More funding, training and recruitment?

Our NHS staffing needs far more than this

David Zigmond

Increasing money and training to refuel our weakening and unstable NHS healthcarers workforce may be necessary, but it is certainly not sufficient. Here is why.

There is growing darkness at the (imagined) light at the end of the Covid tunnel.

As the earlier massive tide-surge of the pandemic seems – for now – to be receding we have many reports of its legacy of damage and cost to our healthcare: not just delays and interruptions of sometimes vital treatments, but of increasing staff burn-out, drop-out and opt-out. And many of those that remain seem like heroically-motivated runners staggering towards the end of a gruelling marathon – painfully determined to continue, yet collapsing into the arms of supportive and restorative care in order to recover.

Thankfully, this is at least now recognised and stated recently by the erstwhile Health Secretary, Jeremy Hunt, and the recently appointed Chief Executive of NHS England, Amanda Pritchard. Both are agreed that this is a serious problem which will be neglected at our peril. Their remedy? Adequate funding for greater training and recruitment of staff. In a post-Covid post-austerity era this may sound encouraging, but it raises many other questions, some very quotidian, others more fundamental yet obscure. How much funding is 'adequate'? How will this be raised, distributed and secured? If we recruit medical and nursing staff from other (often much poorer) countries – as Amanda Pritchard breezily suggested – what are the ethical and practical (elsewhere) consequences of this?

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But there are much greater and deeper rooted problems that threaten our NHS workforce than this Covid-induced concussion: the insidious and cumulative demoralisation and depersonalisation of healthcarers who have lost a sense of

vocational pride and satisfaction, and colleagueial trust and belonging in their work. This deep and widespread dissatisfaction amongst so many nurses and doctors far precedes the superadded – albeit far more dramatic – Covid-crisis. Perhaps because this erosion of spirit and morale has been more gradual and incremental, its substantial damage has received little sustained attention from governing and managing authorities. Despite many years of growing evidence – for example falling recruitment, failing health, increased early retirement and career abandonment amongst primary and mental healthcare workers – little attention has been paid to the human meaning of this. This inattention is highly selective and thus tells us much about the nature of our problems.

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For the last thirty years there have been successive NHS reforms that may be seen as shifting attention, with increasing resources and precision, to money and metrics. The pioneering neoliberal agenda of the Thatcher era converged with the excited early development of digital technology: this enabled the mass-management and commodification of healthcare, and thence to marketised commissioning, monitored performance and regulated compliance – together these are most compatible with corporate tendering and contractual negotiation. All this was much less possible in a previous world informed by mere ledger-books and managed by variable human good faith and judgement. The combination of computerisation and the new economics could then reform healthcare to become more and more like competitive commercialised manufacturing industries – like a giant web of siloed factories.

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Before such serial reforms the NHS functioned more like a relatively informal network of families than such a system of contracted factories. This analogy can tell us much about the pre-1990s NHS and its strengths and weaknesses. As with real-life families there was much variation: there were those that were dysfunctional, even hazardous; but most resembled happier families that functioned well with flexibly adapted bonds of convivial trust that grew from personal familiarity, shared experiences and bespoke understandings. These bonds of personal identifications were shared between the healthcarers and their staff, and then with their patients – a professional community caring for a wider community. This sense of belonging nurtured deeper senses of shared context, meaning, motivation and purpose. This was exemplified by how we looked after and looked out for others: the bedrock of personal continuity of care – the Family Doctor.

It was such 'organic' growth of familiarity, community and care that sustained the practitioners' deep work satisfactions and thus the mostly buoyant morale, excellent recruitment and staffing endurance and stability of pre-1990s general practice. *GPs liked their work*: despite working hours being longer and the pay no better: they usually retired late with poignant reluctance and reciprocated affectionate gratitude.

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There is a German word – *Verschlimmbesserung* – which means trying to fix things, but making them worse. This accurately describes much of the legacy of those serial reforms that did not see, heed or understand the organic nature of healthcare's complex human ecosystems and thought short-circuiting these to inorganic

industrialised systems would be more 'efficient' and cost-effective. This often draconian process – from Family to Factory – was often answered with protest, argument and mounting evidence of its unpopularity, inefficiency and damage. But such reforms, once rolled out, are very difficult to roll back.

The tragic portents of the consequently dispirited and sickening NHS workforce – wrought by its no-one-knows-anyone-but-just-do-as-you're-told culture – have been very evident well before the pummelling of Covid. But that ethos, in its zealed mission, blinded those who designed and managed it.

Now we face the post-Covid denouement.

What will 'building back better' mean?

It will be another extravagant folly to train and recruit a larger tranche of healthcarers if they do not want to stay with us, and for us, for a long working lifetime. And yet they are only likely to do this if their working milieu is one of greater belonging, trust and satisfactions that can dovetail with personal vocation and identification … as so often happened before our serial reforms.

How can an industrialised system, particularly one yoked to corporate and commercial interests, ever fulfil these conditions?

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