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A Culture of Learning for the NHS

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Introduction

A recent report suggests that current conditions in the NHS may be preventing the delivery of optimal patient care. For example, patients with various common cancers or cardiovascular diseases can expect sub-optimal treatment in the NHS [1]. In March 2018, the King's Fund confirmed common knowledge on poor NHS performance, staff shortages, lengthening waiting lists, cancelled operations and financial pressures [2]. The UK is out-performed by comparable countries, coming 30th out of 192 countries in a worldwide study [3] and 16th out of 35 countries in a European study with Switzerland in the first place [4]. In addition to poor outcomes, health-care professionals (HCPs) are shown to have behaved badly in a long series of scandals [5]. Almost 8,000 UK doctors were consulted in the recent BMA's Caring, Supportive, Collaborative project [6]. The findings point to the persistence of a culture of fear and blame in the NHS, despite this being highlighted as a problem in two major reports [7,8]. Today's NHS may be represented as a demotivated workforce with low morale, lacking opportunities for meaningful professional development, and resentful of an autocratic and remote bureaucracy [9]. As an example, the proportion of hospital doctors taking voluntary early retirement in the last decade has increased from 14% to 27% [10]. Medical and surgical firms with their "chiefs" no longer exist. The complexity of junior doctor rotas has prevented seniors from mentoring and supporting juniors. Medical collegiality is vanishing. Poor outcomes and disaffected HCPs suggest a dysfunctional organisational culture.

The Organisational Culture of the NHS

The NHS is governed by a politicised bureaucracy which is strongly influenced by 19 quasi-autonomous non-governmental organisations (quangos) [11]. The largest of these is NHS England among whose 15 directors, only two are medical doctors, and neither is an NHS clinician. There is one nurse on the Board of Directors [12]. Britain has proportionately fewer doctors and important health-care technologies than other similar countries, and this is not all attributable to decreased overall NHS funding. Rather, it is the culture of the NHS bureaucracy that does not value the diagnosis and management of serious diseases as much as equity of access, diversity considerations, A&E waiting times and public health campaigns. This may reflect the priorities of quangos not informed by the expertise of NHS clinicians. In 2010, a much-cited Lancet Commission on "transforming education to strengthen health systems" concluded that leadership had to come from within the academic and professional communities, although it had to be backed by political leaders [13]. All these considerations suggest that the present NHS model is ill-suited for the delivery of successful health-care in a modern European country. Despite this, the present government will allocate to the NHS an extra £20bn annually by 2023, with no consideration for reform of the system.

The NHS bureaucracy relies on extrinsic motivation of HCPs by a combination of monetary incentives such as the Quality Outcomes Framework [14], distinction awards and discretionary points along with the imposition of sanctions for failure to achieve specified targets, a carrot and stick approach. Extrinsic motivation not only involves self-defeating fear and blame but may also impair teamwork. In addition, financial incentives may encourage "gaming" the system [15]. These disadvantages may be avoided by fostering a professional culture which predisposes to intrinsic motivation deriving from satisfaction with work content and recognition of accomplishment by the profession. The relationship to work activity is more important than the relationship to colleagues or to the organisation [16].

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The culture of an organisation should be built on the accumulated wisdom and assumptions of the people working in it and meeting its challenges, often over many years. From such assumptions, which may be unconscious, are derived the values which determine behaviour [17]. The present NHS culture is no longer based on the assumptions of clinicians and therefore fails to stimulate intrinsic motivation. A motivated workforce is essential to improve the NHS by behaving according to its professional and learning culture as recommended by Berwick [8]. We agree but stipulate that the learning should be focused on specific problems that have been identified in the health status of the population.

Modern Continuing Education and the Outcomes Pyramid

The purpose of Continuing Professional Development (CPD) and its main component, Continuing Education (CE) is to improve the performance of doctors and other health-care professionals. A pyramidal framework of seven levels of outcomes has been proposed to aid analysis of professional practice gaps (PPGs) which are defined as the difference between "what is" and "what could or should be" (Figure 1). PPGs affecting the health status of communities (level 7) or of patient groups (level 6) are examined to find out if they are caused by gaps in clinician performance, competence or knowledge (levels 5, 4 and 3). This analysis helps to design learning activities for clinicians aimed at addressing the gaps [18–20]. First, education providers should present information about the gap to clinicians to predispose them to learn how to address the gap. For example, an unacceptably high readmission rate after acute asthma attacks could be shown in a scenario to occur because of inadequate advice to patients before discharge [21]. The aim of the predisposing activity is to generate a "teachable moment" which renders the clinicians receptive to the education. The CE must then be designed appropriately for the desired outcome level on the pyramid [20]. For example, didactic presentation is suitable for a knowledge gap, but a competence or performance gap would need interactive small group discussion, demonstration or simulation.

