# If Scotland's current framework of NHS targets has had its day, what next?

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



Royal College of Nursing
Scotland

March 2016

## *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 NHS to include all those working to improve health and wellbeing.

We don't pretend that there is a simple, universally-held view on how we should measure success in our fast changing health and care service in the future.  But it is only through listening to different perspectives, and then engaging in genuine debate with everyone who has an interest, that we will find a better way of doing things. That is why, at the end of 2015, the RCN commissioned six opinion pieces from a range of civic leaders in Scotland to help spark the mature debate, and change, we've called for.

Our writers have had complete editorial control over their contribution. Their only task was to address a single question in around 1500 words: "If Scotland's current framework of NHS targets has had its day, what next?". We received six very different responses to that question, and some interesting shared themes.

The RCN, in its election manifesto, has called for all parties to agree a new approach to targets by the end of 2016.  We hope that these short articles are an important contribution in that context.  At the RCN, we will use the ideas in them as the basis of further discussions with partners over the coming weeks. Then, building on all that we have heard, we will publish our own outline for the future in June 2016, just as the new Parliament begins its work.

I'd like to thank each of our writers for their time, thought and energy in participating in this work. And I now look forward to continuing the discussions with you.

**@RCNScot #sustainability**

*Foreword*

## *The value of releasing human resources for change: who's afraid of people power?*
# Dr Lisa Curtice

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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 has many years' experience of 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©).

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### What's 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.

### It's 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 Care Alliance Scotland (the ALLIANCE) held a think tank for 50 leaders on the theme of 'Creating Wellbeing'.[1] There was consensus that what is required is not merely improvement in systems, but change in how we see our responsibilities to each other across society.

This suggests that a focus on systems-led solutions will only take us so far. The ALLIANCE argues that human rights provide the best framework for ensuring that services are accountable to the citizens that they exist to serve. Human rights are about everyone being of equal value and they support the idea that people who use services and professionals who provide them are equal partners. Whilst human rights protect dignity, they also offer a robust framework to drive high quality health and social care, focused on the outcomes that matter to people themselves[2] and starting with people's participation in decisions that affect them. [3]

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[1] http://academy.alliance-scotland.org.uk/category/film; http://academy.alliance-scotland.org.uk/wp-content/uploads/2015/12/Think-Tank-Graphic-Report.pdf
[2] http://www.alliance-scotland.org.uk/news-and-events/news/2014/12/snap-health-and-social-care-action-group-briefs-msps/#.VreWWPmLTAU
[3] http://www.scottishhumanrights.com/careaboutrights/whatisahumanrightsbasedapproach

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]  Ways to listen to people's experience 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.

So, where are the hidden resources that can power a new approach and provide the fuel for a humane system of public services that moves beyond short-term targets towards more sustainable improvements in health and wellbeing?

## The capacity for self-management

Supporting people to be in control of their own lives and health would enable those living with one or more long-term conditions to live more hopeful and active lives for longer. And what is true for them, would be true for many others also.

Some of the ways that people with long-term conditions say that services prevent them from self-managing as well as they might include: not having the information they need, such as access to test results, and an attitude that the professional knows best.  Better information, support, trust and a more joined up response from services would be what would make the difference. Donna Barrowman, who runs the Hope Café in Lanarkshire, has written of the "sledgehammer" effect of an early menopause.[5] She writes:

"I am not stupid and do not wish to be treated as if I am.  I consider myself to be the expert in my own life – and would like to work in partnership with the experts in the field of medicine to optimise my quality of life."

## Shared knowledge, power and skills

Enhancing the control that people with lived experience have over their lives is not at the expense of the role and expertise of professional staff.  But it does represent a change in the relationship, one in which there is a greater exchange of knowledge and skills and a rebalancing of power.

The good news is that everybody benefits from a more equal relationship in the care encounter.  For example, a health improvement initiative that aims to improve outcomes for people who have been treated in intensive care, Project InS:PIRE at Glasgow Royal Infirmary, focuses the inputs of the multidisciplinary team on the outcome identified by the person themselves and finds that this provides an effective and efficient way of ensuring that each discipline contributes to a positive outcome for the person.[6]

A personal outcome is different from a service output or outcome; it is what matters to the person about their life. By changing the questions they ask, practitioners find that they can have a 'good conversation' with a patient and move from having to provide all the solutions themselves to enabling the person to contribute to their

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[4] http://www.health.org.uk/alf-collins-measuring-what-matters-patients-front-line
[5] http://smns.alliance-scotland.org.uk/2015/06/my-not-normal-journey/
[6] http://pphw.alliance-scotland.org.uk/resource/project-inspire-inspiring-better-outcomes/

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 are not 'nice to haves', they are essential preconditions for 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 hospital admissions. It is critical that local commissioning strategies see the big picture and are informed by an understanding of the value of local resources that may not be labelled as 'health' services to local people's wellbeing.

