Title: Is it time for a paradigmatic shift in relation to healthcare in the UK? A Reflection.

ABSTRACT

Context

Conflict is a driver of change and unions representing professional groups across the NHS are currently engaged in direct conflict with the government. For the first time in the history of the NHS, healthcare professionals have taken industrial strike action. Junior doctors and Consultant Physicians are currently engaged in their respective union ballots and indicative poll surveys regarding potential strike action in the future. In the wake of such widespread industrial action, we have taken time to think deeply about the confronting challenges and issues and offer this reflection as an opportunity to redefine and re-frame an unsustainable healthcare system into one that is the best it can be in terms of fit for purpose.

Insights and resource signposting

We present the current context with a reflective framework table focused on 'What do we do well? What is not done so well? What could some possible ideas and solutions be? and How could this change be supported?'

We outline how a culture of wellbeing could be strategically and operationally introduced into the NHS workplace using research-based evidence and practical tools supported by expert guidance.

Key messages

We call for wide reform across the NHS, primary care and social care systems along with government financial investment.

We propose a paradigmatic shift toward a culture of wellbeing with re-structuring of the NHS to reverse the critical issues of employee recruitment and retention currently evident across NHS Trusts.

We call for a change in all managerial roles so that they are allocated direct patient facing care tasks for a portion of their time to support the clinical workforce.

Key words: Clinical leadership, health system, improvement, analysis, insight

Context

Conflict is a driver of change. And now more than ever, change is needed within the UK health and social care systems. At the heart of the matter, is an unsustainable healthcare system failing to provide consistently adequate levels of safe care from hospital emergency admission through to discharge back into the community. Many healthcare workers of different professions have voted to strike across the country citing a lack of fair pay and lack of safe staffing levels as urgent issues to be addressed. Making

history, members of the Royal College of Nursing voted to strike in December 2022 citing fair pay and patient safety as the drivers and ambulance service workers have also taken strike action on pay-related issues.

The NHS can neither recruit nor retain staff and there are reports in the media on a regular basis, which identify failings of NHS Trusts to meet basic safe standards of healthcare (1).

Skilled clinicians are leaving the medical profession to work overseas, for example, Australia, citing better pay and work/life balance with more flexibility of working patterns and lower patient to doctor ratios (2). A recent survey conducted by the British Medical Association (BMA) from November to December 2022 reported that 4 in 10 Junior doctors plan to leave the NHS as soon as they can find another job (3) and a new BMA report (4) has identified in detail how 4 governments over the past 12 years have significantly interfered with the Doctors and Dentists Remuneration Body (DDRB), (originally set up as an independent Review body to support an independent pay review process) to prevent doctors and dentists salaries being kept in line with the cost of living and changes in inflation, resulting in pay cuts in real terms. This has caused a loss of confidence in the body by Junior Doctors and Consultants, who no longer see the DDRB as independent and intend to boycott the DDRB this year (5). Junior doctors have voted on taking strike action (result expected soon) because of extremely large clinical caseloads with inadequate workplace support and poor pay (£14.12/hour First Year (FY) Junior Doctor, UK versus £23.76/hour FY Doctor, Australia) (6). A tracker survey from the BMA in April 2022 (7) reported that '62% of junior doctors said they were currently suffering from depression, anxiety, stress, burnout, emotional distress, or another mental health condition, relating to or made worse by their work or study.' This is noted to be higher than the levels of burnout reported at the peak of the pandemic (53%). The recent BMA survey (8) of Junior doctors has also reported that 71% of those surveyed have gone into work, when not well enough to be at work; approximately '78% have felt unwell as a result of work-related stress in the last year' and '81% have reported that their health and wellbeing has worsened or not improved since December 2021.' Such survey data should have set off alarm bells in NHS organisations.

These financial and unhealthy workplace exit drivers must not be ignored. Financial investment is required and improvement of staff support and workplace conditions is essential. Despite the severe shortage of Junior doctors, the Government has announced that the 7500 cap on the number of medical school places offered by Universities must remain this year and that Universities must reduce the number of places offered to make sure that this target is met or otherwise risk being fined (9).

