Royal College of Nursing
Scotland

MEASURING SUCCESS

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

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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:

The current approach to setting and reporting on national targets and measures, while having initially delivered some real improvements, is now creating an unsustainable culture that pervades the NHS. It is often skewing clinical priorities, wasting resources and focusing energy on too many of the wrong things.

This paper, published one year later, delivers the RCN's commitment to develop principles for a new approach to measuring success, which focuses on outcomes for people who need to use services and on sustainable improvement across health and wellbeing services. It is intended to further the discussion on measures of success by setting out some core principles, which could help to shape a new approach. As such it is neither a ready-made list of future outcome measures nor a 'tick-box' list of which current targets to drop.

Over the last 12 months, the RCN has discussed how Scotland measures success in health and wellbeing with our members and with partner professions, with colleagues in the third, independent and social care sectors, and with politicians from across parties. The RCN has commissioned and published opinion pieces on the future of NHS targets from six civic leaders in Scotland[2]; and 'Nursing Scotland's Future: professional voices, practical solutions' – the RCN's manifesto for the Scottish elections[3] – called on politicians from all parties to support a new approach to measuring success.

This engagement has underlined the RCN's belief in the importance of collaborative development and ownership of success in health and wellbeing and the urgent need for change. Scotland must reach a consensus on targets, and transform commitment into action, to deliver that vision. Prioritising investment, and measuring success by looking at the positive impact that services have on the health and wellbeing of individuals and communities across Scotland will be key.

My thanks go to the many colleagues in Scotland who have supported the development of this paper; I hope they will see the topics they raised and debated reflected in its content. I look forward to continuing to grapple with these issues, in full partnership with all professions, service providers, politicians and the wider public.

Many of the issues raised here go to the heart of how services should deliver for the people of Scotland in the future. Scotland cannot afford to get this wrong.

Theresa Fyffe
Director, RCN Scotland

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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 staff across the public, private, independent and third sectors.

The framework should provide a single, shared focus for setting priorities for policy, investment and activity across all agencies. It should simplify, not add to or confuse, the current picture.

Change should be developed, planned and implemented in a phased and responsible manner.

ENSURE CLEAR, PUBLIC ACCOUNTABILITY

Once the national outcomes framework is set, the Scottish Government should develop with all stakeholders, including the public, a small set of new national indicators for health and wellbeing.

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.

LISTEN TO AND EMPOWER INDIVIDUALS

The new approach should empower individuals by listening to them and supporting them to achieve their personal outcomes.

There should be shared decision making and a human rights-based approach embedded across the entire system.

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 should find ways to work together to ensure people with multiple health conditions can still enjoy a joined-up, effective service.

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 fit with the 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 be retired.

Proxy measures should only be used where all other options to measure an improvement issue directly have been explored by partners and reasonably rejected. They should be reported within the context of the wider issue they are intended to help to improve.

Regular reviews should assess whether the unintended consequences of implementing a proxy measure have come to outweigh the benefits, and a new approach is required.

TOLERANCES SHOULD BE BUILT INTO THE SYSTEM

The new approach should build in agreed tolerances to all quantifiable measures.

Performance management within tolerance levels will allow for the best use of resources, particularly at times of unexpected pressure, and a more sophisticated investigation of performance to support genuine improvement.

REBALANCE POWER TO CHANGE THE CULTURE OF SERVICES

The Scottish Government, working with all stakeholders including parties represented in the Scottish Parliament, professionals, providers and the public, should outline clearly the culture of services that Scotland wants to develop. The performance management of services, whether local or national, should live up to those aspirations.

Decision makers at every level should enable and champion a cultural transformation through proactive support for continuous improvement, rather than blame.

All sectors and professions will need to commit to sharing control and resources to best meet the needs of people using services.

The bodies responsible for setting priorities for services locally and nationally will need to collaborate to ensure consistency of purpose and avoid competing priorities which may harm patient outcomes and waste resources.

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.

CONTEXT

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 staff across the public, private, independent and third sectors.

The framework should provide a single, shared focus for setting priorities for policy, investment and activity across all agencies. It should simplify, not add to or confuse, the current picture.

Change should be developed, planned and implemented in a phased and responsible manner.

