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The spread of 'See and Treat'

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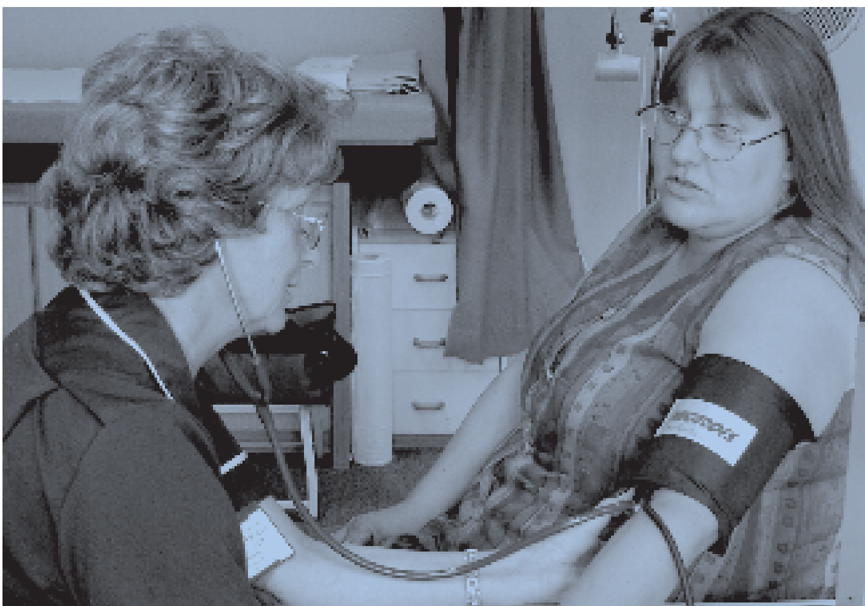

The spread of 'See and Treat'

Why did 'See and Treat' spread so rapidly throughout Accident and Emergency (A&E) Departments in the UK, and what lessons can we learn from this?

Key facilitators included:

- Recognition of the need to reduce waiting times in order to improve patient care
- Department of Health (DH) 'waiting time' targets
- Support and advice from the Modernisation Agency (MA) and the Emergency Services Collaborative (ESC)
- Strategic Health Authority (SHA) reporting mechanisms
- Media coverage in the form of a BBC programme called 'The Service'

Key inhibitors included:

- Resistance, both professionally and personally
- Issues about safety and quality
- Existing performance and practices
- The effects of 'See and Treat' on demand for services
- Lack of resources

What has been clearly identified as the minimum set of factors involved in the spread of 'See and Treat' are: an identified need for change grounded in staff and patient needs; an acknowledged existing system in need of improvement; a trigger to change; a potential simple solution; effective networks; and last but not least, a strong element of choice and autonomy in the local decision-making process.

Introduction

In recent years the process of managing services for patients requiring emergency care has been increasingly under scrutiny, and considerable diversity has arisen in the organisation of A&E care (Byrne et al, 2000; Cooke et al, 2000, 2002). The NHS Plan includes a 10 year strategy, Reforming Emergency Care (2002). This strategy is driving major changes for patients and staff and it specifically targets waiting times in A&E:

> *'By the end of 2004, no patient should spend more than four hours from arrival in A&E, to admission, transfer or discharge.'*

'See and Treat' represents a set of principles that attempt to address waiting times in A&E. It is essentially a simple technique that involves seeing patients as soon as they arrive, assessing their needs for treatment, and providing it. First introduced as part of the IDEA programme (MA, 2001), the model has spread across IDEA sites who 're-invented' the model to suit local needs, and was promoted and renamed 'See and Treat' in 2002.

Promotion of 'See and Treat' included guidance developed with and endorsed by professional bodies such as the British Association for Accident and Emergency Medicine (BAEM) and the Royal College of Nurses (RCN) as well as Ministers. Details were circulated across the service (clinicians and managers) and regional workshops organised by the MA were held to raise awareness of 'See and Treat' and describe how it could be applied in practice. At the same time, the technique was featured on a BBC television documentary (BBC, 2002) and from this an interactive CD-ROM with a video of the implementation of 'See and Treat' was made and circulated (MA, 2002a). From a small start involving only a few trusts, the technique has spread to over 79% of all A&E departments (Fletcher, 2003).