Previously CE concentrated on learning what to do and how to do it (level 3) but is now increasingly focused on competence (level 4), where learners are required to show in an educational or simulated setting that they can do what they are learning. If there is sufficient practice and feedback in these settings, the learners will be more likely to use what they have learned in practice, and it is, therefore, more likely that the health status of their patients will improve. An important study showed that competence (level 4) and performance (level 5) and in some cases, patient health (level 6) are improved by educational interventions which aim to satisfy a defined need (close a PPG), are interactive, employ multi-media and focus on outcomes important to doctors [22]. There has been a recent suggestion that since properly planned CE may have "ascended further up the pyramid" to the performance and patient health levels, analysis of PPGs evident in whole populations, rather than in individual patient groups, should enable CE to affect community health (level 7) at the summit of the pyramid [23].

Figure 1. Outcomes pyramid.

Professional Practice Gaps

PPGs in regional health-care centres may be suspected by the clinicians practising in these areas. They may be confirmed by studying hospital or GP medical records or may become evident during the course of multidisciplinary team meetings. Clinicians do not always recognise gaps in their own practice, and third-party agencies such as quality improvement committees and the National Reporting and Learning System of the NHS [24] could help in identifying gaps. Outcomes aimed at improving competence (level 4) are now being achieved by a combination of formal and workplace educational activities. However, in many cases, gap analysis indicates performance failure (level 5), despite adequate competence, because of a barrier to the transfer of competence to performance. Such barriers may be local in nature, due to stressful working conditions, poor staff relationships, too few staff or disorganised infra-structure. Again, a teachable moment may be created by participation in a scenario [21], e.g. delayed antibiotic therapy for suspected meningitis in an overcrowded A&E department or a cardiac surgery department, where practice coordination difficulties resulted in high mortality rates [25].

Some barriers are systemic rather than local in origin and occur when a healthcare system is generally poorly organised, inadequately funded or wasteful of resources, e.g. delayed diagnosis because of long waiting lists and too few CT and MRI scanners. There may be acceptance of irresponsible patient behaviour, and selfish, counter-productive activities of health-care personnel, e.g. early retirement or emigration shortly after completion of training. In addition, fashionable CPD itself may cause gaps, e.g. excessive attention to computer screens to the detriment of history-taking and clinical examination [26]. Some barriers to performance are due to cultural factors. Most doctors know that active, interventionist management of terminally ill or demented patients is unrewarding if not culpable, but prolongation of life in such patients is commonplace. Medical behaviour which sanctions this cultural practice represents a PPG, which is particularly serious because the financial cost is so high.

Systemic PPGs affect community health at the summit of the outcomes pyramid, but their identification and analysis are not recognised as CE activities in current practice. National agencies such as Royal Colleges and specialist medical societies should accept that it is their responsibility actively to seek PPGs by interrogating big data [27–29]. Once discovered, the gaps must be analysed to determine their causes, after which appropriate education is designed.

How to Implement Learning and Professional Cultures

In the event that the NHS were persuaded to support the development of these cultures, a hierarchical structure could be envisaged in which either a new supervisory body would be established or an existing organisation, such as the Academy of Medical Royal Colleges [30], would have its responsibility redefined to include the design and delivery of CE at various levels. Such an organisation would require all major hospitals to establish departments of CPD, at present unknown in Europe, but common in the US. It would encourage specialist clinical societies and Royal Colleges to set up speciality and national CPD departments, respectively. These departments would actively seek and analyse PPGs at hospital, speciality and national levels and design appropriate education to bring about the necessary changes in clinical behaviour.

Local implementation of this development would require integration of CPD activities into hospital and practice management structures. At the national level for systemic PPGs, Royal College and specialist society CPD experts should become essential and important members of quangos, whose reform is already considered overdue [11,31]. Systemic barriers to performance often occur because of management or political failure, e.g. understaffing due to low morale and unattractive working conditions. In these cases, the corrective CE should be directed both at management personnel and members of the relevant quangos. Some initiatives would need extra funding, but others may result in savings, such as end-of-life care or cosmetic surgery. Better staff retention and more responsible patient behaviour would also save money. The net cost is unpredictable, but not necessarily more expensive and indeed the apparently inexorable rise in spending may slow down. In the first instance, it may be sensible to introduce these innovations in a limited pilot form.

Those involved in this initiative would be the leaders and senior members of the health-care professions. They should also be charged with recreating the professional culture which has been weakened under pressure from the bureaucratic culture. The old assumptions and values which once characterised the best of medical practice will be rediscovered and incorporated into the new culture of learning from which younger HCPs will derive intrinsic motivation to improve the NHS.

Conclusion

In this paper, we suggest that continuing education and professional development could replace the present NHS “culture of blame and fear” with a culture

of learning. The acceptance of a learning culture by NHS England and other relevant quangos could revitalise an ailing system and collaboration with clinicians would add a new dimension and direction of travel. Risk-averse bureaucrats would be encouraged to address contentious PPGs with backing from people with first-hand experience of them. Doctors and nurses would again be able to consider themselves as members of professions with their own distinctive values and assumptions. Recruitment and morale would rise. For all this to happen, the health professions would have to be persuaded to accept greatly increased responsibility, and the politicians and bureaucrats would have to surrender some of their present authority.

Disclosure statement

No potential conflict of interest was reported by the authors.

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