Alongside this, primary care and social care are also overwhelmed with demand and are also experiencing staff recruitment and retention issues. The majority of General Practitioner (GP) practices are run on the self-employed partnership model, which itself is now being challenged as to whether the time is now right for reform of this model, so that GPs move to being direct employees of the NHS (10).

GP practices are accessed by telephone and usually involve telephone queuing. One recent example of a call made at 8am by a patient to book an appointment with a GP, entailed being connected to a recorded voicemail management system, which stated 'You are now in a queue of over 30 people, in a position over 30, please consider calling back at another time or stay on the line to remain in the queue'. The individual patient concerned then remained waiting in the telephone queue for an hour before eventually being connected with a receptionist. This kind of call management system needs to be improved, as patients need timely access to speak with someone within a GP practice when they are unwell. Thus, there is challenge in individuals being able to access to speak with receptionists, even prior to actually being in a position to potentially book an appointment in a timely manner. A recent snapshot winter survey by the Office of National Statistics from 22/11/2022 to 18/12/22, asked respondents of their experiences of accessing a GP (11). Approximately 37% stated that they had needed to make a GP appointment in that month. Of this group of people, 52% stated that it had been difficult or very difficult. In relation to their individual experience of their last attempt to make an appointment, 30% of respondents stated they had difficulty contacting the GP practice; 23% were not able to get an appointment; 39% were only offered a telephone appointment when they wanted a face to face appointment and 37% stated that they had to wait too long for a GP appointment.

In addition, this survey reported that 21% of adults were waiting for a hospital test, appointment or medical treatment through the NHS (11).

UK Healthcare spending

Over the past decade (2010-2019) the average spending per person on health has been £3005, which is 18% below the EU14[1] average of £3655 (12). This underinvestment created an NHS, vulnerable to any unanticipated surge in demand, which occurred in the COVID-19 pandemic. Demand for acute care services surged whilst NHS staff were exposed to a life threatening virus, many of whom subsequently died from exposure. The impact of the pandemic has been lives lost and an NHS stretched way beyond capacity, with long waiting lists and a scarred body of staff survivors.

[1] 14 countries that were members of the EU before 2004

Additional data figures of relevance for 2020, show that the UK has fewer practising physicians and nurses, and fewer hospital beds per person than the EU14 average (11), which highlights one of the key exit drivers from the NHS.

In terms of Gross Domestic Profit (GDP), UK healthcare spending (as a percentage of GDP) fell from 9.8% in 2013 to 9.6% in 2017 (13). In terms of population, the population in England is expected to grow by 3.5% over the next 15 years with an increasing number of older people over the age of 85 years (14). In 2020, it was estimated that 1.7 million (2.5% of UK population) was aged 85 and over, and this is expected to nearly double to 3.1 million by 2045 (4.3% of UK population).

With an overall increase in longevity, size of the elderly population and change in family structure, more support is and will be needed for health and social care services in the coming days. Care home providers indicate that government funding is insufficient for homes to be able to retain care staff as other employers offer higher salaries as an incentive (15). Increased financial investment from the government is needed to make the caring profession more attractive to individuals willing to consider care work and thereby increase potential availability and provision.

There is another storm cloud on the horizon, which merits a pro-active approach. There is an upcoming increase in division of the NHS workforce, into union members versus non-union members. With an ongoing chronic lack of staff, and an inability to retain experienced skilled clinicians, recruitment of skilled clinicians from Asia and Africa has been escalated by the government to try to fill vacant posts. These clinicians tend to come from countries where the unions are subject to governmental control and therefore, they most often choose not to join the relevant professional union body within the NHS clinical workplace. Pre-emptive steps need to be taken to prevent this upcoming workforce division, where qualified skilled staff, who also tend to be more tolerant of poor working conditions, choose not to join workplace unions based on their experiences of unions in other countries.