Throughout the RCN's discussions with partners over the last year there has been widespread support for the move to focus efforts across all health and wellbeing services to delivering shared outcomes.

The SNP, Scottish Conservatives and Scottish Liberal Democrats all made manifesto commitments to look again at targets, with the SNP supporting an outcomes-based approach.

In the Fourth Session of the Scottish Parliament, through the Community Empowerment (Scotland) Act 2015, the Parliament committed successive Scottish Governments to developing and regularly refreshing a new national outcomes framework, in full consultation, to direct the efforts of public services across the country. The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legal framework for health and social care integration, and a new set of national health and wellbeing outcomes have been established through regulation. And the Children and Young People (Scotland) Act 2014 also gives ministers powers to set outcomes for integrated children's services. These are just three examples of where legislation sets different outcomes.

Scotland is clearly in a transition towards outcomes shaping services, which is gathering increasing support. However, the shift to a streamlined outcomes focus is far from complete. Currently the confused market of targets, standards, outcomes, regulatory frameworks, strategic priorities and guidance which determine 'priorities' is pulling partners providing services in many, sometimes competing, directions. It is difficult to over-emphasise how strongly the RCN heard this message in discussions with its members and partners. Different bodies 'own' different measures. Some are on a legislative footing; some are not. This can all stoke friction, rather than underpin collaboration across sectors and professions in the natural jostle for position in a changing landscape.

In addition, whilst there are clear cross-party priorities in health and social care – for example, reducing health inequalities or providing more care outside of hospitals – these are often not the prime focus of the most high-profile measures. And it is those high-profile measures which dominate debates on the NHS, continuing the cycle of attention on hospital investment and performance as the barometer of success.

Setting shared national outcomes should be Scotland's means of agreeing priorities for long-term and coherent improvements in society. A set of national outcomes would, the RCN believes, give a mandate for decision makers and organisations to target decisions on investment and disinvestment and streamline the activities of everyone by bringing people and resources together with common purpose.

The RCN supports the principle of a set of shared national outcomes, developed in full and open consultation with the public, staff and service providers. This will, however, require all existing measures to be systematically reviewed to ensure that the new national outcomes replace the myriad of current measures, rather than just adding to and confusing the picture even more. In order not to destabilise the system, this transition must be undertaken in a planned and responsible way.

The Scottish Government has previously separated online reporting of the national performance framework and the NHS performance framework within the online 'Scotland Performs' portal. To ensure the considerable investment in the NHS is fully aligned with the work and focus of partners, the contribution of the health service should be wrapped entirely into the new national outcomes framework, rather than sitting alongside it.

ENSURE CLEAR, PUBLIC ACCOUNTABILITY

Once the national outcomes framework is set, the Scottish Government should develop with all stakeholders, including the public, a small set of new national indicators for health and wellbeing.

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 figure 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 short term, if the wrong choices have been made and priorities need to shift to meet an outcome. They cannot give assurance in real time that money is being spent effectively and responsibly.

Given that, the RCN believes that Scotland needs a set of nationally-reported and audited short and medium-term indicators, specific to health and wellbeing services and, if appropriate, to the NHS alone. As a rule, the RCN would expect these indicators to be explicitly linked to achievement of the national outcomes framework. On rare occasion, and where all other attempts at improvement have failed, there may be a need to focus on particular service failings, which are having a significant negative impact on health and wellbeing.

The RCN heard different opinions on how national indicators might be set. However, the recent work on NHS indicators and measures from the Health Foundation and the King's Fund in England may provide a helpful basis for a further discussion in Scotland[4]. In completing parallel work for the Westminster Government, both recommended that national indicators are not selected by aggregating local measures which, though appealingly simple, can give crude results, false assurance and too little information to support actual improvement. Instead, they both suggest that a very small set of 'sentinel' or 'headline' indicators should be developed, with the full participation of the public to determine what matters to them, as a means of taking the temperature of health and wellbeing services.

The RCN believes that in addition to politicians and the public, staff from across all sectors should be involved in this process, in order to bring their clinical and professional expertise to the mix. This approach would help to build shared ownership in success from the very start.