Table 1: Principles of 'See and Treat'
• On arrival in A&E, patients are seen, treated and referred or discharged by one clinician. • The first person to see the patients, usually a nurse or doctor, can make autonomous clinical decisions about treatment, investigations and discharge. • More seriously ill patients or those requiring in depth assessment or treatment should be streamed to, and dealt with, in a separate area. • Triage of walk-in patients is unnecessary when 'See and Treat' is in operation. • Dedicated staff should be allocated to 'See and Treat' and only withdrawn in exceptional circumstances. • The system should operate with enough staff to allow effective consultation without a queue developing. • Staff development should be undertaken to ensure that all staff in A&E involved in 'See and Treat' are able to make the system work effectively.

Emergency Services (MA, 2002b)

Study design

To find out why 'See and Treat' spread as it did, a qualitative approach was used to explore staff experiences.

Sampling

Ten A&E departments were selected where 'See and Treat' was in operation. These included departments in:

- large inner city hospitals
- smaller rural hospitals

All departments were classified as 'Type 1' in that they all had full A&E facilities.

Data collection

Two researchers conducted 21 individual interviews with Chief Executives, clinicians (doctors and nurses) and managers with a responsibility to implement and manage 'See and Treat'.

Analysis

Detailed notes from each recorded interview were produced, and analysis undertaken by the lead researcher. Themes developed and were grouped under the headings: what is the problem, why now, what facilitated adoption, how was support organised and what inhibited adoption?

Findings

Many factors were influential in the spread of the 'See and Treat' initiative, as illustrated in Table 2, and each heading and its themes will be addressed in turn.

Table 2:

What is the problem?	Why now?	What facilitated adoption?	How was support organised?	What inhibited adoption?
Identified need Anxiety Inefficient working	Targets Visibility	Roadshows ESC networks Near Peer groups Media Leadership Enthusiasm Ownership Professional development Heterophily It matters It's adaptable It's simple It's testable It's observable Timing Type of decision	MA ESC Existing networks Near peer groups SHA reporting	Interpretation Inexperience Roles and resistance Quality and safety A&E culture Demand Resources Existing performance

What is the problem?

Identified need

There is clearly an identified need to reduce queues and waiting times, amidst concerns around patient complaints and the inefficiency of existing systems and practices:

> *"A lot of our systems and processes are geared to putting people into queues…it doesn't do anything for the people that you put into the queue." (Chief Executive)*

> *"It's something all A&E consultants are aware of, something they are frustrated with. Why do patients who need very little input from an A&E department have to wait so long?" (Doctor)*

Anxiety

The presence of queues and the length of waiting time were issues for staff and patients alike. Staff talked about the anxiety they felt when faced with a full room of anxious patients, and the pressure they found themselves under.

Inefficient working

Staff knew that the issue of waiting times was an entrenched problem in A&E departments, and were aware of existing inefficiencies. Some suggested their departments were subject to a range of modernisation programmes in order to address these issues. However, although participants identified the problem of waiting times, not all of them recognised it as a priority issue. During discussions about service improvement, the perspective of the patient is clearly at the centre of all improvement activities. However, not all staff identified the treatment of minor injuries as part of the solution. If this was the case, why then did 'See and Treat' spread so readily?

Why now?

What was the final trigger to consider a technique like 'See and Treat' as a possible solution and why did it occur now? The majority stated that the key trigger was patient care and improved quality.

Targets

Several individuals however, suggested that the 4 hour target was influential in the decision to adopt, and more importantly, it had the effect of making change happen *now*:

> *"There were two really (motivators to adopt). One was unquestionably the need to meet targets. Secondly the network empowered them to say they were no longer doing triage." (Manager)*

> *"I think the reason it's spread around the country is because of the pressure. Because of the 4 hour targets." (Doctor)*

> *"We did have to address waiting times, so targets have had an impact." (Nurse)*

In all but one of the 10 departments studied, additional staff were drawn in during performance monitoring in March 2003. This gives a clear indication of the intensive work going into target achievement.

