“F
tee tea and coffee is no longer available.” That saves a few hundred pounds a year but is it worth the dent to staff morale? Why shouldn’t staff pay their employer’s extortionate yet unavoidable car parking fees? What are salaries for if not to subsidise collapsing study leave budgets? Who doesn’t want to sit on a grimy sofa when the Trust won’t pay the cleaners to work weekends? And even though evidence shows you’d be a safer doctor after a power nap, who needs an on-call room to rest?

A few such dents can soon rust, and before long you’ve got a hole. When freezing pay, cutting pensions, and expecting staff to work more, it is advisable to try to repair those dents. Holes in an NHS that is increasingly described as a slowly sinking ship can only hasten the inevitable. A few expensive locums might temporarily cover the cracks, but they can’t recreate the organisational culture required to get the ship afloat.

Lessons from corporate mergers provide insight into why engaging a positive culture of improvement is a crucial cog in success. When organisations merge, management consultants make hundreds of thousands of pounds stating the obvious, but neglected, facts. Their value is in discovering the conflicts between the two merging cultures. When a failing organisation is bought by a successful one, what about the staff? Are they also failing or are they victims of uninspired leadership, struggling to save themselves from their own sinking ship?

Despite culture being crucial to success, organisations and their leaders often learn this the hard way: up to 90% of mergers and acquisitions fail (compared with 40% of marriages, incidentally). Arbitrary corporate values (“trust,” “compassion,” “excellence,” and so on) and urging the troops to “work synergistically” to force through integration merely highlight the barriers to any organisational marriage.

Culture is “a general, shared social understanding, resulting in commonly held assumptions and views of the world among organisational members,” and is developed over time through shared experience, according to the NHS.

Arising internally, culture influences how people think and work. As a palpable rather than tangible entity, it is inherently difficult to measure and analyse.

A positive organisational culture can be developed and driven only by engaging a critical mass, so it is no surprise that it is largely neglected. How often do efforts clinicians make go unrecognised and unrewarded? Contribute to a successful project for a private organisation and you receive a thank you, dinner, and possibly even a bonus, because happy staff stay, are more innovative, and work harder. In a cash strapped NHS we know we can forgo the dinner and bonus, but a managerial thank you wouldn’t go amiss.

It is only by empowering staff that a positive team culture can be fostered at the heart of an organisation. In the NHS, however, the bureaucratic barriers to implementing change are immense. The organisational attitude encountered by clinicians in response to innovation is often obstructive at best, hostile at worst.

NHS leaders need to change their view of culture. Leaders consider culture in the context of staff only when it fails. They regard clinicians as “culturally resistant” to change. However, this is increasingly a consequence of unsuccessful change forced from outside rather than the cause of the culture of self preservation. (Has anyone else been proudly commended by their boss for how many referrals they “batted away” recently to control team workload?)

If the NHS is akin to a slowly sinking fleet, then its captains must engage their crews. While financial and staffing constraints are undoubtedly the core of the problem, they are in the hands of higher powers. Leaders, however, seem to overlook the huge rewards to be reaped by inexpensively recognising and rewarding innovation and hard work.

As the now defunct NHS Institute for Innovation and Improvement—another victim of change—stated: “The presence of a positive and supportive organisational culture often goes hand in hand with high quality care and an enthusiastic workforce. Without innovation, public services costs tend to rise faster than the rest of the economy and the inevitable pressure to contain costs can be met only by forcing already stretched staff to work harder.”

Cultural change that challenges tradition cannot be effected by managers through top-down diktat. Yet the NHS persistently assumes the reverse, with clinical staff pawns in enforced implementation rather than active in driving success. Leaders ought to heed the advice of the US investor Warren Buffett: “As a leader you set the culture for the business and the right culture is a valuable and hard-to-replicate source of advantage.”

A recent survey of more than 200 000 NHS staff found that only 69% were enthusiastic about their job; 41% were satisfied that their trust valued their work; and 36% thought that the right culture is a valuable and hard-to-replicate source of advantage. Cultural change that challenges tradition cannot be effected by managers through top-down diktat. Yet the NHS persistently assumes the reverse, with clinical staff pawns in enforced implementation rather than active in driving success. Leaders ought to heed the advice of the US investor Warren Buffett: “As a leader you set the culture for the business and the right culture is a valuable and hard-to-replicate source of advantage.”

