MEASURING SUCCESS

PRINCIPLES FOR A NEW APPROACH TO IMPROVING HEALTH AND WELLBEING IN SCOTLAND

WWW.RCN.ORG.UK/SCOTLAND

@RCNSCOT

FOREWORD

In June 2015, the RCN and the Academy of Medical Royal Colleges and Faculties in Scotland published a joint statement, 'Building a More Sustainable NHS in Scotland[1]', which called for a new, more mature, approach to NHS targets. Together the RCN and the Academy stated:

T a a ac a d a a a a d a a a d d a a c a a a ab a a ad NHS. I – c ca , a c a d a .mai65.2 (o)6.5 loacsre mn06Tfw

JOIN THE DEBATE ON TWITTER AT @RCNSCOT #INTHESPOTLIGHT

PRINCIPLES FOR MEASURING SUCCESS IN HEALTH AND WELLBEING

There is no perfect way to measure the success of services in improving health and wellbeing. On that basis this paper puts forward a set of principles, which the RCN has developed through engagement with partners across Scotland, to shape the detail of a future approach. Taken as a whole, the RCN believes these principles will help Scotland build the new system to measure success in health and wellbeing that it so urgently needs.

FOCUS ON A SINGLE SET OF OUTCOMES TO SET PRIORITIES

Scotland should develop a new national outcomes framework, with the full participation of the public and health and care sta across the public, private, independent and third sectortrl

ACCEPT LOCAL VARIATIONS WITHIN THE NATIONAL FRAMEWORK

The Scottish Parliament should reach a cross-party consensus on the scope of national, local and individual control on setting priorities for success.

Where the setting of measures is devolved to local partners they have a responsibility to state how their decisions □t with the national outcomes.

CONTEXT

FOCUS ON A SINGLE SET OF OUTCOMES TO SET PRIORITIES

Scotland should develop a new national outcomes

These indicators should provide a temperature-check on how health and wellbeing services across Scotland are working to deliver what matters to people.

The indicators should be open to regular review.

The NHS alone accounts for one-third of the Scottish budget. Add social care spending to this in the light of integration and that □gure clearly rises considerably. Health and wellbeing organisations must therefore be able to be held to account for their use of public funds whether by scrutiny bodies such as Audit Scotland, the Scottish Parliament or the public.

The RCN, like the members and partners it heard from, accepts that there is a need for decision makers to be able to measure the impact of the choices made. This is in the public interest and ensures that the Parliament is able to hold the Government to account.

Outcomes focus on broad, long-term aspirational change. They do not, on their own, give politicians or the Scottish public tangible measures of ongoing success. They do not, in themselves, highlight where problems are emerging in real time. They cannot show, in the

wound heals properly and to discuss the e□ects of her painkillers on how she feels, so she can make a better choice about which pills to take and when. And she wants someone to go with her to the shops or to her book club while she □nds her feet and gets her con□dence back. A waiting time target will not empower her to re-gain good health and wellbeing or claim her right to health.

The RCN believes that Scotland needs an urgent reappraisal of a reliance on waiting times as a means of enshrining patients' rights. Instead Scotland should prioritise personal outcomes, a human rights-based approach and a culture of shared decision making. These outcomes are far less easy to measure and report on than a waiting time target. There are, however, already tools in use, such as 'What Matters to Me', that could be used to rethink how Scotland de□nes success at a personal level and in a far more human way.

IMPROVE OUTCOMES THROUGH COLLABORATION AND INNOVATION

Scotland has a strong foundation in clinical collaboration. Work to improve outcomes, test innovation and ensure the quality of care should build on this by devolving power to networks of expert and experienced people to create and implement robust, evidence-informed measures of success.

New collaborative networks should include expertise from across all sectors and from people who have, or have had, particular conditions. They should have access to resources to implement changes that will improve outcomes. And specialty networks must □nd ways to work together to ensure people with multiple health conditions can still enjoy a joined-up, e□ective service.

to hav eh(c)7 -4.3 (e tb7 (e)-5 (y t)4.7 13.9(ei)7 (r e)-19(x)-16.9(ps 7 (n)k0.8(r)-4.7.6a)5 (r)-l 9)]TJ0 -1.23 ertiy ti3 8o havf is8a ch

Empowering communities and individuals to become active participants in maintaining and improving their own health will only occur if it can be embedded in a changed culture that also empowers the professionals who deliver services to have the authority to use their expertise and act. Throughout the RCN7 (t)-2 (h)1.4 (o)1i2on5 (n)3.8(4.5 (5036)1.2 (h)38(t) (n)8(a)6.3 (l)-1]TJ07ss5.50 -1.2 Tc 0.0w8TD[(a)4.8

Where the setting of measures is devolved to local partners they have a responsibility to state how their decisions fit with the national outcomes.

In the UK people cherish the idea of a national health service. In setting priorities through developing new measures, the founding principle of the NHS – that it is free at the point of need – must be clear. Some interpret that as universal, almost identical service provision. Yet in practice, local variation in the availability and delivery of services has always existed.

The RCN has identified three drivers which in Scotland have added to local variation.

First, constitutional devolution has sped a process of divergence between systems across the UK. Structures, priorities, funding decisions and legislation now look different in each of the four countries.

Second, equity is rarely now thought to be achieved by equal provision for all, but by targeted provision that results in equitable outcomes. This is often now described as 'proportionate universalism' in acknowledgement that greater resource should be directed to those in most need if persistent health inequalities are to be reduced.

And finally, there is a cultural shift towards devolution of power and decision making to the local and to the individual level. The Public Bodies (Joint Working) (Scotland) Act 2014, the Community Empowerment (Scotland) Act 2015 and the Social Care Self-Directed Support (Scotland) Act 2013, among others, are commitments to increased local determination of priorities based on identified need.

