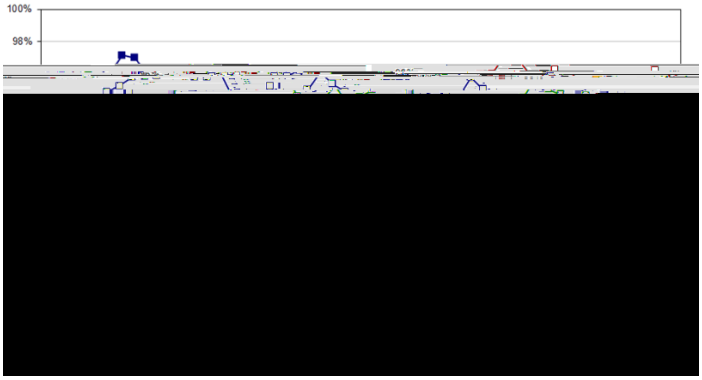

A series of opinion pieces commissioned by the Royal College of Nursing Scotland

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Foreword

Theresa Fyffe, Director RCN Scotland

In June 2015 RCN Scotland and the Academy of Medical Royal Colleges and Faculties Scotland issued a joint statement on the future sustainability of the NHS, calling for visionary change and bold action. This was the first time that the health professions had spoken with a single voice, emphasising the importance of joined up action and the serious and urgent nature of the choices we face in the NHS.

One of our four key actions for improving sustainability focused on targets in the NHS. We stated that, whilst targets had initially delivered some real improvements, they are now creating an unsustainable culture and can often skew clinical priorities, waste resources and focus energy on too many of the wrong things. We committed to develop an agreement across the professions on the principles which should underpin a new model for measuring success in our health service, focused on better outcomes for patients and supporting sustainable service improvements.

Since then we have engaged in many discussions on this issue with our members, with politicians from all parties and with health and social care partners across the public, third and independent sectors. Those discussions emphasised the real need for change and showed us that a new approach must reach far beyond the Scottish

The value of releasing human resources for change: people power?

Dr Lisa Curtice

Dr Lisa Curtice is currently Programme Director, People Powered Health and Wellbeing, Health and Social Care Alliance Scotland (ALLIANCE) and Honorary Senior Research Fellow at the Centre for Health Policy, University of Strathclyde. She is an academic researcher by background, and applying and teaching qualitative and participatory approaches to explore experiences, evaluate services and influence policy with and on behalf of people who are marginalised. For the past 15 years she has worked in the third sector and, from 2001-13, she was the first CEO of the Scottish Commission for Learning Disability (SCLD). Lisa has a longstanding concern for the wellbeing of staff in health and social care and is a facilitator for Values Based Reflective Practice (VBRP©).

Whatôs the problem?

It would be a brave person who argued that change was not needed urgently to chart a sustainable future for services to protect and enhance the wellbeing of people in Scotland. Why then does it seem so hard to get started?

I believe that change is stalling because we do not have the courage to harness the power of people who use and people who deliver our public services to bring about the improvements that could radically change health and social care. Indeed, people in many different roles often feel that they are actually prevented from making a difference as powerfully as they would wish.

Itôs about what we value

Securing a sustainable future for health and social care in Scotland will be dependent on what we value as a society. At the end of 2015 the Health and Social

And what we value, should be what we count. As Dr Alf Collins has argued, we need to change our measurement systems, so that we measure as well as deliver, what matters to the person (Collins, 2014).[4]
have to be embedded at every level of the system if we want a health and social care system that meets the needs of all citizens.

wellbeing and recovery, so minimising the risk of protocols that are not followed and repeat appointments that do not result in progress.

Putting more value on what can be negotiated through the relationship between the person and their practitioner is a powerful counterweight to a task-driven, target culture and holds the potential for returning to a more humane system of healthcare which many, professionals and public alike, see as a key aspiration for future care (Hannah, 2014).