Financial governance and accountability in health and wellbeing services will remain important given the amount of public money involved. The RCN has long argued that setting NHS boards a rigid, annual target to break even reduces their ability to make the sort of long-term investments required to create more efficient and effective services. A more mature dynamic is required to ensure that transparent financial controls and monitoring of budgets do not disincentivise change or result in perverse decision making to the detriment of people's care.

LISTEN TO AND EMPOWER INDIVIDUALS

The new approach should empower individuals by listening to them and supporting them to achieve their personal outcomes.

There should be shared decision making and a human rights-based approach embedded across the entire system.

Neither the RCN, nor anyone it spoke to, wants a return to the 'bad old days' of people feeling disempowered and desperate whilst waiting two years for a routine procedure, such as a hip replacement, which could transform their quality of life. Some specific process targets may have a place in transforming care, but relying on them to enshrine patient rights within the health service can be a blunt tool for genuine empowerment.

Current waiting time targets may give individuals a 'right', on paper at least, to particular types of health care within a set time. But they do not focus on underpinning an individual's right to health itself.

For example, say an older woman who lives alone is discharged from hospital after a serious fall. She is guaranteed an appointment at her GP surgery within a certain time and could probably ask the hospital for an outpatient appointment if she was really worried, but that does not match with her priority which is to be able to do her own shopping and get out to see her friends. What she wants is a regular home visit from a nurse to make sure her leg

wound heals properly and to discuss the effects 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 finds her feet and gets her confidence 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 defines 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 find ways to work together to ensure people with multiple health conditions can still enjoy a joined-up, effective service.

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 RCN's discussions on a new approach to measuring success this was a recurring theme from all partners.

The targets Scotland has at present were often described as disempowering professionals by reducing the value of clinical judgement. An emphasis on raw figures, overlaid by a coercive performance management culture that can prioritise the achievement of a number over a person-centred response added to that feeling of disempowerment.

A new approach should make the most of the vast asset of expertise available in Scotland by trusting professional judgement and allowing staff to bring their skill and experience to making decisions about how to target activity and resources most effectively.

Not every measure of improved health care needs to be a national target. If, in the future, Scotland can focus on just a few national 'sentinel' measures, far more responsibility and accountability could be devolved to experts, working in networks across Scotland, to devise new ways to define and measure success on an outcomes basis.

On numerous occasions the RCN heard positive messages about the collaborative approaches that have emerged in particular areas, such as cancer. This work has brought together clinicians to address a problem or improve outcomes through appraisal of evidence and experience. The participants have embraced peer support and review and have worked to define, measure and own their part in the improvement of care and patient outcomes. The RCN believes there is merit in exploring the development of these approaches to drive up quality, improve innovation and ensure quality standards of care.

But collaborative approaches in an integrated, empowered landscape should be even more inclusive of expertise beyond the NHS, including that held by patients and carers, as well as those working in social care and the third and independent sectors. These partners are all integral to success, but may not at present be enabled or resourced to engage fully in this way.

For care to be genuinely person-centred, Scotland must also find a way to address the tension between individual clinical specialties and the lived reality of patients with multiple conditions who require joined-up services. To be effective these networks should have the means to harness new resources, including funding, where the measures and service changes they endorse could result in significant improvements in health outcomes and user experience.

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 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 be retired.

Proxy measures should only be used where all other options to measure an improvement issue directly have been explored by partners and reasonably rejected. They should be reported within the context of the wider issue they are intended to help to improve.

Regular reviews should assess whether the unintended consequences of implementing a proxy measure have come to outweigh the benefits, and a new approach is required.

As Scotland moves to a more coherent and streamlined set of agreed measures, it needs to develop a more nuanced approach to what each measure is intended to do. It is important that all stakeholders have an explicit understanding of the impact of performance measurement on the culture of services. That will help Scotland's decision makers to design measures that are fit for purpose, to know when they have done their job and to understand how they support people's wider aspirations.

For example, in none of the conversations the RCN had was it said that centrally-mandated,

process- focused targets, like the various access targets, are inherently bad. Rather partners felt that if Scotland is going to use them it must be clear on what they are intended to do and why; how they impact on other parts of the service; how they relate to outcomes; what impact the management of them has on staff and service users; and when to retire them. As Sir Michael Barber, former head of Tony Blair's Delivery Unit, has noted 'command and control approaches might get you from awful to adequate, but they won't necessarily lead to greatness'[5].