Visibility

The issue of visibility is highlighted in A&E departments, and has had an impact upon identification of the problem and the search for a solution. The structure of A&E departments is built around the waiting system. Little else happens in the waiting room other than people are in queues waiting either to be seen, treated, transferred, or discharged. Patients and staff see the queues. It is, as one participant said, 'in your face'.

What facilitated adoption?

The facilitators that aided communication of 'See and Treat' principles and practices can be grouped under the following headings:

- Roadshows and networks
- Mass media
- Social processes
- Characteristics of the innovation
- Timing

Roadshows and networks

Roadshows were arranged by the MA, and took place in short succession around the country. The ESC hosted each event and offered an open invitation to Chief Executives and SHAs. These roadshows were a key contributory factor in the spread of the new practice for several reasons:

- The practice was introduced very much as an optional innovation
- There were few officials from the DH
- The ESC offered substantial support

The ESC waves and the resulting networks enabled the sharing of experiences through presentations and informal gatherings. One person in particular maintained that the combination of roadshows and media campaign had 'sent the 'See and Treat' initiative massive'. Not only did the collaborative networks provide advice and support, there was also the perception that they allowed departments to think of other ways to solve the problem, that is to abandon triage:

> *"I think I first heard about it through the collaborative thing." (Doctor)*

> *"…the network empowered them to say they were no longer going to do triage. Triage was DOH stipulated that had its own targets. Until that was taken out, they could not introduce 'See and Treat'." (Manager)*

Many appreciated that there was a package of processes that took place, the key players being the MA, and the SHA:

> *"Get the SHA to sell it and the MA to work on it." (Nurse)*

Media

The BBC presented 'See and Treat' on a national TV documentary called 'The Service'. The coincidental timing of roadshows and the programme further increased awareness:

> *"What really took it off was the programme seen by David Lammy who realised this could be an ideal mechanism to help the NHS achieve its 90% target." (Chief Executive)*

The programme included an interview with a consultant in A&E who confirmed the success of 'See and Treat' in significantly reducing waiting times. What was evident during the short sequence, was the apparent emptiness of the waiting room, and the almost tangible calm atmosphere surrounding staff and patients.

Social processes

The social processes encompass the ongoing structures and systems that encouraged consideration and subsequent adoption or rejection. They include leadership, enthusiasm, ownership and professional development. Such factors form a rounded picture of the more individual influences on spread. All participants identified one individual who initiated the practice within their organisation. This was usually an A&E consultant, and staff emphasised the need to get consultants on board:

"There's also strong leadership from the top, the director of nursing is evangelical about improving emergency care services." (Chief Executive)

"They have a lead clinician who spearheaded it – it was his responsibility." (Manager)

"The main key factor is the support of the consultants." (Manager)

The influence of ownership is particularly interesting, and many participants agreed that the DH should provide information on agreed principles, advise on and support initiatives like 'See and Treat', but that locality development and modification issues should be the responsibility of the individual departments and trusts:

"It has to be very much driven by staff who are running the services as opposed to managers telling them to go and do it. It has to come from the bottom up so that staff have ownership and they can implement it how they like. Where people are told they must do things, they won't." (Chief Executive)

When people share common meanings, a mutual sub-cultural language develops and communication is likely to have greater effects in terms of knowledge gain, attitude formation and change. This use of common language is called heterophily:

"…it's much easier for groups of consultants to talk to other groups of consultants about the same issue. Also, the networks are far more well developed than in other specialities, they're well established." (Manager)

There were several examples to indicate regular uni-disciplinary meetings between consultants, emergency nurse practitioners and managers, as well as multidisciplinary team meetings. Although not an explicit question in the interview process, it became clear during some later interviews that peer discussions between like minded people had a positive influence in spread.

Characteristics of the innovation

'See and Treat' spread because it works, it is adaptable, easy to implement, testable and observable. Rogers (1983) provides a similar list of characteristics on innovations that help to explain adoption. His characteristics are illustrated in table 3, together with examples from this study.