The need to foster a nurturing, caring culture that makes staff feel valued, respected, engaged, and supported, is known at the highest levels. As Sir Bruce Keogh, medical director of the English NHS, decreed, “All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.”

Rhetoric is endemic but action sparse. Leaders should promise to improve rather than demolish staff culture. And remember: there are lots of good things about the NHS that don’t have to change.

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Talking about death is not outrageous—reducing it to a tickbox exercise is

The Daily Telegraph was outraged. The headline read, “Elderly patients asked during home visits by nurses: would you want to be resuscitated?”

The offending question is part of the direct enhanced service for unplanned admissions.

Essentially, GPs are being paid to try not to send people to hospital. On the basis of recent attendance patterns we are meant to identify patients at high risk of being admitted and work out a plan, as the NHS specification puts it, to “identify factors which could have avoided the admission or future A&E [accident and emergency] attendance with a view to taking appropriate action to prevent future episodes.”

The bias is obvious: no equivalent specification pays doctors for admitting patients to hospital when it is the best place for them. But millions of pounds are being spent on the illusory idea that millions more pounds can be saved if GPs make a plan for patients that avoids admitting so many to hospital. This is patently nonsense; evidence has shown that this kind of “case management” doesn’t reduce admissions. And where is the evidence of safety or the search for harms? How do we know that GPs’ time is being well used? We don’t.

We are all living longer, with more long term conditions, but (as if planned in a parallel universe) the number of NHS beds is going down. We need what we’ve always needed: highly trained GPs with the professional freedom to listen and respond tactfully when people want or need to talk about death.

Tickbox forms always insist on binary answers. But life is complicated and messy, and being ill, alone, or scared can make us vulnerable.

Talking about death is not a bad thing to do, but when health professionals are driven by a policy designed to save money rather than serve patients, we hardly deserve our patients’ trust.

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This is all part of the government’s belief that the work of general practice—which has always included appropriately timed and careful talk of what we want to happen at the end of life—can be splintered off into disparate tasks and forms. Those services can then be contracted out to the cheapest short term provider. Why aren’t we furious that our professional and vocational lives are being run on non-evidence based policy?

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Avastin and Lucentis: It’s time for NHS commissioners to act rationally

The news that a Cochrane Review has concluded that Avastin (bevacizumab) is as safe as Lucentis (ranibizumab) to treat patients with wet age related macular degeneration (“wet AMD”), along with other studies that have shown the two drugs have the same level of clinical effectiveness, comes as no surprise to those of us who have been involved in this debate.

Lucentis is a “licensed” drug for wet AMD, whereas the much cheaper Avastin is not licensed for this particular condition. The drug licensing system is, of course, about the commercial marketing of drugs and not about clinical use. However, clinicians are naturally worried that if they have a choice about using a licensed or an unlicensed drug, they will be hauled before the GMC if they elect to use an unlicensed drug.

The recent GMC guidance favouring licensed drugs over unlicensed drugs was not the GMC’s finest hour. Now that it seems fairly clear that scare stories about Avastin’s use for wet AMD have all the credibility of a chocolate teapot, the NHS has some choices to make. In 2012 the former health minister, Mike O’Brien QC, made his position clear. He said: “Andrew Lansley should refuse to allow the NHS to be bullied by Novartis. The interests of the patient and the NHS must come first.” That statement was issued when Novartis (which has the European rights to market Lucentis) attempted to use a judicial review to stop an NHS body favouring Avastin over Lucentis.

The action was settled before it came to a final trial and so the case was not a precedent for anything.

But the threat of legal action to stop NHS commissioners doing the right thing in this area remains. However, it is just that—a threat. No case has ever (as far as I am aware) resulted in anything for a wet AMD patient under the NHS, and the money freed up would deliver vastly more NHS treatment for so many others. Doctors would also be as fully protected as they could be from GMC action. However, the difficult question will be how many NHS commissioners have been down the yellow brick road to collect their portion of the lion’s courage and will do so.

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“Why should an NHS under vast financial pressure give clinicians the choice to use a less cost effective drug?”

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