Can doctors help to heal the NHS?

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Introduction

The winter months of 2017/2018 saw an unprecedented level of demand, delay and distress in hospitals throughout the UK. This distress was shared by patients, relatives, doctors and nurses. It was documented and discussed by the media and endlessly dissected by our politicians. Yet it does not feel we are even close to articulating, let alone implementing, any solution.

Undoubtedly, there needs to be a significant increase in funding if we are to weather this storm. But this storm has been perfected by a number of factors other than finance. Yes, the changing demographic with increasing frail elderly has contributed: over the last 5 years emergency admissions to hospital have increased by 16% in England,[1] but so too has the diminished ability of primary care to cope with a proportion of the acutely ill within the community. Whether the sick, frail, elderly patient is in hospital or at home, the loss through closure of nearly 1,000 care homes and more than 30,000 beds in the last 10 years[2] has reduced the options. It is very difficult to dissociate this figure from the increase in the numbers of those who are unable to leave hospital because they cannot be placed in social care. Understaffing has undeniably also contributed; results of a recent online survey by the British Medical Association (BMA)[3] indicate that 71% of hospital doctors have reported rota gaps in their departments. So we have a greater number of patients, some of whom spend longer in hospital than medically required, being looked after by insufficient numbers of staff. It is worth reflecting on the limited responses available to a hospital system under pressure: increase the beds and staff, increase the bed occupancy, decrease the length of stay or reduce the number of admissions. There are significant constraints on each of these options.

However, looking through a different lens than that of finance and large numbers, there is another troubling vista which comes into focus. What has happened to our morale, our vocation and our ability to work jointly with other professionals in our efforts to maintain and improve clinical care? Perhaps we need to examine our service more closely through the eyes of our patients. If we do not continually return to seeking solutions with that perspective in mind, we risk attempting to deliver a solution based on targets, finance or performance that does not deliver an improvement in patient care. So what do patients actually want on admission to hospital, besides better food and improved parking facilities for relatives?

The four Cs

I believe what patients want, and deserve, can be addressed under four headings: Competence, Continuity, Communication and Compassion. And what are the obstacles to the delivery of such care? Lack of time, erosion of teams, excessive use of targets and the philosophy of financial constraint rather than financial enablement all contribute. Finance constraint starts with the focus on the available budget, while financial enablement begins by asking what is the best care we can provide. The latter does not have a greater budget, since it recognises that finances are limited, but it starts with an aspiration to clinical excellence rather than fiscal prudence.

Targets in the delivery of healthcare are not, of themselves, negative. Indeed, there is some evidence they have helped to improve the level of care in a number of areas.[4] Dogged and indiscriminate use of targets, however, is expensive, stressful and can adversely affect patient care.[5] A recent review, sponsored by the Scottish Health Department,[6] of the impact of targets on NHS performance concluded that a different approach is required. We measure the things that are easy to measure by relying solely on targets, and those things

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that are less easy to measure can end up being discounted, and then eventually ignored (the McNamara fallacy; recently discussed in the Journal[7]). There is a lingering suspicion in the minds of many NHS workers that targets are so beloved by politicians because they have the public perception of a form of shorthand for proof of political success. Wouldn't it be refreshing to have some targets articulated by patients?

It is notable that three of the four Cs are compromised by the obstacles referred to above – communication and compassion are harder to deliver in a service where stress and time pressures, added to by inappropriate use of targets, are rife. Continuity of care is much harder to achieve when the concept of clinical teams has all but vanished. Assessment and maintenance of competence in general medicine and the specialties, on the other hand, have improved markedly in the last decade. Both the MRCP(UK) and the Specialty Certificate Examinations have now become robust and resilient examinations, adopted by an increasing number of countries and seen as world leaders, primarily through the efforts of the profession. To maintain that competence, we now have embedded continuing professional development into our licence to continue in medical practice, through appraisal and revalidation.

Communication is difficult to test and measure, although we know that a lack of it is the basis of many patient complaints. Scholarly articles on communication abound, but the current state of knowledge is best summarised by two quotes: 'our study highlighted current gaps in the methodological quality of studies (on physician–patient communication) on psychometric properties and the quality of their results'[8] and 'there is no overall consensus on the operational definition of physician–patient communication'.[9] That said, we know that effective communication with our patients needs time (mainly to listen but also to speak), privacy, trust and compassion.

If compassion can be taught at all, it has to be through example rather than by any didactic method. Empathy, the less active relative of compassion, has received some attention of late in the Journal[10,11] but neither is likely to be taught successfully other than by example. With this in mind, earlier this year the College organised an excellent meeting centred on a (fictional) patient story.[12] The important distinction between empathy and compassion was further explored by O'Mahony,[13] who felt that compassion required courage, competence and integrity along with personal substance. The body of thoughtful literature is larger than some clinicians may realise and the theme of links between a stressful environment and less than compassionate care has been explored in some depth.[14,15] It is clearly important to keep the concept of vocation alive in student selection, then not squeeze it into extinction through disjointed and impersonal training programmes. Perhaps the most important action is for the medical profession to speak clearly, without compromise, on the importance of constructing a more supportive healthcare environment, for staff as well as patients.

Turning to continuity, it is difficult to overemphasise the importance of real, functional teams in the delivery of good clinical care. It is very encouraging to see the work that has been done by our sister College in London.[16] This is an online resource developed in response to some of the problems highlighted in the report on the experiences of being a junior doctor,[17] with emphasis on the building, culture, communication and development of teams in medicine. Quite apart from the improved ability of functional teams to deliver high quality care, the trust which patients have in those responsible for their care is eroded if they see a rapid succession of different doctors. In addition, judgements by clinical staff on illness progression are more difficult to make and vital teaching opportunities at the bedside are missed because the trainee who admitted the patient is not present at the consultant ward round.