Table 3:		
Relative advantage *Is the new innovation a better idea than current system or practice?*	Participants suggested triage on its own does not work in the patient's best interests. It represents one more method of queuing. However, some staff felt there was a safety risk in the abolition of triage.	*"If you go into any A&E department you will see a lot of wasted energy…we need to look at the amount of energy we're wasting, transporting patients to the room, getting the doctor to see them, telling the patient to go for x-ray or go back to the waiting room." (Doctor)*
Compatibility *Is the new innovation consistent with existing values, beliefs, past experiences and the needs of potential adopters?*	Despite the negative publicity around A&E care and the perpetuation of ineffective practices, participants still wanted a better deal for patients. Several spoke of the needlessness of excessive waiting and all were passionate about finding a solution to address this emotive issue.	*"It picks out those patients who haven't necessarily got the most urgent problems but are waiting 2 to 4 hours for something that we can sort out in 5 minutes. This is what frustrates the doctor and is extremely frustrating for the patient." (Doctor)*
Complexity *Is the new innovation difficult to understand or apply?*	Simplicity of use was essential to successful adoption. Potential adopters did not need specialist equipment or expert knowledge to help them to understand the practice, and the main idea could be grasped easily and quickly. 'See and Treat' requires one clinician with decision making ability to see all (or some depending on existing streaming) patients with minor injuries/conditions.	*"…it felt do-able. It didn't feel like we had to take on the whole of the culture of the trust." (Doctor)* *"There's no magic bullet. It's a very simple idea. Sometimes the simple ideas are the most powerful. Sometimes the NHS incredibly overcomplicates things." (Chief Executive)*
Trialability *Can the new innovation be tested?*	The potential to try out the principles of 'See and Treat' in practice was a very strong motivating factor. In most cases the A&E consultant adopted the role of 'See and Treat' lead person, sometimes with the help of a lead nurse. The results from each trial were rapid in that usually the waiting room cleared very quickly as patients were seen, treated and either discharged or transferred.	*"They were able to demonstrate themselves how successful it was… so that helped them get on board" (Chief Executive)* *"Let's do that as close as what we can do it, in the department we've got. We did a one-off morning …(lead nurse) and I sat across there; he was my triage nurse. We used the triage room, although it wasn't ideal, but it was next to reception." (Doctor)*
Observability *Are the results of the new innovation visible to others?*	All departments show a reduction in waiting times, although for staff in those departments who state they are already performing well, the improvement is much smaller. When 'See and Treat' runs with adequate staff, the patient and staff experience is perceived to be much improved, and complaints about A&E services have reduced.	*"Today patients are only waiting 25 minutes to be seen. They would have waited 20 minutes to be triaged." (Nurse)* *"It's much better for patients. Rather than sitting here for 4 hours wondering what's going on, in pain and discomfort, they come in now, they're seen, and they go." (Chief Executive)*

Timing

Spread is influenced by the time it takes for an individual to make a decision about an innovation. This timing, according to Rogers (1983) is in turn influenced by the starting point of any decision. Arguably, any decision to adopt begins with the knowledge awareness stage, where an individual is exposed to an innovation's existence and gains some understanding of its function. But what comes first, awareness of need or awareness of the innovation? In the case of 'See and Treat', this has been difficult to tease out. Several individuals heard about 'See and Treat' via the ESC, or from peers. They did not actively seek the innovation. However, all participants were aware of the need for change, and may have become more responsive to ideas that were in accordance with their interests and needs.

Type of decision

Types of decision range on a continuum from optional decisions where an individual has almost complete responsibility for the decision, through collective decisions where an individual has a say in decisions, to authority decisions where an individual has no influence in the decision. Generally, the fastest rate of adoption results from authority decisions, and optional decisions are made more rapidly than collective decisions.

Although most participants agreed that decisions in A&E were team based, decisions to either adopt or reject 'See and Treat' appear to be mainly optional decisions. Such decisions were made by one or two key individuals with the status and expertise to drive a decision forward without challenge. The reason for this is unclear, but it could be that 'See and Treat' began as an option. It was not presented as a practice that must be adopted. There was no planning or evaluation prior to going 'live'. The practice was simple and the concept or principles were already in operation, to some degree, in a few trusts and could be observed. Also, in the beginning at least, it needed only one senior clinician to test it out.

How was support organised?