Too often initiatives have been funded and then withdrawn without an overall analysis of local community needs. Whereas, when people are engaged as influential participants in creating solutions to local needs they can uncover a wealth of local resources to keep themselves and others well.[7]  Local community plans provide an opportunity for a different approach.  In Kincardine and Mearns, for example, the community planning officers involved elected members, professionals from across sectors and residents in different local communities in describing what kept them well. This then informed the development of local priorities. The focus was on learning from what worked because:

"if we keep looking at the problems, we'll just keep creating problems".[8]

What is different about this way of working is that it is focused on building up the strengths in communities (GCPH and SCDC, 2015). However the approach

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[7] https://www.aliss.org/
[8] https://vimeo.com/153923102

challenges many existing professional cultures, behaviours and organisational systems:

"A move towards asset-based working reflects a commitment to work and operate in a different way: to involve people, to take risks, to share power, to facilitate and enable rather than provide, and to unlock the potential of people, places and organisations to work together more effectively for the common good". (GCPH and SCDC, 2015, p.80)

### A question and a challenge

What is it that we want from our health and care services in Scotland in the future? There is momentum towards a more humane system that not only puts the common good above profit, but people, individual people, above political or institutionally driven change.  That means we have to respect each other more and blame each other less.  It means we have to value what others have to offer, even when it means we have given up some power and control ourselves. And it means we make tough choices to shift investment to community priorities that are determined by people who live and work locally.

So the challenge is this.  What are we so afraid of?  It is time to trust that the whole will be bigger than the sum of the parts, that the only outcome that counts is whether the person's wellbeing is enhanced or maintained and that no one discipline or service has all the answers.  The challenge is to share power for the benefit, and with the active participation of, citizens.

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## *Targets won't go away; how we can make them better*
# Dr David R Steel OBE

Dr David Steel OBE was Chief Executive of NHS Quality Improvement Scotland until 2009.  In retirement he has held an (honorary) Senior Research Fellowship at the University of Aberdeen working in the Health Services Research Unit and the Business School.

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NHSScotland, like all healthcare systems, is facing unprecedented challenges as a result of the demographic pressures of a larger, older and frailer population with more complex needs,  technological advances that ever-increase capacity to save and improve the quality of life, rising expectations, and financial constraints resulting from the global economic situation.

This has led to claims, not just from the political right, that the principles upon which the NHS is based – comprehensive, universal, funded by taxation and largely free at the point of use – are unsustainable.  However there is no evidence that this is what the public wants in the UK, still less in Scotland; nor that it would significantly ease – still less solve – the NHS' challenges.  The NHS retains levels of public support that are the envy of other public services in this country and of most healthcare systems overseas.  The independent US Commonwealth Fund has repeatedly judged the NHS to be the most efficient and effective healthcare system of the 11 major developed countries it surveys; and a recent King's Fund blog shows that spending on healthcare in the UK is one of the lowest among the original members of the EU.

The problem is not the affordability of the NHS; the issue is the willingness of taxpayers to pay more and the reluctance of our politicians even to open up debate on using the growing tax powers of the Scottish Parliament or the introduction of a new progressive tax specifically linked to health and social care. Nor would any of the piecemeal changes proposed to raise more money, such as a token charge to visit a GP or abolition of free prescriptions, have more than a marginal effect. Ending the council tax freeze might in the short term ease the crisis facing social care but only a completely new system of local government taxation would have a significant impact.

Realistically therefore, in the present political climate, the response to the NHS' challenges needs to come predominantly from making better use of the resources currently provided.

In this context performance management and monitoring are critical.  Without them, how would those running the service know how money is being spent and what progress they are making?  Equally important, how else would the public and their MSPs know how well the resources they have provided are being used to meet agreed objectives and how well those who manage them on their behalf are performing? Effective performance management is essential to the management and accountability of any public service.

If Scotland's current framework of NHS targets has had its day, what next?

Targets were introduced into the NHS before devolution and subsequently their use has been extended significantly by first the Labour/Liberal administration and then by the SNP Government.  Evidence gathered by organisations such as the [King's Fund](#) show that they have been successful in improving aspects of NHS performance that matter greatly to patients, notably waiting times and infection control; but also that they have had unintended consequences, such as distortion of clinical priorities and neglect of other important non-targeted activities; that they have led to gaming, 'artificially' to boost performance in relation to specific targets; and that, after some years of improvement, performance is slipping back in the face of current financial pressures.

Targets also fuel the 'NHS in crisis' clamour by encouraging unbalanced media coverage – a 'near miss' of a few percentage points on waiting times focuses attention only on what are often only very small numbers of patients adversely affected not the overwhelming majority who are treated within the target.

