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The Ten Essential Shared Capabilities: Reflections on education in values based practice: A qualitative study☆

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SUMMARY

Background: This paper presents the findings of a study exploring the impact of a values-based training initiative on the practice of mental health workers. This work is set within the context of increasing attention on the values of nurses and other health care workers as a response to national reports on care failure and negative media attention.
Objective: To examine written response feedback from participants on a national training programme for values-based practice (VBP) in order to examine any intention to change practice.
Design: A national evaluation using quantitative and qualitative methodologies was conducted to gather data on reflections and self-report impact of the Ten Essential Shared Capabilities' training programme.
Setting: The training was delivered in a range of hospital, community and third sector training programmes across eight regions in England.
Participants: The participants were predominantly nurses but all sectors in the mental health community including service users as co-facilitators and participants were represented.
Methods: This study presents the qualitative findings from a cross-sectional survey. Using NVIVO 10 software, data were analysed using the framework method of qualitative analysis.
Results: Four principal themes emerged from the data'Thinking differently''Changes to practice''Creating an effective learning environment and skills for practice development' and 'Increasing self-awareness'.
Conclusions: The quality and safety drive in the NHS has an emphasis on delivery of evidence based practice. It was concluded that an active focus on values based practice merits equal attention and status.

Introduction

Standards of nursing practice and education in England are subjected to much external scrutiny. There are a number of critical reviews that focus on the mismatch between the values of the NHS (Department of Health (DH), 2013) and the practice and behaviour of nurses and those from other disciplines (HM Government, 2013). There have been large-scale reviews on mortality rates in hospital such as that conducted by the Chief Medical Officer (Keogh, 2013). Other reports also provide details of where care and support of nursing and other personnel have fallen well short of acceptable standards (Parliamentary and Health Service Ombudsman, 2011; Healthcare Commission, 2011). These reviews focus not only on nursing practice but also seek fundamental answers about the commitment of the NHS to patient safety (Berwick Report, 2013). A common element is the reference to 'values' and 'quality' in NHS provision.

The highest degree of public concern has focused on the standard of care at the Mid-Staffordshire Hospital Trust in the Midlands of England. This led to a national enquiry by Lord Francis, culminating in 290 recommendations for improvement in health care practice. In the recent response to the Francis enquiry, the Department of Health set out a commitment to the values in the NHS constitution (DH, 2013). Central to this is the understanding that patients are at the core of decision-making, not simply passive recipients of care or treatment. Previous policy has set out the value of 'respect and dignity' and 'compassion'. A commitment to putting the interests of patients before those of any organisation or system was made (Department of Health, 2006).

This recent scrutiny of the NHS has led to a recognition of the need to reflect on current culture and practice in the NHS and the revisiting of the values that underpin practice. One direct initiative is the consultation by The Care Quality Commission on a new set of fundamental standards: the inviolable principles of safe, effective and compassionate care that must underpin all service delivery in the future.

Public declaration of a commitment to quality health care is further evidenced by the Chief Nursing Officer's articulation of the 6 Cs (compassion, courage, care (quality/safety), communication, commitment and competency) (Department of Health/Chief Nursing Officer, 2012), and the introduction of over two hundred care makers as ambassadors

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for the 6 Cs. This focus on quality and values is the result of a number of high-profile quality failings (Parliamentary and Health Ombudsman, 2011; HM Government, 2013).

Despite these recent high-profile cases and the responses at the national level, discussions on values in underpinning practice is not new. Values-based practice (VBP) is an approach to health care delivery seeking to compliment evidence-based practice (EBP) (Fulford, 2008). It involves the utilisation of skills to promote balanced decision making in patient care, whilst also accounting for the complex web of differing value perspectives that lie behind the decision-making process.

In 2004, services in England launched a specific national initiative on values and practice, called the 'Ten Essential Shared Capabilities' (DH, 2004). To support this policy guidance, a set of 'values-based' educational materials were developed by the Sainsbury Centre for Mental Health and the National Institute for Mental Health England (NIMHE).[1] Since the closure of the NIMHE, a team of Mental Health academics at Lincoln University maintained responsibility for the ongoing development of ESC-related resources (CCAWI/MHRED, 2009).[2]

The ESCs are a description of the core aspects of practice that support service user focused care and treatment in mental health. They set out a range of core values and capabilities that all staff working in mental health services should achieve as a minimum within their fundamental care delivery. They were developed with the assistance of mental health service users, carers and personnel. To support their introduction and to gain detailed understanding of their potential impact, an educational learning resource of a values -based practice (VBP) education programme aimed at linking the values held by clinicians to their practice. was piloted across England.