The main support mechanisms were the MA, the ESC network, existing A&E networks and the support of near peers.

MA, ESC and the existing networks

As well as being pivotal in the awareness raising stage of 'See and Treat', especially organising regional roadshows, the MA, or more particularly the ESC, continued its support of 'See and Treat' through its continued involvement with subsequent collaborative waves. One participant argued that continued work with the ESC had moved the emphasis away from A&E and repositioned the waiting times issue within the larger trust. Others mentioned the difference made by being in one of the collaborative waves:

"We are in the first wave of the ESC and so we're coming to an end now. But I think we already had a good network, but it's opened up now because we get information from others in the first wave." (Manager)

Near peer groups

As already suggested, mass media channels were influential in the spread of 'See and Treat', certainly at the knowledge stage. However, the interpersonal channels were relatively more important at the persuasion stage of the decision to adopt. Good and effective leadership was the trigger to ongoing support, and it is difficult to see how, without this leadership, the support systems would have flourished:

"Consultants made it clear from the beginning that they wanted it to be successful…" (Manager)

"Overall we started the process well as we had an enthusiastic manager who employed a G grade nurse from a minor injury unit who was very experienced and pro 'See and Treat'. This set the scene for staff development and support." (Nurse)

SHA reporting

The DH 4-hour target was a key feature of SHA monthly reports. One participant suggested that the reporting mechanisms became mandatory quite soon after the introduction and roll out of 'See and Treat', and other participants spoke of the impact of SHA reporting:

"There is a definite message to trusts to operate some form of 'See and Treat'. We have to report 'See and Treat' figures on a monthly basis. Previously the SHA asked you to tick a box on whether you had an ENP (Emergency Nurse Practitioner). Now they want to know what our plans are for 'See and Treat'. The inference is we're expected to do it." (Manager)

If the question on this feedback form was answered in the negative, i.e., the trust was not practising 'See and Treat', some SHAs asked what was being done in its place. Consequently trusts had to justify not using 'See and Treat'.

What inhibited adoption?

Has this spread always been acceptable? Have the consequences always been anticipated and welcome? There are several limitations to the implementation of 'See and Treat'.

Interpretation

Despite the recognition by all participants that 'See and Treat' offers an effective way of reducing queues and waiting times, the practice was not perceived as the overall solution to all problems in A&E. For example, several participants argued that patients with minor injuries did not represent the whole of A&E:

"…a patch in a complex system, it's worked. There hasn't been enough fundamental thinking about the whole system. What doesn't happen is the thinking through of the impact on other areas." (Manager)

"There is a paradox that patients needing the least level of care and attention have the highest profile. We can get caught up in this and it could be dangerous." (Doctor)

There were many references to the need for whole system reform, rejecting any one initiative as the answer to all problems, although arguably, 'See and Treat' was never sold as a solution to all ills.

Inexperience

Staff with less experience was a strong inhibiting factor. Departments run their version of 'See and Treat' using various levels of skills, qualifications and expertise, and staffing seems to be dependent upon the interpretation of the 'See and Treat' philosophy and/or the availability of staff, as well as perceptions of staff capabilities:

"The other limitation on 'See and Treat' for nurse practitioners is that …they tend to spend longer per patient, whereas if you've got senior medical staff they're more prepared to speed up – that's perhaps a little unfair as a more experienced nurse may work equally fast." (Doctor)

Some senior doctors maintain they alone have the necessary high level skills and experience to make assessments and treat patients, and the patient journey is quicker than when nurses practice 'See and Treat'.

Roles and resistance

Some participants suggested doctors were not willing to be involved in minor injuries, and others suggested that nurses were unsure about 'See and Treat' being led by medics because they saw it as undervaluing their skills:

> *"…some consultants couldn't see why they should get involved in treating people with sprained ankles." (Doctor)*

> *"ENPs don't like it. They feel like a spare part." (Nurse)*

Resistance around change itself was not thought to be a problem, however, the introduction of triage several years ago and the constant pressure to introduce more changes to improve triage, meant staff were uncertain and anxious about replacing it with yet another new system.

