DH Department of Health

Days out in the NHS:

Listening to NHS Staff

Andy Burnham MP
Minister of State for Delivery and Reform

NHS

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Introduction

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The NHS has come a long way in the last ten years. Today, nine out of ten patients rate the care they get as good or better.

We can say with confidence that the NHS is providing a better service than at any time in its 59-year history.

But it has not been easy. Getting the NHS to this point has required a lot of change in a relatively short period. We know we have asked a great deal of NHS staff.

And yet, after a decade of change, the difficult prospect facing us all is this: if we want the NHS to be both financially sound and to continue making the best of modern medicine available to all, the shape of services will have to go on changing in the next decade, possibly even more so.

I accept that, at times, it must seem to people working in the service that ministers and the Department of Health are obsessed with change for change's sake. Perhaps we fail to articulate clearly and succinctly why we propose change and why we are impatient for the NHS to improve further.

This is, and always has been, our case for change: to show beyond doubt that the NHS model, its innate fairness never in question, can also rise to the challenge of providing care quickly and to the service standards that people expect today.

By building public confidence, we secure the NHS's future. In a fast-moving world, standing still would leave the NHS stranded and weakened, unable to meet modern expectations and prey to its right-wing critics who are never very far away.

The irony is that the process of change necessary to secure long-term public support for the NHS risks driving a wedge between the coalition of its strongest supporters.

It was for this reason that the Prime Minister and the Health Secretary asked me to consider what more could be done to engage staff in the difficult process of change and reform in the NHS, learning from recent experience.

With this challenge on my mind, I asked Josie Evans, a senior staff nurse in the Outpatients Department at Leigh Infirmary in my constituency, the question that had preoccupied me

since my appointment: 'We've got more staff, better pay and the NHS is improving. So why is there a problem with morale?'

It was one of those moments when as soon as you've asked a question, you wish that you hadn't. Like a typical Leyther, Josie gave me my answer: 'You've absolutely no idea what it's like or what pressure we are under.'

She was right, of course. I didn't know what it was like to have worked through the changes of recent years, nor was I sure what staff felt about the prospect of further change in the NHS.

It is over six years since the publication of the NHS Plan signalled the start in earnest of the largest change programme in the service's history. While the direction set remains the course, the time is right to take stock. If we are to succeed in making the NHS as good as we all want it to be, we know that needs support from staff.

So, after my telling-off from Josie, I set out to address my knowledge gap. I wanted to understand the pressures on staff and get first-hand impressions not mediated by the many filters between ward and Whitehall desk. The engagement plan requested by the Prime Minister would succeed only if infused with a dose of realism.

Between June and November 2006, I spent seven days out of the office shadowing people in different jobs in the NHS. Not a lot, I know; but it was enough to gain some real insights. I did not set out to find 'the best' but what you might call 'normal'. However, as it happens, I met a number of inspiring people doing exceptional things.

Some personal observations on my days out follow. I would welcome comment and feedback on any of the issues raised. I can be emailed at andyburnham.workshadowing@dh.gsi.gov.uk.

My days out have been a great experience and I wish to thank everybody who put up with me. Without exception, people were welcoming and helpful. They confirmed for me a view that will sound corny coming from a Health Minister, but which nevertheless happens to be true: our NHS is staffed by thousands of unsung heroes who believe in the values of the organisation they work for and who show true public service day in, day out.

Day 1: Emergency response paramedic, West Midlands

Heading for the very front line of the NHS seemed the right way to begin and, in wanting to see 'normal', a damp Tuesday in the Black Country felt about as normal as you can get.

But my first day out of Whitehall, shadowing an emergency response paramedic from the West Midlands Ambulance Service, brought home to me from the very start how a normal working day for many NHS staff would be exceptional for most of us, such is the range of situations it covers.

I started by listening in alongside a call handler at the Dudley call centre. For thousands of people across Britain every day, this process begins their journey into the NHS.