My central argument is that the problem is not targets themselves but rather the way in which they have been designed and enforced, particularly in recent years.  Getting rid of targets altogether is in any case not an option.   No government is going to give them up. Nor would this be desirable, particularly at a time of financial stringency, when public spending is under pressure and waste in one area means less for other deserving areas.  The challenge is to develop a target regime that is both effective and sustainable in delivering the Government's objectives for health and social care and for public spending as a whole without the unintended and perverse consequences of the present system.

This may sound an impossible pipedream.  However, experience of both performance management and clinical standards in Scotland since devolution suggests otherwise, and that our size, history and culture give us opportunities that other larger and more politically diverse countries may not have.  The new system of performance management introduced to the NHS in 2005, and subsequently developed and linked to the National Performance Framework by the SNP Government, represented an attempt to develop a system that was based on agreed priorities for the NHS, which emerged from dialogue with the service rather than being imposed by the Government, and was tied into the NHS planning system including improvement and risk management plans for each Board.  For a period the system, known as HEAT (health improvement, efficiency, access and treatment), seemed to work but over time it has become more complex and it has lost the support of the service, particularly among clinical staff.

Useful lessons can also be learned from experience of setting and monitoring clinical standards in Scotland since 1999, and the proposals set out below draw upon this and my own experience in its development and operation until 2009.  From its inception, the Clinical Standards Board (later NHS Quality Improvement Scotland and then Healthcare Improvement Scotland) decreed that standards should be evidence-based and, to be sustainable, that they had to be developed and owned by staff and by patients, and that monitoring of performance should be constructive and non-punitive.

If Scotland's current framework of NHS targets has had its day, what next?

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 improvements in patient outcomes and/or experience (recognising that levels and types of evidence will vary)
- closely aligned with agreed priorities for the NHS and comprehensive so that all the main priorities are covered (crucially including also those relating to social care services provided by integration joint boards). This requires a much more open debate about priorities.  The NHS cannot do everything and, whilst it has been remarkably effective in fudging this issue over the first 68 years of its existence, this is no longer sustainable or, in my view, politically acceptable in a mature democracy
- developed in partnership with patients and with health and social care staff (to win their support and to reduce the likelihood of gaming)
- realistic in terms of resource availability
- relatively few in number and regularly reviewed to ensure that they remain relevant.

The monitoring process needs to balance two essential requirements: external accountability; and shared ownership between government, Boards, and staff and patients.  On the basis that most breaches reflect underlying and often intractable problems affecting either the service as a whole or particular parts of it rather than incompetence or lack of will, monitoring should be non-punitive.  The focus should be on improvement.  Again the experience of monitoring clinical performance is instructive.  Initially reporting was seen as the end of a process rather than one - albeit very important – stage towards improvement.  Since the development of the Scottish Patient Safety Programme, increasing emphasis has been placed on implementation, and provision of active support to Boards in making improvements. When HEAT was first introduced a similar approach was intended through the creation of a central support team but, particularly as it was based in government, it came to be regarded by the service – rightly or wrongly – as a hit squad.

Monitoring should therefore:

- start with self-assessment, but with agreed and validated national metrics
- include external review involving representatives of the service and the public as well as government; and potentially it should be entrusted to an organisation with a degree of independence from government
- be conducted in a constructive manner designed to disseminate good practice and encourage improvements in performance
- be backed by support, including where necessary additional resources specifically linked to agreed improvements.

A targets regime along these lines may be caricatured as soft but it is more likely to produce results and to be sustainable.  The challenge to the service would be to make it work and to demonstrate improvement.  There is however one significant elephant in the room – media coverage of the NHS.  There is an apparent inconsistency in present coverage: support for the NHS as a much-loved institution but frequent and sometimes exaggerated exposure of every failing as evidence of

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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The views of this article are those of the author and do not necessarily represent the views of the Royal College of Nursing.

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## *There are better ways to improve the NHS than setting targets*
# Sir Harry Burns

Sir Harry Burns is the University of Strathclyde's Professor of Global Health. He also has a leadership position within the International Prevention Research Institute (IPRI). He graduated in medicine from Glasgow University in 1974, then trained in surgery and was appointed Honorary Consultant Surgeon and Senior Lecturer in Surgery at the Royal Infirmary in Glasgow in 1984. Working with patients in the east end of Glasgow gave him an insight into the complex inter-relationships between socioeconomic status and illness. In 1994, he went on to become Greater Glasgow's Public Health Director. From 2005 until 2014, Dr Burns served as Chief Medical Officer for Scotland, where his responsibilities included public health policy. He was knighted in 2011.

Target setting as a means of managing the NHS began in the 1990s by a Conservative government. The number of targets expanded during the subsequent Labour government. Many similar targets have been used in Scotland, probably on the basis that the Scottish Government does not wish Scots patients to receive any less of a service than is available in England. However, Scotland has developed different and more effective ways of improving health services. It can be argued that wider use of such techniques would be more effective in creating a modern NHS responsive to patient needs.