However, when it comes to measuring success in practice the NHS is still driven largely by national prioritisation, national process targets and national performance management. This leaves an important question – how does Scotland square the genuine concern of 'postcode lotteries' in NHS services with the reality of recent legislation that actively promotes variation in service commissioning to be more sensitive to local need and aspiration?

In discussions with partners the RCN repeatedly heard concerns about the emerging dissonance between national and local priorities and fears that unresolved strategic conflicts in approach result in local tensions that are hampering attempts to integrate care on the ground.

So, as the Scottish Parliament and Scottish Government address the future of health and wellbeing services, the RCN believes that transparency about where the power to define, invest in and measure success is being devolved, and where active control over setting and managing priorities for the whole of Scotland is being retained centrally, will be crucial.

National scrutiny of local variation will still be important, but where there is devolved decision making justifiable differences in service provision and delivery will need to be supported. With an outcomes approach to measuring success it will be more difficult to make simple comparisons between services and the decision to permit variation may prove a challenging one, requiring a new way of describing success in the public domain. Where local partners have been given accountability for defining and measuring success, they should have a responsibility to demonstrate how their decisions will help to deliver on the new set of shared national outcomes.

BE CLEAR WHAT ANY MEASURE IS INTENDED TO DO

The purpose of any new measure should be transparent to ensure that it is developed, implemented and reported on appropriately.

All measures should be developed with an exit strategy so that when they are no longer needed they can

implementing the National Clinical Strategy – are taken forward in the future. Where local bodies can determine their own success measures, and shape investment and services to match, there will be direct consequences for the shape of national changes that operate within the same system

For example, an Integration Authority might make a decision to prioritise measures on improved prevention activity and, as a result, shi historic investment in community hospital beds to increase funding for early interventions o ered by the third sector. If a future national hospital regionalisation programme were to be developed without taking this into account, and it was built on the assumption of local rehabilitation bed provision, patients simply will not have the right services in place.

This is a fundamental rebalancing of the current power dynamic. Scottish governments of the future will be unable to assume primacy of central policy direction where measures, and consequently resource allocation, are determined locally. And no local partner will be able to ensure the quality of their care without fully understanding how their transformation plans will interact with changing national provision. For that vision to become a reality there needs to be a mature and respectful dialogue between national and local decision makers to set joined-up priorities for investment.

INVEST IN DATA TO SUPPORT THE NEW APPROACH TO SUCCESS

The Scottish Government, with cross-party support from the Scottish Parliament, should create a data investment plan to accompany the transition to a new approach to measuring success. Scotland's analytical and improvement experts need to be supported to help drive transformational change.

Any new policy priority or strategy set by the Scottish Government must include a statement on its impact on existing measurements and the investment required to develop any new measures to assess success.

In the RCN's conversations with partners, a clear consensus emerged that at the moment Scotland is creating a bold vision of the future, but too o en measuring the past. If what is measured is what is delivered then however aspirational Scotland might wish to be about transforming services, it will continue down its current path if it fails to address the fact that it is measuring many of the wrong things and not always focusing existing rich data sources in the right way. Creating robust, evidence-informed measures and then changing systems and cultures to prioritise the collection and

GLOSSARY OF TERMS

Words such as 'target' 'indicator' and 'outcome' are o□en used rather loosely and interchangeably in public discourse, whilst being the focus of detailed academic debate on the margins of terminology. This can be confusing. This glossary is intended to explain how the RCN has chosen to use certain terms within this document.

Target: A speci□c and measurable goal to be achieved. Targets in health care tend to focus on measuring service activity or processes, such as the maximum amount of time someone should have to wait for a particular service. In health care they are generally set by governments or organisations.

Outcome: A type of measurement, in health, that focuses on improvements in the quality or length of life or in the experience of receiving care. Outcomes focus on the end result of care. They can relate to an individual, communities or wider populations and can be set by governments, organisations or individuals (personal outcomes).

Standard: A way of setting out what quality care looks like. Clinical standards are informed by evidence and developed by expert clinicians to improve quality and reduce unwanted variation in how care is delivered for best clinical results. In various forms, standards are also used as a means of regulation, both for individual professions and service delivery organisations. They are also commonly used by governments and organisations to set out what services and behaviours patients and carers can expect of any particular system (e.g., the National Care Standards).

Indicator: A means of using data to provide an indication of performance. Indicators are o□en used to provide regular information on how well an organisation is progressing towards meeting a long-term, aspirational outcome.

Sentinel/headline indicator: Terms coined by the King's Fund and the Health Foundation in recent work on performance measures in England. Essentially a measure chosen to help give an overview of how well a system is performing in those areas deemed to matter most to people.

Measures: In this report the RCN uses the term 'measures' to include all of the terms listed above, each of which should lever improvements in services or health and wellbeing, help prioritise activity and resources and provide accountability.

Proxy measure: A measure chosen as the best possible substitute when it proves impossible to measure a required change directly. Di□culties in direct measurement might arise, for example, where it is not feasible or cost e□ective to collect certain data that might help measure a change.

Collaborative: The RCN is using this term to cover any collective of peoplorig t20of phe Rany -3 .47c 0.01nnteay

[1]ROYAL COLLEGE OF NURSING SCOTLAND and THE ACADEMY OF MEDICAL ROYAL COLLEGES AND FACULTIES IN SCOTLAND (2015) *Br[illegible]*

[2]ROYAL COLLEGE OF NURSING SCOTLAND (2016) *I[illegible]*