With specific reference to the issues outlined above, this paper reports on the evaluation of the national pilot.

Initial quantitative data from the evaluation of the pilot study have been published elsewhere (Brabban et al., 2006). This current paper provides an in-depth analysis of the qualitative data relating to the experiences of the learners on the pilot of the national rollout of the programme.

The training initiative: development of the educational (ESC) resource pack

The resource pack, which consisted of a set of learning materials in both CD-ROM and paper format, was developed as part of an implementation plan on the core skills, values and knowledge needed to deliver service user-focused practice. The basis of VBP views 'values' not as philosophical constructs, but rather as a highly practical, behavioural endeavour with significant application in everyday practice. The aim of the programme was therefore to move beyond an acknowledgement of a statement of values, to the understanding of how values are manifest within nursing and other professional practices and to identify the challenges and opportunities that VBP presents.

Principles governing programme delivery

The ESC programme had an emphasis on self-reflection and group discussion around the practical application of values in practice. A key principle of the programme was promoting 'respect for difference of values'. The aims were to support and challenge participants to feel able to talk openly about their views on work, mental health and care delivery. Differences of opinion were considered a valuable resource when exploring the role of values in guiding personal approaches to practice.

The programme comprised the following five modules:

i) Introduction to the ESC
ii) Involving service users and carers
iii) Values-based practice
iv) Race equality and cultural capability and
v) Developing socially inclusive practice

Implementation

To identify the implementation sites, the Chief Executive of each NHS Mental Health Trust was contacted and invited to participate in the pilot programme.

This resulted in sixty sites from across eight regions in England offering to participate.

Following participation consent from the Trust Executive, a nominated lead from the region was identified to coordinate activities. Preparation events were planned and delivered by these regionally nominated leads.

The national programme manager and principal investigator (IMcG) attended planning events in each region and had ongoing contact with a representative of every site. Each site had flexibility on how to deliver the programme as long as the national manager was satisfied that they adhered to the national objectives.

Three options were available for the delivery of the programme:

1. Full face-to-face group sessions
2. Provision of the resources for self-directed study with subsequent group follow-up/discussion
3. Provision of the resources for self-directed study alone

The first of these three options was by far the most popular with very few opting for option three.

The programme was delivered over a period of three months.

Local training facilitators (service user trainers, university lecturers or organisational in-service training leads) were recruited to the pilot. Selection was based on their experience and competence as facilitators.

Methods

This study presents the qualitative findings from a cross-sectional survey. A questionnaire was developed to measure the experiences and views of the participants. To achieve a high response rate, participants were asked to complete the paper questionnaire and return it to the facilitator, who, in turn, posted the full batch to the principal investigator. Envelopes were coded numerically so that responses from individual sites could be identified. Consent was implied by virtue of completion of the questionnaire.

A total of sixty sites offered to participate in the training, but only thirty-seven sites provided any follow-up data in the form of questionnaire responses. Therefore, in this study, we consider the sampling frame to constitute all known trainees on the programme ($n = 579$) who were located in the thirty-seven training sites in England. The questionnaire contained multi-choice scales and the opportunity to provide free text responses. The research team received multi-choice questionnaire data from all 579 participants. The number of participants who provided qualitative written feedback totalled 385, equivalent to a sixty-six percent response rate for additional free text data. It is this qualitative data that forms the basis of this study.

Respondents were asked to provide basic demographic data but were not required to identify themselves. Questionnaires were coded

[1] The NIMHE was later disbanded and a new body, the National Mental Health Development Unit was launched in 2009. However, the NMHDU was also disbanded in March 2011.

[2] The Centre for Clinical Academic Workforce Innovation (CCAWI), a research centre at the University of Lincoln has now been re-established as the Mental Health Research, Education and Development (MHRED).