The volume and variety of calls – even at 10.15 on a Tuesday morning – was surprising. They ranged from routine requests for ambulances for patients in nursing homes to urgent dramas being played out at that very moment in the bus shelters and off-licences of the West Midlands. All were handled calmly, skilfully and quickly.

Many office-based jobs are stressful. But dealing with hundreds of calls like these day in, day out must create a unique kind of pressure. 'Don't you ever feel like doing an easier job?' I asked. Only on bad days, she said. However, the feeling didn't last long, she added, as those jobs don't give the satisfaction that comes from helping people in need.

After this, it was out on the road with Steve in one of the service's rapid response vehicles. They are used to get help to patients quickly in advance of the ambulance crew and, in doing so, help meet performance targets.

Steve dealt with a number of jobs that day – a COPD (Chronic Obstructive Pulmonary Disease) patient struggling with his breathing, a middle-aged woman who had fallen and was unable to get up – but one stands out in my mind and will stay with me. This is despite the fact that it was probably routine for Steve and there wasn't a great deal we could do to change things.

The call was to attend a house in the Wolverhampton area where an elderly woman with a terminal illness was in severe

discomfort and having difficulty breathing. Steve told me afterwards that he knew straight away that the woman was very near the end of her life. Her husband and son were with her in the house and in considerable distress.

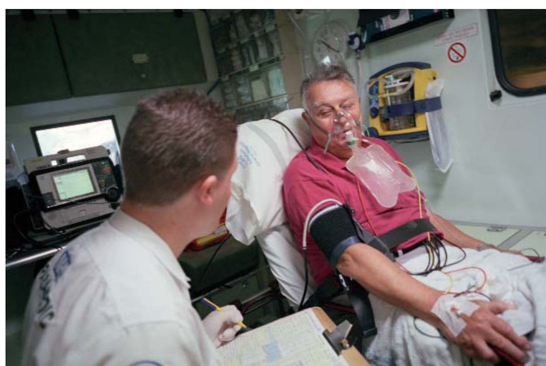
By the time the ambulance arrived, the situation had improved. The elderly patient was more comfortable and her family were calmer. Her son then travelled with us to Wolverhampton A&E. On the way, Steve talked things through with him and gently prepared him for the difficulties that lay ahead.

It was a sad situation, but an everyday job for ambulance staff in any part of the country. It was a vivid illustration for me of the exceptional nature of the job that Steve and his colleagues do in serving the public, in addition to the high-drama emergencies that we all see on TV. Doing the job well requires communication and people skills that go well beyond anything that formal training could provide – and, in my personal experience, most ambulance service staff possess these skills in abundance.

These everyday situations for staff also happen to be the most momentous and distressing events of their lives for the members of the public involved. Over time, you might think that relentless exposure to these situations must make people inured or hardened to such scenes. From what I saw, the opposite is the case.

Over the course of the day, we called in at a number of ambulance stations and A&E departments. In general, I got a clear sense from those I spoke to that the service provided by the ambulance service had improved in recent times. But it was interesting to hear an insider's view of the differences between various hospitals and their A&E departments.

Overall, while I stand to be corrected, the impression I gained from the staff I spoke to was that they were broadly satisfied with their jobs and working conditions. They did, however, raise a range of concerns, including the delayed implementation of Agenda for Change, rising public expectations and performance targets. All felt strongly committed to the NHS.



Steve and I spent much of the day talking about the pressures of the job and performance targets. It is undeniable that

ambulance staff are working under increased pressure today. Rising public expectations are felt very directly by the ambulance service and, going forward, could make it hard to meet performance standards. There would appear to be big differences in attitudes between the generations. Younger people will often demand an ambulance and assert their right to go to A&E, even with minor ailments. By contrast, elderly people will often begin by apologising for calling out an ambulance crew – even in urgent and life-threatening situations.