### The origins of target setting
"If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be looking for the people in charge." With these words, Sir Roy Griffiths ushered in the era of general management in the NHS. In 1983, Griffiths, then Chief Executive and Deputy Chairman of Sainsbury's, was asked by Margaret Thatcher to lead an Inquiry into Manpower in the NHS. Griffiths decided that it should be about how the service was managed.

Until that time, the NHS was run by "consensus management". Decisions around the running of hospitals were supposed to be made by agreement across all staff. Administrators implemented the group decisions. Where staff were prepared to compromise, the system worked. However, entrenched opinions of senior staff, more often than not, got in the way of sensible decision making and necessary change was often blocked. The widely held view was that consensus management could not modernise the NHS and Griffiths provided the ammunition the government needed to usurp the power of senior doctors. General managers were appointed to run hospitals and around 10% of them came from industry. Few were healthcare professionals.

A few years later, the pre-eminence of the manager became absolute with the introduction of internal markets and the division of the NHS into purchasers, who had the money, and providers who needed the money to maintain care.

## 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.

The solution was to pay for increased capacity for surgery. Fortunately, funding for the NHS was growing consistently during this period and the target was achieved in many places by having treatment carried out in the private sector. Few clinicians objected. Indeed, several earned significant amounts of money by carrying out these "waiting list initiatives" in the local private hospital. Waiting times for surgery in UK hospitals now compare favourably with other countries. However, the targets did not make the change happen, the extra funding was what made the difference.

## Targets as a means of political control of the NHS

Having achieved success over waiting times, government obviously concluded that setting targets should become a preferred method of control for the NHS. Since then, governments have increasingly pursued performance management by targets.

Where did the focus on targets come from? As the culture of management took hold in the NHS, various management styles and processes began to be discussed by health policy and management academics. One of these was the concept of "Management by Objectives," a concept first proposed by Peter Drucker in the 1960s. MBO was offered as a way of keeping managers' eyes on the priorities of the organisation. Drucker saw these objectives as a way of preventing busy executives losing focus. It may be that, initially, target setting was seen as a form of MBO which had been effective in various production industries.

What seems to have escaped the attention of the politicians was that objective setting, as originally described by Drucker required participation by all members of the organisation. If everyone had a say in shaping the plan, when it finally emerged, the workforce would feel a sense of commitment to it. They would be committed to monitoring performance measures, ensuring they were on the appropriate trajectory towards delivering the objectives. If the monitoring suggested that the desired objective was not being achieved, the workforce would also be committed to modifying its approach

It is this whole system involvement in target setting which is missing from a top down imposition of targets. Many of the targets set by government have been seen as clinically inappropriate or thought to have potentially harmful consequences. As a result, front line staff in the NHS are often alienated and stressed by what they see as problems which they might have anticipated and prevented if consulted. Their imposition by managers in the face of clinical argument caused distrust and alienation amongst the very people the system needed to deliver the necessary improvements. An alternative approach was required.

## The alternative to targets

In 1995, Professor Charles Gillis, Director of the West of Scotland Cancer Surveillance Unit came to me with data that showed variation in survival from breast cancer across Glasgow hospitals. Women treated in one unit appeared to have better survivals than those treated in the other Glasgow hospitals.

Professor Gillis brought the data to me as Director of Public Health at the time. "What," he asked, "are you going to do about it?" We had two options. As purchasers in an internal market, we could have withdrawn funding from the four less well performing centres and given it to the best performer. Alternatively, we could see what was producing good results and spread the good practice across all Glasgow hospitals. We chose the latter as being in the best interest of patients. The other important step we took was to allow the clinicians themselves to develop the clinical protocols. It seemed clear that, for outsiders to impose a protocol would provoke disagreement and resentment which would make further improvements in care difficult.

The end result of this process was the creation of the first Managed Cancer Network, a multidisciplinary breast cancer service which included medical, nursing and other specialists and which increased survival from breast cancer by more than 20%. Giving the clinical staff, surgeons, oncologists, nurses, freedom to solve the problem produced unanticipated benefits for patients as well as enhancing the job satisfaction and commitment of the staff.

This inclusive process for clinical improvement was taken further in Scotland when the Scottish Patient Safety Programme was launched in 2008. Its aim was to reduce Hospital Standardised Mortality Ratios to 20 per cent by the end of 2015. Figures published to the quarter ended December 2014 show mortality has reduced by 16.1 per cent. The overall aims are achieved by applying evidence-based interventions to reduce avoidable infections and improve safety of routine healthcare processes.

Staff caring directly for patients design and lead the changes and monitor the improvement through the collection of real time data at individual unit level. The SPSP is based on the Breakthrough Series Collaborative designed by the Institute for Healthcare Improvement in the USA. It was developed to help health care organizations make "breakthrough" improvements in quality while reducing costs. Evidence exists of the effectiveness of interventions in improving costs and outcomes of current health care practices but much of this evidence is not routinely applied. There is a gap between what we know and what we do. By bringing together

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.