Measurements can be used for all sorts of ends. They can be used to improve patient outcomes; to improve clinical practice; to set expectations or priorities; to monitor areas of significant risk or failure; to force or incentivise a desired change in service or behaviour; to support patient choice; or to provide transparent accountability. Being clear about intent matters and understanding the impact of that intent on setting a culture is key.

There is a world of difference between gathering data on specific clinical performance measures within health boards to support benchmarking between teams to improve practice, and using that data to create league tables to enable patients to decide where to get their surgery performed. Similarly, setting a target to change clinical practice based on financial rewards or penalties sets quite a different culture from attempting to make the same improvement by a process of benchmarking and peer review.

It is never simple to set meaningful measurements and some things lend themselves to being counted more easily than others. As a result, sometimes proxy measures are set because they are simpler to assess.

For example, the RCN has heard the A&E four-hour target described as a proxy measure for improvements in community services. The premise is that if people can access their GP surgery easily they are less likely to turn up to A&E unnecessarily; or if district nursing or pharmacy services are properly resourced then people with chronic conditions are less likely to experience sudden escalations in symptoms that require emergency admission. So, invest in community services and the number of people turning up to A&E falls, meaning hospitals can speed the throughput of patients arriving at the front door using available resources and meet the four-hour target.

There is nothing wrong with this premise, in fact the RCN would support it: no-one should face long waits when they need urgent care; people shouldn't have to go to a hospital A&E department at all unless they face an unavoidable crisis. But the problem comes when the focus of the target becomes narrow and both investment and attention concentrate on the problem, not the cause, of the issue that requires a resolution.

The RCN heard from partners that targets can focus attention so closely on specific issues to the point that a whole systems approach can be lost. So, the A&E target focuses additional resources in A&E departments because the point becomes meeting the target, not changing the system. Over the last four years, the balance of health spending directed at community services, including GP practices, has hardly changed (maintaining at roughly 43% of spend), despite the presence of the A&E target and despite successive governments committing to shifting the balance of care to communities.

Pragmatically, sometimes proxies will be the only way to begin to measure, and provide accountability for, changes that are difficult to quantify. The sentinel measures that the RCN is suggesting are reported nationally, for example, will be proxies for the performance of the entire service. But proxy measures are a compromise position that should only be used explicitly and where no other effective and reasonable choice is available. And where proxies are needed, the performance reporting of these should not be limited to headline statements of blunt numbers, but should be set in the context of the wider issue being addressed.

TOLERANCES SHOULD BE BUILT INTO THE SYSTEM

The new approach should build in agreed tolerances to all quantifiable measures.

Performance management within tolerance levels will allow for the best use of resources, particularly at times of unexpected pressure, and a more sophisticated investigation of performance to support genuine improvement.

The RCN felt that there was a clear message from partners that building tolerance into measurement could avoid deeply unhelpful obsessions with the minute margins of success. In a complex world, like health care, there are very many instances where the language of 'pass' or 'fail' is too simplistic to be of use.

Say, in a hypothetical world, following a number of high profile failures in care the Scottish Government were to set a national waiting time target to guarantee assessment by a specialist, within an hour, for anyone with a serious head injury. But what happens if Scotland faces unprecedented winter weather that results in a spike in serious car accidents over a one month period; or, as a result of a helicopter accident elsewhere, the entire air ambulance fleet is grounded for safety checks, meaning accessing specialists is far slower for those at a distance from the major hospitals? In either instance, the target is likely to be missed, but reporting this as a pass/fail only may have a number of unintended consequences.

For example, managers would likely feel under pressure to throw resources at the target by taking money or beds from elsewhere in order to meet it in the short term, with other patients not protected by a target losing out. Or simplistic reporting of the target would not support a sophisticated ongoing appraisal of where improvements are needed to deal with risks. So it might not prompt a public debate on whether Scotland has enough trained specialists or has located them in the right place to deal with the unexpected.