There was an acceptance that performance standards and targets will always need to be part of life in ambulance services to some extent, given the nature of the work. But staff warned of the danger of over-reliance on targets: basic data may not tell the whole story about the quality of the service being provided to the public.

There was much that I found reassuring about my day in the Black Country. At the call centre, I was also struck by the fact that members of the public were not walking by on this drizzly Tuesday morning but had disrupted their day to get help to people in need. When the blue light was on, most of the traffic (but not all) pulled over to let us through.
It suggests that most of us value and appreciate the exceptional job that Steve and his colleagues do on our behalf.

Day 2 (overnight): A&E sister, South London

June 28th 2006 felt like a busy night in South London, right in the middle of the World Cup. It was probably not the best time to choose to work-shadow an A&E sister on the overnight shift. But, then again, is there a good time?

I had decided to go to this hospital at the suggestion of a local MP. It had been experiencing financial difficulties and there was the threat of some redundancies. I wanted to know how this had affected morale.

Judging by the numbers waiting in A&E reception, I suspected we were in for a busy night. Inside, every bay was occupied. 'I can't believe you've come on such a quiet night,' said Tracey, the sister on duty.

It quickly became clear that, while there was plenty of activity, this A&E on this particular summer night was dealing with far more As than Es. I don't in any way seek to trivialise the obvious difficulties that some patients were in, but it is certainly the case that many of them could have been quite properly treated elsewhere.

What I had not expected was the extent to which this was a cause of frustration for all the staff. Reception staff, ambulance staff, nurses and doctors all spoke of the relentless pressure it placed on the unit. It was not the pressure itself that was the problem – staff expect that in A&E – it was more that much of it was seen as avoidable and wasteful of staff skills and resources.

At around 11pm, this point was brought home starkly. Tracey was deep in conversation with a team of two paramedics from the London Ambulance Service (LAS). One of the crew didn't look at all pleased, shaking his head and waving a bit of paper. 'He's the man you need to speak to,' said Tracey, pointing in my direction.

The paramedic came over and showed me the job sheet for the patient that the LAS had just brought in. In the box detailing the nature of the emergency were the words: 'CUT FINGER OPENING TIN.' He said: 'I've been flying round South London on a blue light, putting the public at risk, just to get to a f***ing paper cut!'

It was clear that this incident was not unusual. Like their colleagues in the West Midlands, LAS staff spoke of rapidly rising public expectations and a major shift in attitudes between the generations. On occasion, when staff questioned the need for an ambulance and A&E visit, people said they had paid their taxes and demanded an ambulance. It made me think how our messages about creating a patient-centred NHS need to be balanced by calls for more responsible use of its valuable services.

Around 3.30am, I went into the reception area to speak to reception staff. It was a genuine shock to find a full house. On busy nights, Tracey explained, she managed the workload by going into reception and asking people to leave if their problem was not urgent. Surprisingly, a good number would always get up and leave.

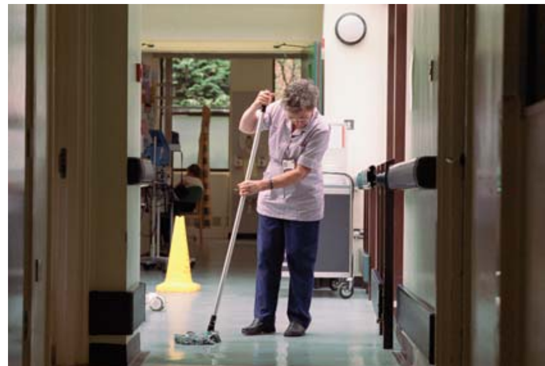
Despite the frustrations, it struck me that the people here believed in what they were doing and were doing an excellent job. They were under real pressure, there is no doubt about it, but were coping well. All the staff I spoke to said they did what they did because of a strong commitment to the NHS.