## *From a good health system to a system for health?*
# Dr Katherine Trebeck

Katherine is a Senior Visiting Research Fellow at the University of Strathclyde's International Public Policy Institute and an Honorary Professor at the University of the West of Scotland. She is also part of Oxfam GB's Global Research Team. Katherine is writing in a personal capacity and the views expressed in this article are not necessarily shared by any of the organisations she works for or with.

This paper begins with a brief discussion about the link between health and the economy, and then describes the system level perspective necessary to make life easier for those in working in the NHS. It finishes with some thoughts about translating this ambition into action and how to know if we are making any progress or not.

### Introduction
This is an article about the NHS that is not *entirely* about the NHS. It starts with a query – if a Health System is to be 'successful', what constitutes 'success'? Which necessitates another question, is it really up to the Health System (in the organisational sense) to deliver this success?

Discussions about the future of our Health System cannot be separated from the context in which it operates. A truism perhaps, but the broad perspective it demands is often lost as targets, departmental budgets, organisational silos, and numerical performance management push people into narrowly defined tasks and short term outcomes. In line with the 2011 Christie Commission, which pointed to inequality and deprivation as driving much demand on public services, so too is our Health System's future inherently tied to the health of the Scottish people (and inequalities in their health). Health and health inequalities are, in turn, inherently tied to the operation of the wider economic and political system.

Without attention to the health of this wider system we are setting our Health System up to fail.

### Health is society
Health, however it is measured or assessed, to a great degree is the manifestation of the extent to which the economy meets people's multidimensional needs. Given the social determinants of ill health, inoculation needs to come in the form of an economic system that protects people and meets their needs (security, relationships, shelter, autonomy, and so on). In particular, the health of individuals reflects the control they feel over their lives – something that is shaped by how we configure the market, how we design institutions, and how we look after each other.

When these structures of our economy and society do not deliver security, people feel stress and can adopt unhealthy 'consolation' strategies. In the extreme, great levels of inequality cause people to feel more anxiety about their status and self-esteem. This leads to raised levels of cortisol and increased blood sugar which suppresses the immune system and undermines health. Michael Marmot states that

the socio-economic gradient in health stems from what people's position in the hierarchy means: access to resources.

The need for dramatic change is apparent with just one example: a 2010 report from the International Futures Forum warned that 'annual increases in healthcare spending across the developed world, whatever the precise nature of the system, are becoming unsustainable'. IFF's qualification that *no* Health System in the developed world is sustainable suggests that no country has found a way to design the System for success. This leads us to look beyond departmental mandates, organigrams, and internal memos to the drivers of demands on the health service. It means that before pointing the finger at over-worked staff or buckling processes, we need to start with an acknowledgement that health is the manifestation of how we set up our economy, our politics, and our society.

But if our economy continues to offer precarious work, jobs that do not pay enough to live on, let alone nourish a family, if people continue to feel they have little say in the decisions that affect them, how can we expect the NHS to cope?

Will Hutton once said, the NHS is an example of everyone sharing in each other's 'bad luck'. This 'luck' pertains not just to tripping over or catching the flu, but the unequal distribution of the determinants of health. From this perspective, we're expecting our Health Services to pick up the pieces of not just broken bones, but broken lives and stressed minds.

This calls for intervention up-stream – paying attention to housing, the quality and distribution of work, the strength of social connections and so on. It means discussing, assessing, and striving to improve these factors of health as core to a sustainable and successful Health Service.

Hints of an approach that takes a wider perspective are surfacing on the Scottish scene, with pockets of interest in the 'Nuka' philosophy for health care provision. Nuka is a native Alaskan word meaning a strong, living, and large structure; in terms of caring for patients it prioritizes achieving physical, mental, emotional, and spiritual wellness. Embracing Nuka requires creating a system based on reconnecting people with the entire living systems of their community, in recognition that health is a product of quality relationships.

## Holopticism for health
Can the same holistic perspective be applied to the operation of the Health System itself? Can change be driven not from an approach akin to a Panopticon, but one based on Holopticism?

Panopticon is the name of an 'ideal' prison designed by philosopher Jeremy Bentham. In the Panopticon, surveillance, isolated units, and hierarchy dominate. In contrast, an approach which embraces 'Holopticism' means that each individual is conscious of the wider entity in which they operate (the example of a jazz band is often given). They undertake actions informed by their awareness of the objective of the whole system – rather than being at the beck and call of an unquestioning chain of command.

If Scotland's current framework of NHS targets has had its day, what next?

Imagine this as the mentality governing NHS ways of working, with measures of success akin to the audience enjoying an afternoon listening to a jazz band rather than whether 'second saxophone' hits 95% of the notes in a four hour period.