An enabling culture for practitioners

Changes in culture and practice and a return to a more relational approach to care cannot happen if practitioners are struggling to cover basic tasks and are managed within a system that is fragmented and target-driven. What looks like efficiency is actually very wasteful if it leaves staff without the capacity and freedom to innovate and improve the care they offer. We know that what makes this possible is the absence of a blame culture, time and opportunity for teams to reflect on their practice and to share learning with their peers, a priority on practice development and improvement. These a
workforce that is supported to deliver safe, effective and person centred care.

Time to build relationships and share learning is especially important if health and social care integration is to deliver better outcomes. Differences of understanding and ways of working between professions and organisations cannot simply be eliminated overnight, but need to be negotiated by discussion between people.

Community strengths

The 20:20 Vision cannot be achieved in isolation from a flourishing community sector. Local projects, such as libraries and peer support groups enable people to stay well. Cuts to these services will reduce the capacity of communities to grow and maintain the support that can keep people from unnecessary hospita1 Tmmmu( )8(f)-112annr0 0 1

challenges many existing professional cultures, behaviours and organisational systems:

So what might a new target regime look like? For target-setting the aim should be to have targets that are:

based on evidence that progress towards the target will result in

terminal crisis. There is no easy solution but that is not a reason for rejecting an approach that seems right for patients provided at the same time efforts are made to develop greater public understanding of what it is reasonable to expect the NHS to deliver within the resources it is given.

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Waiting time targets

One of the first targets to be introduced related to long waiting lists for inpatient treatment.

In the 1980s, I was a consultant surgeon and, like most surgeons, I managed my waiting list myself. We ran two lists. One contained the names of those patients who need to be admitted rapidly because of the seriousness of their condition and the need for urgent treatment. The patients on the other list were those who needed non-urgent, routine operations. We would schedule for surgery the urgent cases and depending on the time their operations were likely to take, we would add some of the routine cases to the list. The reality was that, each week, the number of non-urgent cases taken off the waiting list was roughly equal to the number added after being seen at clinics. The waiting list never got smaller.

Waiting lists for routine surgery were unacceptable with many patients waiting more than two years for treatment. The Conservative government and its successor Labour government pursued waiting times by setting progressively shorter waiting time targets so that the vast majority of patients are now seen, investigated and treated within 18 weeks.

teams to test interventions that might bring about improved outcomes, they learn from each other and effective change is scaled up across the system. The SPSP has extended beyond acute care and is now transforming delivery in maternity and children services, mental health and primary care.

In the US, such Collaboratives have achieved dramatic results, including reducing waiting times by 50%, reducing absenteeism by 25%, reducing ICU costs by 25%, and reducing hospitalizations for patients with congestive heart failure by 50%. It is difficult to imagine that politically set targets could have achieved such results.

The evidence from the US, Scotland and Scandinavia is that radical change in service delivery can be achieved, usually within existing resources, by allowing frontline staff to identify problems, test possible solutions and share their successes and failures. In this way, improvement is scaled up across the whole system. In empowering staff, change happens because of them, not despite them. It is sustainable and becomes a habit which allows the service to adapt positively to new challenges. NHS Scotland knows how to do this. Giving them space to create their own improvement programmes will produce a better NHS than targets ever could.

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the socio-economic gradient in

Time to stop the dancing of opposites?

Robert Carr

the way in which services are now provided. Patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are treated as consumers exercising choices. A wider range of healthcare professionals now provide treatment and advice of one kind or another to members of the public, either as individuals, or as members of a team drawn from different professional backgrounds. The treatment which the team can offer depends not only upon their collective clinical judgement but upon bureaucratic decisions as to such matters as resource allocation, cost/containment and hospital administration, decisions which are taken by non-medical professionals. This integrated teamworking gives rise to challenges in defining and establishing professional standards in the context of evolving practice. There is a need for health and social care providers and the relevant regulatory bodies to provide advice, guidance and exemplification. It has become easier for the public to obtain information about symptoms, investigations, treatment options, risks and side-effects via the internet and support groups. The labelling of pharmaceutical products and the provision of information sheets is required by laws premised on the ability of the citizen to comprehend the information provided. It is a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent upon a flow of information from doctors. The idea that patients were medically uninformed and incapable of understanding medical matters was always a questionable generalisation but to make it a default assumption on which the law is to be based is now manifestly untenable.