The UK economy has been damaged by Brexit and Covid and there has been substantial turmoil within the leadership of the government over the past 12 months. The COVID-19 pandemic adversely affected the NHS in multiple ways and has depleted resources including staff to a barely functioning level. Political inertia and instability are contributory negative factors on the NHS healthcare system, which increasingly appears to be on the brink of collapse. Rather than ignoring the issues and watching increasingly limited and diminishing resources, including staff, disappear, could there now be an opportunity to change the lens? and offer an alternative perspective for consideration.

A paradigm shift?

'We should not be defined by our failures but by what we do well' (16). Such a reflection challenges the unattainability of targets set on assumed levels of staffing and assumed unlimited levels of service capabilities. How do we define our healthcare system? Can we re-define it? Can we reframe the system? And consider how and what reforms would be of value?

We believe that it is now imperative to re-define the NHS. We have taken time to reflect and consider the multiple complex challenges which confront the NHS and we present our shared insights, analysis, thoughts, ideas and potential enablers of positive change in Table 1. (See Table 1: A Reflective framework).

Table 1

A reflective framework

WHAT DO WE DO WELL?

- Provide emergency care at the point of hospital admission
- Enable diagnosis and treatment of life threatening conditions
- Build relationships with patients
- Provide the most cost effective health service in the modern world

WHAT IS NOT DONE SO WELL?

- A managerial focus on financial business targets at the cost of patient care
- It offers a sheltered space to managers who have no clinical role
- Regulation of managers and training in essential workplace skills eg. interpersonal skills
- Too much mandatory and unnecessary bureaucracy which removes clinicians' time away from patients (17)
- Inefficient Information Technology systems
- Support for clinicians to maintain their continuous professional development
- Support for individuals to safely work across roles if needed
- The delegation of care tasks after patient admission
- The fostering and creation of inclusive positive work climates
- Support and encouragement for the taking of lunch breaks
- Early supported discharge across acute hospital wards
- Options for staff to work flexible hours
- Long night and day shift rotas
- Staff recruitment and retention
- Protection and respect for staff who chose to work part-time hours
- Building and nurturing of relationships across professions, services, departments and teams
- Attitudes and behaviours awareness and impact, eg. bullying, harassment and abuse from fellow colleagues and managers (18)
- The identification of workplace stress and burnout
- Targeted provision of support for individuals at risk of burnout
- Support for individuals in positions of clinical and service leadership
- Private hospital transport contracts with providers who fail to bring vulnerable dependent patients in for their correct appointment time and fail to pick them back up afterwards at the correct time for safe transport back to their community residence which might be a care home.

WHAT COULD SOME POSSIBLE IDEAS AND SOLUTIONS BE?

- To introduce accountability at Board level for cultural improvement
- To introduce managers to clinical service work tasks
- To reduce the number of tick box forms that clinicians are required to complete in relation to patients
- To introduce order communications systems to enable speed, efficiency and ease of access to test results for clinicians (17)
- To introduce Standard Operating Processes for common procedures, eg. catheter insertion, to support clinicians and enable reduction of documentation demands on clinician time
- To change the hierarchical structure of service teams
- To create early support discharge teams who work across the whole hospital site, regardless of patient's location
- To support individuals and teams to work across professional and organisational boundaries (19)
- To encourage and nurture the development of a culture of compassion from staff towards staff
- To introduce standardised national care pathways for people admitted to hospital with acute stroke, eg. rapid access to appropriate imaging (20). Current data shows that '43% of patients with stroke are not being scanned within one hour of arrival at the hospital' (p.9, 20).
- To reform and strengthen primary care and social services
- To initiate and support public health awareness campaigns to encourage awareness and adoption of healthy lifestyle behaviours to encourage improved population health and less reliance on hospitals unless acute or speciality health care is needed.
- Support funding of interdisciplinary research which has the potential to generate value and benefits in terms of reducing primary and secondary clinical workloads, eg. development of wearable ring sensors for remote monitoring of heart rate, blood pressure and blood oxygen saturation levels (21).
- The consideration of introducing a small charge to access a GP and hospital service, entirely dependent on a democratic process via political election.
- Potential removal of small specialist services, perhaps deemed as not essential to primary health (eg. varicose vein operations for cosmesis). These could potentially be outsourced to private providers.