Again dramatic change is required: 21st Century complexities – with their nonlinearity, tipping points, and inter-linkages – require nimbleness, agility, responsiveness, initiative, and trust. The doyen of government 'deliverology', Michael Barber, observes that while it is possible to mandate a system to improve from 'awful' to 'adequate', it is not possible to mandate greatness. Campaigners for better business practices have seen that in the private sector, even the most worthy, eloquent mandates from the top will crumble when they hit the hard wall of how people are incentivised in their individual roles (performance measurement, promotion standards, remuneration, and so on). Barber says we need to 'unleash greatness' – allowing delivery units to decide how to deliver. Enabling individual initiative because front line staff, when they know the objective of the whole system, invariably know the best way forward.

Again there are hints of this approach already in Scotland. We see customer facing staff empowered to ask 'Is there anything else I can help you with?' in many businesses and the 'Think Yes' agenda of Glasgow Housing Association (in which staff use their professional judgment to deliver what customers want: 'leaders...create the space...for staff to manage themselves and take responsibility and accountability for delighting our customers').

Staff discretion rather than managing by mandate is a core part of Frederic Laloux's thesis. Laloux points to Buurtzorg, a successful Dutch home care organisation that operates via 800 self-managing teams (comprising 10 to 12 people). They are driven by a clear sense of purpose, but not bound by strategic documents or yearly plans. When innovations emerge from the fringes (as they do), if successful they spread throughout the system. Recently this led to nurses 'doing' prevention, partnering with physiotherapists in the neighbourhood and teaching patients how to prevent falling. This has led to 'Buurtzorg+', with the '+' indicating prevention work.

Can we imagine NHS+? It would not be about adding to the NHS's responsibilities, but seeing many of the drivers of the NHS's workload as everyone's responsibility. This change will be facilitated by a shift away from the tyranny of short-termism to preventative spending; connected polices; long term budgets; and less territoriality in government departments so benefits accrue in another department's balance sheet and down the line.

## Knowing when we are getting close

But how will we know when we get close? We need appropriate measures of success. Inevitably indicators are proxies for the outcomes we really want – they're a technical interpretation of our goals.

But they are fraught with challenges – look only to the perverse incentives of Gross Domestic Product (GDP) or remember that Lehman Brothers was AAA rated just days before crashing.

Also important is how an indicator is used – look no further than the many environmental and social indicators that seem to exert little influence on policy goals compared to GDP. There is also a question about whether indicators are selected because they are do-able or because they are right?

Inappropriate, too many, or partial targets are also problematic. Picture an afternoon tea party measuring its success if 100 cupcakes were served – regardless of whether they were eaten, if people wanted sandwiches instead, or if the four guests (who could never have eaten 100 cupcakes) had a good conversation. Too many targets would leave the host cooking as opposed to interacting with guests. And inappropriate or too strict targets would see the host searching for hours for lemons for a lemon cake when an orange cake would suffice perfectly.

Hence Barber recommends looking for negative impacts of targets and accounting for them. But doing so at the 'good to great' stage seems to require a heroic level of anticipation and mapping of combinations and permutations.

Perhaps, at this stage, encouraging holopticsm for NHS+ is more useful? Success would be going beyond the search for perfection via the numbers game to a messier, multifaceted and sometimes even intangible sense of whether the system, in its widest sense, is working. In other words, Holopticism for our Health System.

*Time to stop the dancing of opposites?*
# Robert Carr

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## Introduction

We are right to cherish our health service in Scotland and to value the dedicated professionals who provide care to our people. We can take pride in our successes, for example in addressing smoking, reducing violence and the work in building health assets. However, there is a recognised need for all stakeholders to engage in an open conversation about where the health service is now, including the maelstrom of challenges we face, where we want to be and how we are going to get there. This conversation ought to be conducted not as a dance of opposites fuelled by self-interest, point-scoring or political sentiments but as an open heartfelt dialogue to collectively create and deliver a common vision for the future. Legal experience can contribute to that dialogue. Lessons can be learned from case law and from official reports into failings in healthcare and other sectors, such as finance, as well as from other jurisdictions. Despite formidable hurdles there are many reasons for optimism. We should have the confidence to be bold and ambitious.

## A maelstrom of challenges

Scotland has a legacy of health and other attainment gaps. Our demographics are changing. We have an aging population and a high incidence of diseases including psycho-social problems where the root causes include poverty, alienation and the aftermath of heavy industry. We are feeling the effects of climate change. In Scotland there is a drift from west to east and into cities. We face the largest ever squeeze on public spending. The drivers of more for less, technological disruption and the need for increased efficiency and productivity are here to stay. Most professions are seen as too expensive, unresponsive, inaccessible and elitist. The public want the democratisation of special knowledge and judgements. That is now achievable through cognitive technologies that process information as humans do. Scientific developments are moving faster than the public debate on the beginning and end of life, the consequences for healthcare of the digital surveillance trail and what tasks cannot or ought not to be replaced by machines.

