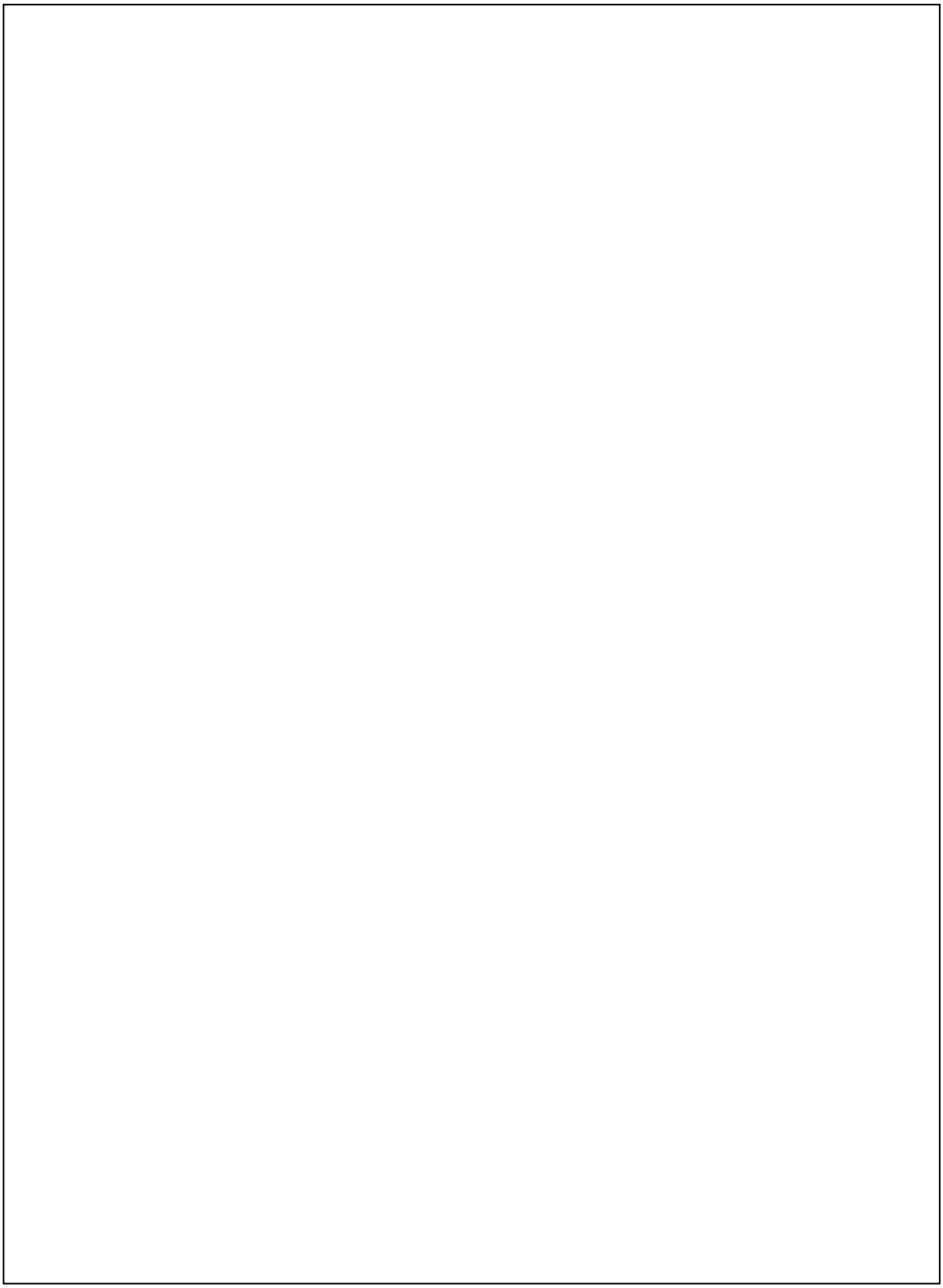
Standard 8: Promotion of health

A health promotion officer suggested that a fear is that health promotion could be viewed as an "add-on" function conducted only by specialists, while in fact this was a skill to be encouraged in staff in their day to day practice.