That night, I watched Tracey monitoring the state of play via the whiteboard. There were no breaches of the four-hour target. Given the workload and pressure on her, I hesitated before asking what she thought of the target but her answer surprised me. She recalled how chaotic the A&E environment had been before it was introduced, with ambulance staff queuing out of the door with patients on trolleys. The target had brought a focus that was good for the public. It also helped A&E staff do their job, strengthening them in their dealings with the rest of the hospital. 'Just don't make it a two-hour target,' was Tracey's parting shot as I left.

As I had anticipated, talk of redundancy elsewhere in the hospital had dented morale but not as much as might have been expected. During a break, a junior doctor talked of the uncertainties that he and other graduates were facing in the London area.

As it turns out, while there was relentless activity right through the night, I had come on a quiet night in the sense that there were not as many real emergencies as might normally have been expected. But, around 4am, the atmosphere changed as an ambulance sent a message ahead about a serious road accident. It was impressive to see things swinging into action and reassuring to see Tracey organising a team of 15 or more people to get ready for the arrival of the patients. And it made me realise why these highly-skilled staff get annoyed dealing with cut fingers.

Day 3 (morning): Hospital cleaning supervisor, North West



It has always seemed to me that the job of a cleaner in any large organisation is a thankless one. If you do your job well, people don't notice. If you have a bad day, or a bit of bad luck, people will be quick to complain.

Cleaning is a hard job anywhere, but particularly in healthcare settings where high standards are demanded, and rightly so. The unexpected can always happen. I know this because my grandmother worked as a cleaner at our local GPs' practice for many years. She used to enjoy shocking us with her stories of what she found lurking in the bins and behind closed doors at the surgery.

That was in the 1970s and 1980s. Now, the job of a cleaner in the NHS is a lot harder; it is in the spotlight as never before.

Over recent years, concerns about MRSA have brought a unique level of public scrutiny on jobs that are relatively low paid and low status. Some have asked, sarcastically: "How hard is it to clean a hospital?" However, anybody who gives that question more than a second's thought will probably conclude that it is, in fact, a very hard job.

It was certainly my conclusion after a morning work-shadowing Sheila, the cleaning supervisor with this trust's contract partner.

To begin with, Sheila took me through the induction and training materials given to all new members of staff. It was very clear that this job was not at all like giving your kitchen floor a quick once-over with the mop.

I looked through the staff manual, 'An Introduction to the Control of Infection'. It detailed the complicated procedures that had to be followed, including a colour coding system for the different cleaning methods to be used in different areas (such as toilets, kitchens and ward areas). All equipment had to be maintained to the highest standards and there was even detailed advice on how to wash hands properly.

On a tour of the hospital, I saw how difficult it is to clean a busy multi-bay ward during the morning ward round. Hospitals are never a quiet and empty environment. Dust can gather

in a multitude of places around the ward. There is all the routine cleaning to do as well as the extra that crops up as a result of incidents on the ward.

I readily acknowledge that a single morning was not enough time to get a complete picture of what goes on, but it was long enough to gain two clear impressions.

First, to the people I met, this wasn't just any old cleaning job, like cleaning a pub or an office. They had a clear sense of pride in their work and of its value as a public service. They took satisfaction from the fact that they were serving the local hospital and the NHS in general. How they did their job mattered greatly. Sheila told me that one of her best members of staff had been devastated by a recent anonymous letter to a local newspaper criticising the standards of cleanliness on the ward where she worked. It was a revealing insight into the pressure felt by staff at every level.

Second, it was clear that the cleaning team wanted to feel more closely involved with the running of the rest of the hospital and to be part of the same team as the ward staff. It is a personal view but I think that it is a legitimate request, given the importance of the cleaning service to local perceptions of the trust and the sense of accountability that staff feel. There are a number of ways of providing cleaning services – and these are matters for local trusts to decide – but the views of staff should be an important consideration when these matters are reviewed.