Lord Reed observed in the 2015 Supreme Court case of Montgomery that the traditional paradigm of the doctor/patient relationship implicit in the way that the law and the public have viewed care has ceased to reflect the reality and complexity of

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 traditional values including the value of self-determination and the values that underlie the European Convention on Human Rights such as the respect for private life.

These social and legal developments point away from a model of the relationship between doctor and the patient based on medical paternalism and towards an approach which treats citizens, so far as possible, as autonomous individuals who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.

All these challenges are occurring in the context of an increased expectation on the part of the public and heightened scrutiny by the press and politicians. "Waiting times scandals" and "icebergs" such as "bedblocking" where patients are said to be trapped in hospital due to a lack of social care, as well as severe difficulties in recruiting key staff, are productive of regular headlines.

## Lessons to be learned
Inquiries, for example into Shipman, Midstaffs, the Princess of Wales and Neath Port Talbot Hospitals, Vale of Leven as well as HBOS, RBS and Northern Rock, reached uncannily similar conclusions.  The reports identified a lack of vision, strategy, leadership and delivery.  They described negative cultures and a lack of openness and candour. Often senior management was seen as autocratic or ineffective. Poor standards, poor reporting, poor risk management and poor recording were tolerated and whistleblowing discouraged.  When challenge occurred it was not accompanied

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 right staff in the right place at the right time; involving citizens in the way standards are set and care and practice is monitored; creating simple lines of accountability and reporting and adopting a fresh approach to complaints based on openness, early dispute resolution and mediation.

## Reasons for optimism
The "Building a more sustainable NHS in Scotland" initiative is to be commended. It focuses on common concerns about the impact of the current targets culture on care. There is a commitment to developing an agreement across the professions on the principles which should underpin a new model for measuring success in our health service. This places patients and service users at the heart of supporting sustainable service improvements. This initiative coincides with a shared vision of a health service which plays a leading role in the creation of a sustainable, respectful Scotland, where individuals and communities can flourish, and our diversity is celebrated. That vision recognises that our health and wellbeing is dependent upon individuals, workplaces and communities participating in taking informed decisions about our futures. Our innovation and creativity is released and we are more productive when we collaborate in discretionary spaces in diverse teams. That vision recognises that our health and wellbeing is interconnected and dependent upon good housing, education, transport, our perception of safety, our lifestyles, skills development and social mobility. That vision recognises that our traditional form of decision-making needs revision. The way we decide things is often as important for deliverability and outcomes as what we decide. There are ways of organising and

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 service because we have a reputation for being a great place to work, where you can stretch your own professional development, find creative solutions, make things work better and make a difference. We will find meaning in all that we do.

## *The dance of caring practices – capturing the mood and the beat*
# Professor Brendan McCormack

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### Introduction
The history of nursing is one of conflict between the rules of regulation that are somehow meant to enhance performance, whilst simultaneously placing expectations on nurses to respond to the individual needs of patients expressed through their needs, wants, desires and goals.  Nursing theorists have extolled the virtues of care, compassion and kindness whilst the performance culture of the healthcare system places greater value on technical expertise and clinical behavioural competence.  These complementary but more often competing perspectives on nursing have placed nursing values in conflict as seen through the eyes of scandals and controversies – the ugliness that often dominates the public discourse of nursing.  Given this values conflict, why are we then surprised when some nurses seem to lose their way?  I have always believed and will always continue to believe that nurses who on the surface seem to have lost the ability to care can show examples of everyday seemingly insignificant acts of kindness when enabled to do so.  In this blog therefore, I hope to argue the case for a nursing future that privileges flourishing persons over a rule-bound, competence driven, measurement-obsessed straightjacket of professionalism. My argument is based on two beliefs – 1) the caring 'self' of nurses has to be continuously nurtured; 2) health systems need to be clear about what 'matters'.

### The caring self of nurses
The caring 'self' of nurses has indeed to be continuously nurtured if it is to be sustained and nourished.  The nurse theorists, Ann Boykin and Savina Schoenhofer beautifully describe the core of nursing as 'The Dance of Caring Persons' .  Boykin and Schoenhofer argue that nursing is about nurturing persons; living through caring and growing in caring.  'Persons are caring by virtue of their humanness'. They argue that we don't need to measure that, it is a given!  However, whilst it may be a 'given', hanging on to a sense of 'self' in cultures that are dominated by technical and behavioural targets erodes 'the spontaneous dance of caring practice' and its ability to rise to the surface and be the norm.  Of course readers of this blog will already be thinking of situations where nurses are not caring, where we do harm and where we are disrespectful of the personhood of individuals and therefore we need targets to prevent such situations from happening.  There is no doubt in my mind that rules and some targets are necessary – necessary as a framework to shape the boundaries of our practice and to provide a framework of accountability.  But do they lead to better

caring practices and greater effectiveness in outcomes that matter to patients and families – I don't believe so and there is little evidence to suggest this is the case.