There has been much effort in the last 10 years to improve performance. What about those who are called upon to perform better? There is some talk of leadership, but very little talk of teams – we need both. The educational and human resource 'correctness' might be apparent in some of the changes over the last decade – rapid rotations of junior staff through specialties, shift working, centralisation of the trainee appointment process – but these have had a cumulative negative effect on team-building. When teams are eroded, recruitment and retention suffer. And when this is not addressed, the strategy to date has been to source additional staff through locum agencies, and the excess expenditure exacerbates the current funding gap. It is time to have a conversation about how we can bring teams back into medicine. It will benefit patients and staff.

Can anything be done?

It is only too easy to criticise the NHS and, by implication, politicians and managers. Making constructive criticism is hard. Even harder is coming up with ideas that might bring about improvement.

So how can teams be resurrected? There are several strategies that may help, involving senior doctors who deliver training, and the Charge Nurse. We need to construct training programmes which do not rotate junior doctors every 2–3 months – a period which often then becomes 6 weeks or less once night shifts, annual leave and off-site training are taken into account. In addition, we need to explore ways to appoint doctors to training posts in which the individuals who deliver the training contribute more directly to the appointment. The current system does little to bring out the best in either the trainee or the unit where they will be trained – at present the two are so distant as often to be unknown to each other before appointment.

With specific reference to the Charge Nurse, this role needs to be made more attractive both to aspire to and remain in. This can be done through a combination of additional administrative support and enhanced financial reward, in terms of salary and pension. There exist at present several

different grades of nurse managers, between the level of Senior Charge Nurse and Deputy Director of Nursing, in virtually all hospitals. If there were a need to identify additional funding for the enhanced financial reward for Charge Nurses, perhaps this would be an area that might merit scrutiny. Not only should this crucial role be properly recompensed, it should be associated with high kudos in the profession. We need nurses in many different roles, but the very best should gravitate to, and wish to remain as, Charge Nurses. The Charge Nurse has a vital part to play in the development of the clinical team, the training of junior staff (doctors and nurses), standards of hygiene and catering, and therefore the delivery of good patient care. She, or he, should also be uniquely placed to coordinate senior nurse staffing on the ward to ensure that the large majority of ward rounds once again became a shared activity between medical and nursing staff. In order to fulfil these roles, the prime area of activity of the Charge Nurse should be the clinical arena – often the ward, but also the clinic, theatre or day bed area. The tendency to pull Charge Nurses off these areas for an increasing variety of management tasks needs to be resisted and reversed.

All the four Cs referred to above are more difficult to deliver when the intensity of work is magnified by staff shortages. We need agreed levels of staffing in the different disciplines, determined by specialty, bed numbers and clinical activity, which are not subject to cutbacks and freezes because of budgetary constraint. The importance of adequate staff numbers also applies to the many other skilled workers - pharmacists, porters, radiographers, secretaries to name but a few – who are all crucial in the delivery of excellent patient care. There has to be open and honest discussion between senior hospital management and their political 'managers' that acknowledges that this invidious and persistent trimming of staff budgets does real harm to the quality of care provided to patients. A good start to such an honest dialogue would be the portrayal of NHS staffing as hours of front line clinical service vs. hours of management, rather than in numbers of personnel employed. This second method takes no account of increases in part-time working. By all means, let us scrutinise value in the health service, identify and root out inefficiency and waste, but we really do need to change the culture which depends on a mix of good will, guilt and stress in order to provide an acceptable (let alone an excellent) level of healthcare with persistent downward pressure on budgets for essential staff.

The last thing that this presently ailing health service needs is more management. The shape and size of NHS management has grown largely in response to the political need for control. This is entirely understandable given that perceived failings in the NHS are seen as a millstone around the neck of the government of the day. Trying to stay afloat on the sea of volatile voter opinion is difficult enough, without the presence of millstones. This desire for accountability has driven the requirement for control of ever-increasing complexity and expense; this needs to be effectively challenged by our profession. Have the Colleges done all they could in sustaining the effort for direct dialogue with politicians? And have the politicians recognised the importance of ongoing direct dialogue with the Colleges, the only professional representatives of service providers who themselves continue to provide a service? Along with a negative reply must surely come a responsibility for greater effort, from both parties.

And what part might patient opinion play in all of this? We have Patient Opinion, Care Opinion, the Friends and Family Test and many more informal, local tests of patient opinion. There are several problems with the approaches to date: some depend on computer literacy, some invite response to pre-determined topics, the response to others is binary with a simple yes/no. In addition, there appears to be very little engagement between interviewer and interviewee at the outset. Surely, the more patients we ask the greater is the certainty generated around the answers. Why not ask one simple question of every patient – 'What is the one thing we could have done that would have most improved your experience in hospital?' Even a moderately-sized district general hospital would generate around 10,000 replies per year, of which the top three topics could be identified and addressed, with feedback on local media annually.

Conclusion

In summary therefore, the following strategies are proposed:

- Improve the conditions, pay and kudos for Charge Nurses, who are so crucial in the formation and function of clinical teams.
- Lengthen each unit attachment to 6 months or more for doctors in training.
- Seek agreement with politicians on a much more considered and judicious use of targets.
- In appointing trainee doctors, explore ways in which the clinicians involved in training might contribute more directly to the appointment.
- Seek the view of every patient on the most important aspect of their care which requires improvement, and commit to action on the top three topics every year.

In making these suggestions, the intention is to promote dialogue and possibly arrive at better solutions. We do have power as a profession, if we speak with clarity and consensus – agreement will not be reached unless we begin to talk together about the things that matter.

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