Day 3 (afternoon): Hospital porter, North West

I'll be honest. I thought a hospital porter's job was fairly easy, limited to wheeling patients along corridors and in and out of lifts. It is only when you spend time with a team in a busy hospital site that you realise this is hopelessly off the mark. They do all of those things, but a lot more besides.

Porters are a vital part of the hospital team. From what I could see, they are regularly asked to go beyond the strict call of duty in dealing with the vast range of situations that are part of their everyday work. Or as one put it: 'We're like the glue of the hospital, picking up the jobs that no one else will do.'

When I shadowed the overnight shift in A&E, Tracey had told me how much the staff depended on the porters to get the patients through the department, to meet waiting targets and keep the whole place working. She said she felt sorry for them as they often picked up the flak from staff under pressure to meet deadlines and didn't get the recognition they deserve for the important job they do.

I put those points to one of the porters that night, a young man in his mid-twenties originally from the North East. He is paid £5.88 an hour; in London, that doesn't go far. He told me he chose to work nights to maximise his income and took most of the overtime he could get. I asked him why he did the job. 'I just enjoy chatting to the patients and helping them out,' he said. 'Most of them are great and we can help things feel more normal for them.'

It was a similar story when I spent an afternoon with a team of two in a busy North West trust on a spread-out and uneven hospital site. The porters had to use an ambulance to get patients where they needed to be. In winter, there were real difficulties in moving the patients around the site safely.

What surprised me was the extent to which porters were at the sharp end of the friction between different parts of the hospital. As we took patients around the trust, I watched them having to work to gain the attention of staff on the ward because of the need to prevent other waiting breaches. As with the cleaning team, I picked up a wish to feel more

involved in the hospital team as a whole perhaps even more so because of this need to negotiate with other staff.

I had also underestimated the importance of the role porters play as a help to patients, providing information, normal conversation and, where necessary, reassurance. As with many roles in the NHS, doing this job well demands the best people skills.

The most striking moment of the day came when one of the porters I was with described how they routinely pick up the unwanted jobs. A few weeks earlier, a body that had lain undiscovered for three weeks had been brought into the hospital. As with all incoming bodies, a wristband had to be placed on it. This body was in an appalling condition and it was hard to find a volunteer to do the formalities. 'We do all the shitty jobs that no one else will touch,' he said. 'I had to put that band on the body and I'm on £5.88 an hour. But I don't mind. Someone has to do it. I like working for the NHS.'

Day 4: Community psychiatric nurse, County Durham

I wasn't sure what to expect spending time with the members of an 'Assertive Outreach Team' from Easington. It conjured up a formidable image of no-nonsense northerners you wouldn't want to mess with. But the reality couldn't have been more different.

With most of the other jobs I shadowed, I had a reasonable idea in advance of what the day would involve. But I couldn't say the same about a community psychiatric nurse. As it turned out, this Friday in County Durham was both the most revealing and uplifting of my days out. It gave me a glimpse of the work that goes on day in, day out across our NHS, largely unnoticed, to help some of the most vulnerable people in society.

This felt to me like the 'hidden front line' of the NHS. The work done by this team and others like it prevents people from breaking down and accessing other parts of the NHS system – GPs' surgeries, the ambulance service, A&E or, indeed, the police and other public services. These staff don't receive the same public recognition as do other health service roles, but nor do they seek it. Yet the work they do delivers enormous value to the public; we are all lucky that there are people willing to put huge energy and enthusiasm into this unglamorous work.

This team of committed people was helping people cope at home and live better lives than they would otherwise have had. Years ago, the service users I met over the course of that day would most likely have been in institutional care. But what I saw was not community care on the cheap; it was intensive support and intervention. The independence of the service users was not achieved at the expense of the quality of life of those living around them.

I spent my day with four members of the team and accompanied each on a home visit. All four had come to the job from different backgrounds, but they shared a passionate commitment to helping vulnerable people. One had recently made the transition from a hospital setting to this community-based work. While it had been a daunting prospect, she was pleased to have made the change and was finding the new way of working rewarding.