HOW COULD THIS CHANGE BE SUPPORTED?

- All hospital employees, including managers, to be trained to take on patient contact care tasks
- All hospital managers to undertake interpersonal skills training and emotional intelligence training
- Seek to create a multi-professional skilled early discharge support service across every hospital site
- Structural change of NHS organisations to appoint an individual at NHS Board level who is the strategic lead and is responsible for cultural improvement
- Appointment of a Director of Wellbeing to work with the strategic Board level lead, who is operationally responsible for the implementation of a health and wellbeing focused cultural audit, evaluation and change
- The adoption of relevant metrics and indicators to enable data collection and analysis of internal organisational issues requiring investigation and improvement, eg. ASSET stress assessment tool (24), stress related ill-health, number of staff leaving etc.
- Investigation of all failures of private transport providers and to then instigate a change of provider contract for specific vulnerable patient groups
- Engender resilience in the workforce by introducing the concepts of burn out and resilience to all undergraduate medical and healthcare students' curricula, along with providing teaching and learning on practical strategies to recognise signs and manage and cope with these inherent workplace risks and challenges.
- Encourage Trusts to volunteer to act as pilot sites for independent research into staff wellbeing and health improvement.

The concept of wellbeing relates to a sense of positive emotions and feelings relating to how an individual experiences interactions within relationships and how well they are subsequently able to function (22). The work environment and how individuals experience interaction with colleagues and managerial structures is acknowledged as having the potential to impact on an individual's health and wellbeing 'work can make you sick - and work can make you happy, which one depends on who you are, what you do and how you are treated at work' (p.4, 23).

Our reflection underlines the central importance of the workplace climate and culture and the need for NHS organisational structures to change to address unacceptable internal imbalances of power. We believe that there are 3 key elements, which require implementation in order to enable and facilitate a measurable shift toward a culture of wellbeing in the NHS workplace. Websites with web pages that act as information portals do nothing to create cultures of wellbeing. To introduce and create healthy workplace cultures, where employee wellbeing is taken seriously, the following structural organizational changes are needed. Firstly, the appointment of a strategic lead for cultural and structural change is needed at Board level of NHS Trusts to recognise the importance of health and wellbeing in the NHS workforce and workplace with visible accountability. This individual would be responsible for the development of a Health and Wellbeing Strategy, which would include a simple statement of achievable meaningful goals, and identify objectives which would articulate exactly how the goals would be achieved (24) and how measurement and progress toward the goals would be evaluated.

Secondly, the appointment of a Director of Wellbeing, to work with the strategic Board level lead, who would be operationally responsible for the implementation of the Health and Wellbeing Strategy across the organization. Thirdly, gaining expert advice to enable adoption, use and analysis of relevant objective metrics and survey instruments, validated within the field of organizational wellbeing, to gain the employee voice, ie. employee perceptions of workplace risks to their health and wellbeing. There are many different survey instruments, which can provide benchmarking and measurement of different aspects of health and wellbeing workplace related risks (p.121, 24). One such tool is ASSET (A Shortened Stress Evaluation Tool), which enables examination of an employee workforce and identifies the extent to which individuals and groups are affected by stress (24). ASSET

covers 6 key areas relating to an individual's perception of 'work relationships, work-life balance, workload overload, job security, control and resources and communications' (p.120, 24). Another potentially relevant instrument would be 'The Scale of Perceived Organizational Support' (25), which seeks to understand to what extent employees trust that their employer cares about them. These survey instruments should not be used without professional expert guidance because it is imperative that the process and evaluation is done properly and accurately, to ensure reliable results and subsequent accurate targeting of potential interventions. Alongside these metrics, other measures like the number of nurses leaving over a 6 month period and number of stress related staff sickness would also enable some illumination of unhealthy workplace cultures, in need of improvement. We would also suggest that encouraging employees to reflect to improve self-awareness at an individual level, could also potentially help 'This journey of transformation starts with discovering and developing self' (p.18, 26).

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