Changing dreams into reality

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The wind of change across Europe has brought unprecedented change to society: the falling of the Berlin Wall, the raising of the Iron Curtain, the end of the cold war, the demolition of nuclear weapons, the declaration of peace in Northern Ireland and Israel. These changes are the result of people having vision and then taking dreams and turning them in to action. The human race needs to dream, to examine new futures. It is said that "the future is not some place we are going to, but one we are creating. The paths to it are not bound but they are made, and the activity of making them changes both the maker and destiny". Often dreamers are thought to be non-productive. But without them the world would be static. Plato, Archimedes, Gallileo, Einstein and others have all dreamed and contributed to the changes in terms of understanding. But it is not only in the world of art and science that men have dreams. Managers and politicians have been known to have vision. Martin Luther King had a dream.

Vision should be part of strategic thinking. However it should be part and parcel of daily life. George Bernard Shaw said "You see things and you ask why, but a dream, things that never were and I say why not. " Vision needs the 'why riots?'.

Understanding by itself is not enough. There is also a need to recognise the need for change, the risks and the required actions. Many of the reorganisations and changes in the health service in the past three decades have been about structural realignments. They have been about the basic hierarchies, professional barriers and practices which have remained and in some cases strengthened. As a student of organisational development I have noted the emergence of new professional bodies such as ASSIST and Unison with great interest. The evolving and increasingly discrete roles of such people as operating department assistants and business managers are in themselves part of the mechanisms for perpetuating the hierarchy and the professional barriers.

Years ago my name badge went through a series of transitions during the many restructurings of the service. My role and work remained largely unscathed, but then I worked within the splendid world of nurse education. In the real world of service provision, the NHS is in a state of constant change. We hear many voices repeating the phrases "we can't finish off one change before they want another". and "we do not have the time to make all the changes that they want." Often such voices are referring
to projects which are integral to their own, or the government's philosophies. Frequently the schemes are implemented as discrete projects, detached from the day to day reality of the management of health care. In America, a famous philosopher, Dan Shula, who works for Miami Dolphins, which is one of the national football teams, said "Success is not final and failure is not fatal". Unfortunately in clinical practice the slightest possibility of failure is considered a barrier to risk taking. Risk taking is fairly low on the list of NHS skills. Professionals would not wish to think that they have put their patients at risk and managers would merely deny any rumours. However risk is inherent in any change.

Making a calculated risk requires good information and intelligence. Organisations which encourage risk-taking have a culture and organisational design which allows for the calculation and monitoring of variables in order to control and minimise the risks. The bureaucracy of the NHS has often denied dreamers and risk takers alike.

Sharing information allows people to dream their dreams and aspirations and to together share in making them reality. It allows them to monitor and minimise risk but also encourages them to take a chance on new ideas and initiatives. This requires the sharing of hard and soft information. The transformation of hard data, together with the addition of soft information requires more than technological analysis: it requires experience and vision to give it intelligence.

If the health service is to be in the business of patient care, then the majority of its information should be patient-based and its intelligence should be patient-focused. The dreams of many visionaries are shared at NSG conferences. People like Anne Casey with the Nursing Terms work and Liz Finnegan with SAGNIS, Ray Rogers and the many benefits of the IM&T strategy. At NSG'94 Liz Winder of the Royal College talked of her perspective and mentioned the College's new nursing information group. John Kelly talked about education and Helen Betts about 'Changing Childbirth'. They in themselves cannot change the multitude of organisations that make up the NHS, but they can help others to share their dreams, visions and knowledge. In the NHS the wind of change has seen major transformations for the first time since the inception of the service some 50 years ago. The lowering of professional barriers, the increase in collaborative care, the sharing of information, the introduction of generic care workers, and multi-professional working.

How does it feel?

Imagine the illustration of Edward bear coming down the stairs held by the leg by Christopher Robin, "with the back of his head going bump, bump, bump. It is, as far as he knows, the only way of coming down stairs. But sometimes he feels that there must be another way. If only he could stop bumping for a moment and think of it". How many people in the health service feel like poor Edward bear?

The business of re-engineering has overtaken many a manager's imagination, but the re-organisation of anywhere starts with the simple question, if I were to look at the provision of care without having any existing knowledge, how would I arrange that care?

Recently I saw a television programme about two very similar people, both were paralysed from the neck downward. One woke at 06.30 each morning and waited in his bed for the district nurse to arrive and she gave very professional care, then the
physiotherapist came to give him passive exercises, then the occupational therapist and the social worker visited to arrange his care. He spent his day waiting for the next professional to arrive.

In the next district the other person had a live-in helper, who dressed her, then took her to work. They sent for the professionals only when the patient required them. The same level of incapacity was viewed from two different perspectives. The first from that of the professionals, the second from that of the patient. I know which one I would rather have applied if I was so paralysed.

Shaping the future

Sharing ideas about care must start from the perception of its recipients. Their needs are not always the same as the needs of the professionals who want to supply the care. Why do we have the nursing process? Surely we need to be thinking in terms of the patient-process. Basing models of care on the premise that the focus of our endeavours deserves a real say in our decision making.

Sharing information must therefore start with the user. To do that we need patient-focused information which they and everybody else can understand.

Change often has as its hallmark a number of firsts. The 1994 Conference of the Nursing Specialist Group had a number of firsts:

- the conference was organised with the British Journal of Health Care Computing;
- the four of the five Focus Groups, which are made up of members rather than committees, led their own sessions;
- NSG asked a computer systems supplier to share its vision of the future and Roy Simpson flew over from America to do this;
- NSG invited the views of physiotherapists, dieticians and an ex-Labour counsellor turned fundholding general practitioner;
- a certificate of attendance was provided, it was approved by the Health Service Management Unit at Manchester University.

The NSG also has to face the need for change, and to address a number of key issues. The question of whether it should continue to be a nursing group or move towards a more generic patient-care information group will be answered by those active in the Focus Groups. NSG also has to ask itself if this style of conference best suits our members needs. NSG is doing its own re-engineering in collaboration with other information groups, most notably the Royal College of Nursing, the Royal College of Midwives and the Community Practitioners and Health Visitors Association.

George Bernard Shaw said "The reasonable man adapts himself to the world. The unreasonable man persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man."

I hope that the wind of change continues to blow and that all the sharing of information between patients and professionals will enhance the provision of care. And that one day I shall be remembered as an unreasonable man!