Easington's Assertive Outreach Team

Each member of the team had an in-depth knowledge of the people they cared for and of their family support networks. It was a concern combined with what seemed like genuine friendship. They knew exactly what made the people they cared for tick and what made them anxious. The smallest tell-tale signs were noticed and a careful assessment made of whether the individual had made progress or gone backwards since the last visit.

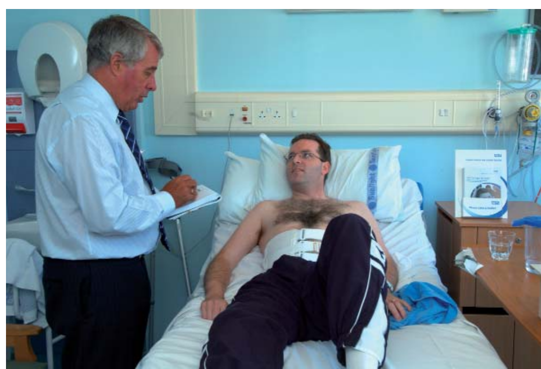
This was preventative healthcare at its very best. In one case, we went to pick up a service user from a community nature reserve where she spent occasional mornings volunteering in the garden. She had made this step at the instigation of her outreach worker, unthinkable only a few months earlier after a major breakdown. But, because he had understood her and what she might like, it was working out well. Later in the day, we visited the parents of another patient who was failing to take medication. The judgement was that they were the people best able to reach him and influence his behaviour.

This is a job that requires a combination of medical and nursing expertise with finely-tuned social skills and a real resourcefulness. As elsewhere, I found a huge commitment to the principles of the NHS. There was frustration that mental health services didn't receive the attention and focus that they deserved. But, in this area at least, there was a recognition that there had been major improvements in recent years.

In the afternoon, I accompanied a senior member of staff who had worked in community mental health in the area for many years. She recalled the closure of the coal mines in the early 1990s and the subsequent steep rise in the number of referrals to the service. But there were then only two members of staff and much of the need went unmet. There had been piles of cases in her in-tray of people in their hour of need, proud working men who had never sought such help before, that simply went unanswered.

On the day I visited, morale seemed high and the people I met took personal satisfaction in the job they did. It was reassuring to know that this area now had a team of motivated professionals sufficiently resourced to give a number of disadvantaged communities in this part of the North East the support they needed.

Day 5: Bed manager, Cambridgeshire



To some, this person's job title would be like a red rag to a bull. Received wisdom in some quarters has it that all NHS managers just sit behind a desk and exist only to make the jobs of doctors and nurses more difficult.

It would be interesting to ask some national newspaper editors to spend a few hours with this particular manager. Every day, she walks around the entire hospital more than once, talks to a huge number of her nursing colleagues and deals with a whole stack of problems as they emerge on her pager one after the other.

At times, it is easy for us all to underestimate the challenge of running a modern hospital. Unlike other businesses, they can't simply put up the 'full' or 'sold out' signs at busy times. They have to strike a balance between using available capacity as efficiently as possible and having enough spare to cope with the unexpected that can come through the doors at any time.

The day-to-day responsibility for juggling what at times must seem like impossible demands – and making sure key targets are met – falls to people like Nicki at this high-performing trust. 'Bed manager' is far from the desk job that the title may suggest.

First, she is a qualified and experienced nurse. Second, her whole working life seemed to me to be focused on making the working lives of her ward friends and colleagues easier by relieving pressure in the hospital system.

I joined her on her morning trip to all the main wards. Before I came, I had expected to spend most of the day watching her at her desk and on the phone, dealing with the challenges of finding appropriate beds for patients and meeting A&E targets. I was surprised that she walked round the wards in person, maintaining a close relationship with ward colleagues and gathering a detailed picture of the number of empty bays, the number of patients with an infection and any other information that would help her deal with the day's problems.