Quality and safety

There were perceived risks associated with 'See and Treat' and the abandonment of triage:

> *"…with the old system, at least you know who's in the waiting room. With 'See and Treat' you don't and your queue gets big, it's very uncomfortable knowing there might be someone really sick in the waiting room. We can't get past that. So we stop it." (Doctor)*

Another issue concerning risk was, ironically, a perceived downside to seeing and treating patients quickly. According to participants, some nurses expressed concern that patients were not given enough time for a full and thorough examination. In one example, a patient was seen and discharged within one minute. Arguably, this must raise questions about safety, thoroughness and patient satisfaction.

Linked to issues of quality and safety were other perceived detrimental knock-on effects that 'See and Treat' would have on the rest of the department. Some focussed on the effect the practice would have on patients with major injuries, others were more concerned about patient satisfaction in minor injuries, as some patients were seen and treated, leaving others to wait.

Certainly not all participants identified a detrimental effect on other services. Indeed some mentioned the beneficial effects in terms of a reduction in radiology services due to experienced clinicians making 'See and Treat' decisions.

A&E culture

Varied perspectives of staff are of course a valued part of every team or group, but perhaps it is worth commenting on the perceived differences of A&E staff.

Table 4:		
The 'emergency' response	Participants suggested that clinicians work in A&E because of the crisis element.	*"One of the behaviours they had to overcome was that emergency medicine clinicians think too often that they're only about the emergencies, the 2%. We're looking at the margins rather than the bulk." (Chief Executive)*
A different kind of department	The structures surrounding A&E are seen to be positive factors in the transferability and adoption of new systems. Participants suggested the newness of A&E as a discipline in its own right, generates dynamic networks, both within local peer groups and the newer ESC networks. This clearly could be included in facilitating factors.	*"A&E doctors and nurses are always prepared to blur boundaries because it's always been a team effort." (Doctor)* *"A&E is a fairly new speciality and you take on board lots of new things. I think that's why a lot of things are transferable in A&E. They're picked up, looked at, utilised, modified. And A&E has a very strong network based round the nursing and medical faculties." (Nurse)*
A demand led service	Although all wards and departments have separate identities and are distinguishable by their different working arrangements and levels of skill and expertise, the work of the A&E department does appear to be very different, in more visible ways.	*"There's a certain siege mentality that people who work in emergency medicine have, with an ingrained belief that there's unlimited demand for their services, that they'll never keep up and that there's never enough."(Doctor)* *"It's very visible where the short falls are. It's more in your face than in other departments." (Chief Executive)*

The culture of the department can be seen as a facilitator or an inhibitor to the spread of 'See and Treat' – and is worthy of further exploration.

Demand

Since the implementation of 'See and Treat', participants reported an increase in demand for A&E services. There was also a suggestion that those patients who would normally have registered and then left before treatment (Did Not Waits, or DNWs), now wait to be seen:

> *"I think the word is getting round. Monday morning is a good time to go because you see someone senior." (Doctor)*

> *"Interestingly, the DNWs are waiting now, so more patients are being treated." (Manager)*

Staff behaviour changed as they became aware of when to operate 'See and Treat', and when to abandon it. There were suggestions that staff revert back to traditional processes and practices when faced with uncertainty and possible risk:

> *"A problem arises when the department gets too busy, staff revert back to old practices " (Manager)*

> *"In the main it works. Only one session had to be abandoned and it's been running for 5 months. It was abandoned due to the sheer volume of people coming in. They were waiting 90 minutes to be seen. It works as long as you have no more than 10 patients coming in each hour. It doesn't matter how quick you are with each patient if they're piling in at the door." (Nurse)*

Resources

The lack of resources was seen as a powerful obstacle to spread. 'See and Treat' is interesting because a pilot exercise was essentially cost neutral and participants described its simplicity and immediacy of results. The ease of introduction may have prevented the need for a full national evaluation prior to roll out, and it is clear that trusts were expected to operate 'See and Treat' within existing resources:

> *"There's a positive impact when it works, but the problem up until last week was that we haven't had the resource to keep it running all the time. When ('See and Treat') is in place, performance improves. But when it doesn't it all falls apart again." (Chief Executive)*

A lack of space was another inhibiting factor. All departments had triage rooms, but most were inappropriate for use as a 'See and Treat' room where extra staff were needed, and patients may require examinations.