The RCN appreciates that many national targets have been set in the spirit of tolerance, but they have not always been permitted to operate within that spirit. Tolerance must be reflected not only in how data is collected, but also in how it is reported, debated and actively performance managed for improvement.

REBALANCE POWER TO CHANGE THE CULTURE OF SERVICES

The Scottish Government, working with all stakeholders including parties represented in the Scottish Parliament, professionals, providers and the public, should outline clearly the culture of services that Scotland wants to develop. The performance management of services, whether local or national, should live up to those aspirations.

Decision makers at every level should enable and champion a cultural transformation through proactive support for continuous improvement, rather than blame.

All sectors and professions will need to commit to sharing control and resources to best meet the needs of people using services.

The bodies responsible for setting priorities for services locally and nationally will need to collaborate to ensure consistency of purpose and avoid competing priorities which may harm patient outcomes and waste resources.

When targets lever new money, alongside political and public attention, they inevitably also lever power (which when gained is hard to give up) into a complex system. As the RCN has debated the future with partners across sectors, this consequence of a system in which targets are perceived as the way to investment and importance has arisen in a number of ways.

Some third sector partners noted that lobbying for a target has sometimes been their only way to have a direct influence on the workings and considerable resources of an otherwise impenetrable and powerful public sector. However, some also noted that this does not always sit comfortably in a sector committed to improving personal outcomes. Also, whilst success in getting a target set may result in better investment, it might not always focus money on those things that could have greatest impact for a particular client group.

The RCN heard anecdotes from clinicians of the negative impact on morale and resources after being told to get on and deliver their 'P45 targets' at all costs. Conversely, partners spoke of the negative impact on how care is delivered in NHS departments that do not 'have' a target, when all those around them do – creating 'Cinderella' services.

In designing a new approach all stakeholders must be willing to redistribute influence and control in pursuit of improved health and wellbeing outcomes and a more sustainable health and wellbeing sector. The power inherent in setting and reporting on priorities must be wielded responsibly by all involved and stakeholders must hold each other to account in this. Ensuring that the process of choosing, setting and monitoring success measures is conducted with the full involvement of relevant client groups and all sectors and professions with a mandate to make a difference, will, the RCN believes, go some way to ensuring that targeted investment genuinely improves outcomes.

The cultural shift required should not be underestimated and all health and wellbeing staff should be supported to build new, respectful relationships.

A more dispersed model of measuring success will also have implications for how nationally driven service reforms to improve service – for example,

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, shift historic investment in community hospital beds to increase funding for early interventions offered 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 often 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 analysis of new data is neither easy nor cheap. But not investing in this is, the RCN believes, a false economy. Without it, Scotland risks wasting many millions of pounds of investment in transformational service change, never really knowing if hoped-for improvements in health and wellbeing have ever been genuinely achieved.

Much as the RCN is calling for Scotland to build on its considerable assets of professional expertise and user experience to set meaningful success criteria, so a new approach must empower and resource analysts and improvement experts across Scotland to develop innovative and appropriate measurements.

CONCLUSION

The RCN is confident that the ideas considered and included in this publication are transformative. If implemented fully they will change priorities, culture, funding, service design, participation and the very data we collect. But Scotland must guard against the temptation to simply add priorities to existing ones, rather than fundamentally reshaping what success looks like in a contemporary context. And throughout any transition Scotland must ensure ongoing, appropriate accountability for the quality and safety of services and the use of public funds. The shift the RCN is advocating must be developed in partnership, fully planned and phased responsibly to ensure that Scotland builds sustainable health and wellbeing services for now and for the future.

GLOSSARY OF TERMS

Words such as 'target' 'indicator' and 'outcome' are often 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 specific 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 often 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. Difficulties in direct measurement might arise, for example, where it is not feasible or cost effective to collect certain data that might help measure a change.

Collaborative: The RCN is using this term to cover any collective of people brought together, formally, from across geographic and organisational boundaries to work together to improve care and outcomes.

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[3]ROYAL COLLEGE OF NURSING SCOTLAND (2016) *Nursing Scotland's Future – Professional voices: practical solutions*. Available from: https://www.rcn.org.uk/nursing-scotlands-future/our-manifesto

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