Ultimately of course targets don't shape everyday practice. Targets don't change the 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 'Idio culture' (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 see the development and further expansion of regulatory frameworks and targets. Nursing, like many other professions needs to demonstrate that it has controls in place; that it is accountable to the public and that it is strong as a profession. Being strong is a characteristic of our humanness that enables us to meet the challenges and opportunities of each day and draw on our inner strengths to achieve caring outcomes. However, being strong and having strength also places significant responsibilities on us as we strive to meet what may at times seem like unrealistic or unachievable expectations of others and ourselves. We have ample evidence to show that this strength can only be transferred into caring practices in cultures that nurture the flourishing of individual practitioners and teams. But is this what matters to organisations? I believe that health systems are often unclear about 'what matters' – my second point!

## What does matter?
It is my contention that the expectations placed on nurses are often unachievable because of a lack of clarity in organisations and indeed in the nursing profession as a whole about what nurses need to pay primary attention to and what aspects of the nursing role are secondary – or what is foreground and what is background in nursing work? In our recent research into person-centredness, we identified that in clinical settings, patients are placed in vulnerable situations by the system – this vulnerability arises because of the often conflict between health and social care systems, care processes and how the nurse navigates her way through these, i.e. how the nurse determines what is priority (or in the foreground) and what is less important (or in the background).

The theme of 'background and foreground' is an important consideration for nursing development and is a critical issue for nursing in Scotland in the context of the development of our 'Care Assurance' or 'Care Excellence' system. How we privilege background or foreground is an important issue when thinking about our potential to flourish as nurses. In the vastness of the nursing role and contribution, we can become overwhelmed by the need to objectively 'measure' the nursing contribution to all aspects of practice in which nurses engage. Continuing my metaphor of 'the dance of caring' in nursing, I was reminded of the importance of prioritisation by the Irish playwright, Brian Friel, in the play, Dancing at Lughnasa. We are reminded of the importance of human flourishing through the metaphor of dance. Dance is a metaphor for freedom and being alive – or the parts that brought joy and happiness. In the play, the narrator Michael says:

> *… everybody seems to be floating on those sweet sounds, moving rhythmically, languourously, in complete isolation; responding more to the mood of the music than to its beat*

### The mood or the beat of nursing – which do we want?

And so this is a critical question for the future of nursing – do we want to respond to the mood of nursing or to its beat? The mood of nursing represents all that is good about nursing at its best. It represents nurses who know the boundaries within which they practice, know what is foreground and adopt a form of being that makes their practice dance. It is observable and describable but is hard to measure because it is irreducible. The beat of nursing however is easier to objectify. It is represented by the objectified characteristics of practitioners (e.g. 'the good or the bad nurse') and by the assessment of the quality of tasks achieved. It can be measured. It can be reduced and it can be reported in ways that make sense to those who have a need to defend the 'nursing contribution'. But does it represent the essence of nursing – absolutely not!

It is my contention that nurses and care workers need to be 'emotionally touched' by their everyday caring encounters and that the systems in which we practice need to be structured and managed in such a way that they enable the quality of such encounters to be maximized. Through a range of research projects into person-centredness in healthcare, our data suggests that patients place a high value on these encounters. I have the privilege of seeing such encounters in my role of Consultant Nurse in a Scottish Health Board – I have the privilege of working alongside nurses who value the significance and importance of such encounters and who understand both the mood and the beat of their practice. Here is one such example:

> *Shaun is an Advanced Nurse Practitioner in training. It is only 2 years since he graduated from his undergraduate nursing programme. He assesses older people who are frail and plans care programmes for them that are genuinely holistic and person-centred. Mary, an older woman transferred from a care home, is not allowed to eat or drink due to the need for further investigations – a decision made by a medical consultant earlier in the day. Shaun meets with Mary and determines that she should be able to eat and drink and that keeping her fasting is inappropriate. He connects with Mary through his very being and determines that the thing Mary most wants in life at this moment is a 'glass of cold milk' – that becomes Shaun's mission. He assesses Mary and ensures he has all his evidence in place; he engages the consultant and in minutes, Mary is sitting up drinking a glass of cold milk. The emotion that passes between Shaun and Mary is profound – "you are a life saver son", she says. "You enjoy your milk", he says.*

Shaun represents everything that is good about nursing – person-centred practice at its best. But how would Shaun's intervention be measured? Well Mary's length of stay in the unit will have been shortened, her transfer back to the care home will have been expertly coordinated and if asked I am sure she would report high levels of satisfaction with her experience. But what about the emotional connection and the glass of milk – how will that feature in the 'clinical dashboard' and the evidence that

demonstrates the effectiveness of the nursing contribution to the quality of the care experience – sadly it is highly unlikely to do so, and Shaun's effectiveness will be 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 to measurement and to seeing 'what matters'.

## 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.