> *"…a district nurse might may well visit, and they have a particular task that they have to go for in terms of medical issues, but there might still be a chance for a quick chat about, I don't know, improving nutrition, maybe cooking a meal, a hot meal for a person, or maybe getting meals-on-wheels and things like that, so it's trying to use opportunities where they exist really."*

Although such a move involved the training of staff to change their habitual ways of working, there was an additional concern expressed about the fact that health promotion wasn't always an issue related directly to older people. As this interviewee

added*, "a lot of health promotion courses can be related to older people, but they are not specific to older people".* Staff members have an opportunity to share knowledge about such matters as "smoking cessation, nutrition", etc; existing "systems or networks" might be used to such an end. Obstacles included releasing staff for training, and getting health promotion established as a priority. The effectiveness of health promotion was also claimed to be *"very difficult to evaluate".*



Different viewpoints from stakeholders
Here we report the similarities and differences between the different stakeholders interviewed.

There was overall agreement that the NSF was a positive development, although many concerns were expressed about its implementation. Prominent among these was the fact that it is a framework that ought to be practised, and not just be discussed. Funding was a major concern - most thought the document required support in terms of resources. There was a need expressed to include everyone in any new measures, whilst recognition should be accorded to existing organisational complexities.

What follows is a break-down of the opinions of representatives of each of the following subgroups: social services, housing, intermediate care, NHS Trusts, nursing and residential homes, older people carers, primary care trusts, university educators, and voluntary organisations.

Representatives of the social services stated that training needs to start with senior staff members and work its way through them to other members of teams. It ought to be needs-related, and everyone should possess a baseline of knowledge with regard to older people. Large staff groups render such a process difficult and expensive. One recommendation was a mentoring system, involving senior staff members shadowed by their colleagues in order to learn in practice. It was additionally emphasised that major differences between different areas of care - for example, social and health services - required staff of each to trust one another, to mix and work together. Ultimately any training strategies should be wide-ranging, impacting on everybody involved in care.

A representative of housing claimed that a good policy would be for all staff to recognise and appreciate each other's roles in care. This involved the raising of awareness, including that of the patients who might be encouraged to care for themselves in terms of accident prevention, etc. It was regarded as particularly crucial that other staff were made aware of how the housing system works, although this task was assigned to housing itself.

Representatives of intermediate care focused on prioritising patients, claiming that a lack of funds forced training to take second place to practice. The rooting out of age discrimination was regarded as a particularly pertinent issue, as was health promotion in older people. Some methods of achieving these goals included the production of information leaflets, and the meeting of whole teams in order that each other's roles might be better understood (it was stated that intermediate care was already focused on the multi-disciplinary approach). Training should be informal, and not always be concerned with expensive courses; rather general awareness of the system as a whole was regarded as a major aim. Key members should be trained, the better to reach all staff, while official guidance ought to be offered and recognisable targets outlined.

Representatives of NHS Trusts claimed to have made some progress in addressing the proposals of the NSF though further recommendations were put forward. These included the value of forums for all staff to exchange information and understanding and training needs analysis to determine what exactly was needed. Teamwork and mixed skills were claimed to be important, as was the mutual understanding of roles among staff. Some of the problems mentioned were a lack of funding and resources, and the complexity of existing organisations (a slow-moving system claimed to be in

turmoil) that would render any progress problematic. Again practice and patients were prioritised, and it was felt that senior staff should be targeted in order that knowledge could be passed on to all staff (who want to do a good job, and desire the necessary skills). The tenets of intermediate care should be well understood. Previously separate budgets - for example, in social and health services - might be pooled, while an assessment of existing measures could be useful. Finally, all staff should promote health habitually, as part of their day to day practice.

Nursing and residential homes had made some progress in addressing the NSF through development of an NVQ for younger staff and in-house training. This was regarded as important by older people's carers who claimed that nurses needed training to update their skills (especially mental health awareness), while a member of the general public suggested that all nurses required regular updating. This sentiment was echoed by representatives of a primary care trust, one of whom also suggested that NVQs should relate directly to the NSF. Again it was considered that forums and training needs analysis would benefit future strategies.

University educators said that they were using the NSF as part of their education curriculum, and that factors missing in existing schemes would be covered in future developments. More specific recommendations about training included the proposal that whole teams in care required more awareness about the overall service; this might be achieved by bringing people together to pool resources. Again specialist roles ought to be developed to facilitate knowledge reaching other staff. The NSF should receive long-term monitoring. With regard to university education, a specific concern was expressed about age discrimination: many students chose not to take modules related to older people, and there was a paucity of existing research about health promotion for older people. Encouraging the media and schools to eradicate ageism, might help newer students to enter higher education with more inclination to study such essential areas of care.