There have also been developments in the law. Under the stimulus of the Human Rights Act 1998 the courts have become increasingly conscious of the extent to which the common law reflects tradisJETBT10 1 214tof unninglylnt -3(h)-3rts hagu 3(v)10()6(m)-6s

by support. The wrong things were measured with a focus on inappropriate targets. There were multiple failures in communication. Periods of change coincided with a loss of institutional memory. Prolonged uncertainty over changes had damaging effects on recruitment, on staff morale and on the physical environment of hospitals and clinics. Where systemic concerns were identified these were not addressed. There was a lack of coordination and real collaboration. Boards lacked true diversity and the necessary skills and experiences to challenge management effectively. Organisations became slow and bureaucratic. Silos developed. At an operational level managers failed to employ their judgement and take appropriate actions in response where necessary. Clinical governance and monitoring did not operate effectively. Rigorous inspection systems of prevention and control were not instituted. Regulators failed to intervene timeously. Effective systems were not in place to enable lessons learned elsewhere to be applied. Stakeholders including service-users, employees, victims, survivors and the general public were not listened to. Many vulnerable and frail patients suffered a lack of dignity causing enormous distress.

These reports recommended that a number of central issues be addressed including: making sure that both staff and the public understand the needs of patients within a hospital and community setting; creating an organisational culture which enables staff to practise professionally with confidence at all times, both individually and collectively; developing a consistent, whole-organisation approach to quality and patient safety which uses intelligence and data about services and experiences as the basis for decision-making, action and change; making sure professional staff operate in cohesive clinical teams; embracing strategic organisational development and rigorous workforce planning with the righqQigorous inctively

conducting dialogues over difficult, dangerous and controversial issues which are more effective than the traditional means of adversarial dispute resolution.

The more successful Scotland's economy is, the better funded and better quality our public services will be. Scotland lags materially behind countries like Norway, Australia, Austria, the USA and Switzerland in Gross Domestic Product Per Person. The principal reason is that these countries are more productive than us. The solution is better skilled people, better infrastructure and better innovation and efficiency. Investment skewed to the health and education of our very youngest is needed but this requires a collective commitment to a longer term agenda. This has begun with the Early Years Framework and Curriculum for Excellence but needs stepped up and more consensus. In time, the benefits for Scotland's economy and the wellbeing of our people would be significant.

Success in our health service is an ever shifting frontier. We will know that we are close to that frontier when stakeholders consistently report back to us their high levels of satisfaction and recognise our commitment to excellence. Talented people across the globe will seek us out because we are seen as powerfully collaborative by adding value to all those we work with and for. Other nations will look to us for leadership, inspiration and best practice. Other international influencers and opinion formers will regularly talk about us as a progressive nation delivering real value to service users and our communities. People in Scotland and beyond will want to work in our national health s want8eo(n)-3(n)6(o)6(v)10(a)-3(tB3(n)tgrl35(d)6(a)-5(n)6())-5(p)ro72.023(ic

caring practices and greater effectiveness in outcomes that matter to patients and families the case.

culture of practice but instead create a façade for the public face of practice. The real culture, or what Kim Manley and colleagues have referred to as the (the culture created and recreated each day in small semi-autonomous units) that exists under the radar of the dominant target-driven culture is very different to that.

Over the years I have come to realise that no amount of targets, monitoring, hierarchies or controls would prevent patients from experiencing neglect as we have seen most recently in a number of healthcare scandals in which nursing standards have been shown in a poor light. But that lesson is a hard one to learn as we s

demonstrates the effectiveness of the nursing contribution to the quality of the care experience
judged by his clinical assessment profile, patient throughput and compliance with pre-specified performance indicators. If we are able to capture the beauty of caring encounters demonstrated by Shaun and the many other Shauns in our healthcare system, then the dance of caring practice can be fully understood and realised. That requires a different mind-set

Concluding comment

I believe that now is the time for us to embrace the dance of contemporary nursing, to capture the real mood of nursing and shape its beat as one that is firmly rooted in its traditions of care and compassion, but with all the qualities of a contemporary visionary confident profession.

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