Generally participants felt let down by a system that called for more intense work, demanded certain objectives to reach targets, promised funding for those trusts who did achieve performance improvement, but failed to back up support with money.

Existing performance

Staff identified 'See and Treat' as a way of reducing waits for minors, and some did not feel this was a problem in their department:

> *"Because we already performed well, and patients were not waiting too long, there was not much of a problem. That's probably a reason why it has not taken off very well…so for us I don't think it's needed all the time." (Doctor)*

However, despite suggestions that waiting time performance was at an acceptable level, targets forced people to think that there was still room for improvement:

> *"I'm not sure it grabbed us, to be honest. It has merit. That's partly to do with where you're starting from. If you're down at 65 to 70%, you need fundamental wholesale change. Because we haven't been in that situation, we've been able to tinker. But I think a lot of people saw the 90 minute target as hugely challenging…It's been a high priority for us to hit the target, but the work we had to do to get there wasn't enormous." (Chief Executive)*

Conclusions

In order to address the key issues of spread, the study started with five questions, all of which have been addressed in turn in this report. The questions were:

- What is the problem?
- Why now?
- What facilitated adoption?
- What support was in place?
- What inhibited adoption?

What is the problem?

The problem is lengthy waiting times. Participants were aware that that this was a longstanding issue and were also conscious that triage was no longer appropriate. However, considerable work was already being done to address inefficiencies in A&E and several participants did not see waiting times as the only issue to be addressed. In fact, some believed they did not have a problem with waiting. Instead, many identified the need for a 'whole systems' approach and saw waiting times as one of many existing issues to be resolved.

Why now?

If participants were already addressing these concerns via service improvement programmes, or if participants had not identified waiting as a major issue, why did ‘See and Treat’ take off now? What was ‘See and Treat’s’ tipping point which made it cross the threshold from being an idea to spreading like wildfire?

Although a key stated motivation to consider ‘See and Treat’ was a growing awareness of inappropriate care in a very visible department, targets clearly factored strongly in its rapid spread. Targets may have encouraged exposure to potential solutions which would not have been adopted had it not been for that performance measure.

What facilitated adoption?

The regional roadshows followed by positive reporting of the initiative on a BBC programme were powerful vehicles to get the message of ‘See and Treat’ across to a wide audience. The successful marketing by the ESC all added to the momentum.

Personal and professional factors and characteristics of the innovation itself all gave support to adoption of ‘See and Treat’, and perhaps the timing was crucial in that the issue of waiting was being heralded as *the* issue in A&E.

How was support organised?

Support from the MA, the ESC and other social networks are perhaps part of every national innovation, and are perhaps expected. What was interesting however was the impact of SHA reporting on the continuation of ‘See and Treat’. This process encouraged trusts to consider this innovation, and perhaps gave little choice in adoption as all participants were aware that something had to be done to reach the targets.

What inhibited adoption?

The key impacts or inhibitors are quality and resource driven. Issues of inexperience, safety, resistance and culture, all have quality as a common denominator. The need for experienced staff to do a proper job; potential resistance to changing practices; fear of working in unsafe practices; and the need to work in an environment that caters for individual needs and desires, are all quality issues.

Quality is linked to resources. Without additional funding, many individuals may not search for solutions and continue to accept existing performance levels, given existing funding. Lack of funding may mean that ‘See and Treat’ can run on an ad-hoc basis, but cannot operate full time, all of the time.

The impact of targets and subsequent monitoring cannot be underestimated, as they were the catalysts or triggers to do something now, despite the undeniable desire for quality. Results show that work was already being done, but the speed at which this change occurred, must be strongly associated with NHS targets.

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This paper was written by Sharon Lamont on behalf of the Research into Practice Team at the NHS Modernisation Agency.

The Research into Practice Team is part of the Innovation and Knowledge Group (formerly the Redesign Team). We work with partners within the Modernisation Agency and the broader NHS to capture learning and generate knowledge about modernising healthcare. We aim to share our findings as widely as possible to help inform staff as they pursue service improvement locally.

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