Finally, a representative of a voluntary organisation focused particularly on the neglect by many staff of mental health awareness, and generally a lack of understanding of older people. One recommendation was the involvement of older people in the planning of training, including the production of an older person's guide to the NSF. Additionally, all staff should be aware of what support was available for patients, and ought to be up-to-date in terms of what changes have taken place in the service at all times. Mutual role comprehension was also mentioned as a significant aim.

Summary of different stakeholder views
The following were recognised as important by different stakeholders:

- *Developing mutual understanding through inter-disciplinary and inter-agency training and practice.*
- *A systematic educational needs assessment that addresses what exists and what is required by way of meeting the proposals of the NSF.*
- *The targeting of leaders or significant staff members, whose position can be used to pass on knowledge to all other employees.*
- *A focus on practice as opposed to only the intellectual aspects of training.*
- *The establishment of a baseline of awareness among all staff with regard to all aspects of care.*
- *The eradication of discrimination, so that new and existing staff might be encouraged to attach more value to the care of older people.*
- *A recognition of existing complexities and problems which are inevitably engendered by the co-performance of different organisations.*
- *The encouragement of funding opportunities and resource development; also the establishment of clear educational guidelines, and targets to be achieved in specific time spans.*

Limitations of this study

Small scale

For a qualitative study the number of interviewees was quite reasonable. Nevertheless they only represent a microcosm of all the people who could have been spoken to and there is obviously the risk that the opinions of interviewees may have been unrepresentative. However, the individuals we spoke to had between them many years of experience as providers and users of health services and many were also experienced educators. We can therefore have some confidence that we have tapped into the rich knowledge and wisdom of these people. This piece of work is also to be seen as part of a strategy to develop a sound educational basis for delivering the National Service Framework for older people. It is only by changing people, perhaps on a relatively small scale, that we can really change the way that services are delivered and implement the standards of the NSF.

Single centre

This work was conducted in and around Huddersfield. Others must judge how much the findings can be applied in other places. Some of the detail will be different as health services in different parts of the country are in different stages of evolution (some might say revolution). However, many of the general points such as the difficulty of ensuring adequate knowledge of older people's needs on non-specialist units and the issue of adequate training for all who have to deal with old people with mental health problems will surely apply elsewhere. Because Huddersfield does not have a medical school, the views of those involved in undergraduate medical education are not represented.

Single methodology

We only used individual interviews. Ideally we would like to have also used focus groups and perhaps backed up our findings with a wider survey, to see how far they could be generalised. However, it was hard to get into people's diaries even for single interviews and a more comprehensive approach was beyond the resources at

our disposal.

6. Conclusions and Provisional Recommendations

How do we improve services? The NSF gives us a vision of what needs to be done. It needs to be backed by resources. You cannot have first class services for third class prices! It also needs to be backed up by management that refuses to be distracted by constantly worrying about meeting central targets and focuses on supporting practitioners to deliver constant improvement in the quality of services to patients. We need to move from the “carrot and stick” philosophy of management to one of leadership and education, more appropriate to the practitioner culture in health and social services.

To succeed, the NSF needs to be backed by development of clear educational strategies. Leadership for these should come from NHS workforce confederations. This report is published in the hope that it will support this development. Our earlier work on the Forget-me-not audit suggests that a strategy supported by continuous effort is needed if glaringly obvious positive changes are to receive the priority they deserve. In this study we set out to discover what key stakeholders thought was being done, what the gaps were and what was needed for the future.

To take forward the educational agenda for the NSF a strategic approach is needed to do the following:

- Embrace different methods - personal agency and service design as well as courses
- Include a variety of content - attitude-changing and technical
- Cross boundaries - health and social, mental and physical, caring and technical
- Be co-ordinated - sharing resources and best practice
- Be pervasive - starting in schools and involving all providers of health and social services
- Be planned like a marketing campaign - continually reminding commissioners, managers and providers of the needs of older people
- Be persistent: - changing attitudes takes time, knowledge & skills need constant updating
- Be well led - “champions” for the NSF in all relevant areas with support to facilitate delivery of the standards.

In addition we have noted what was known to be happening at the time of the study, what gaps and obstacles were perceived and what was needed in the future for each of the standards and each of the stakeholder groups. We hope this will be of use to those considering the educational needs arising from the NSF in different areas.

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