What came over very clearly throughout this day was the importance of a high-quality working environment for both staff and patients. This trust was many like many English hospitals; a piecemeal collection of buildings all reaching the limits of their usefulness. It was a busy day and not easy to be a patient or a member of staff. Even after an unprecedented building programme, too many parts of our NHS still do not provide staff with a decent working environment.

As with everyone, I asked Nicki what she felt about the NHS and some of the changes she had seen in recent years. Her perspective would be interesting as her job, unlike many others, provided a broad view and could give an insight on the morale of staff across the hospital.

Nicki's answer was typical of what I heard many people say. She believed strongly in the NHS and couldn't imagine doing a different job. She felt there had been improvements in recent times; targets in A&E caused pressure but, on balance, had helped in the overall management of the hospital. But, while she was pleased with what her trust had achieved, the year's financial pressures had led to insecurity and low morale. She was not sure where the NHS was heading in the long term or what the full implications of the reform programme would be. I don't think it would be far off the mark to say that Nicki's views were probably a reflection of majority opinion.

Day 6: House officer, Somerset

On the wards with Sarah

Most people like to ease themselves into their working day, health ministers included. From what I could see, this is not a luxury available to a junior doctor.

I had arranged to meet Sarah at 8am at a ward entrance to join her and senior colleagues on the morning ward round. By the time I got there, typically a few minutes late, they were already well under way and proceeding at pace.

Like most people, I have observed a ward round from afar, most recently when one of my children was a patient, but I hadn't seen one at close quarters. To the individual patient, the consultation may seem quick compared to the long day in hospital stretching out before them. What they don't see are the discussions between the clinical team before and after or the follow-up work that is then set in train.

It has to be this way. The team of three doctors – including a senior vascular consultant – had to get round a considerable number of patients, up to 20 or more. Things couldn't slip; there were other unmovable appointments later in the morning. This round, and the decisions it produced, would be vital to the functioning of the hospital for the rest of the day. It was time that had to be used to the full.

As with all the staff I have shadowed, I was impressed by the care with which the team communicated with patients and the detail with which they knew each case.

I had expected the role of the junior doctor to be to watch and learn. I hadn't realised that, once it was over, Sarah's job was to liaise with other hospital staff and departments to set in motion the work that had been agreed.

Sarah was well into her training at this large trust in the West Country. She explained that by far the main topic of conversation among her contemporaries was the availability of employment and security of training places. In the last 12 months, the employment situation had changed, with pressure on training budgets and talk of trusts being unable to turn placements into permanent positions.

These concerns are understandable. Listening to Sarah, you become aware how people in her position have invested a considerable part of their life so far in becoming a doctor. It is unlike other professions in that employment must be found relatively quickly if skills are to be maintained. Not for the first time, I got the sense that the NHS could do a better job by providing more certainty to the people coming through the training places.

At the same time, it would be unwise to base workforce policy on the premise that clinical staff should be insulated from the pressures that affect us all from time to time or offered levels of protection that are unsustainable. At one point in the day, a doctor stopped me to say how outraged he was that two consultants had been made redundant from a trust in another part of the country. While appreciating the concern about any redundancies, it revealed the different perspectives that exist among staff.

To be honest, what made this day different from the others was that it was not difficult to sense a fair degree of cynicism about politicians and their role in the health service. That's fair enough and something that I had expected (and I probably didn't help matters by arranging for a photographer to come along – something I had studiously avoided up to that point!).

The mutual suspicion between politician and doctor has been there since the health service began. To some degree, it will always be there. Given the need for further change in the NHS, a better way of doing things needs to be found and I left thinking about how we might do more to help clinicians lead the debate about health service change. I would argue strongly that targets are the expression of the will of the public but it is undeniable that clinicians can feel turned off by what they sometimes see as arbitrary decisions lacking clinical justification. We need to work harder at aligning these legitimate but potentially conflicting views.

I also left with a chance conversation with a senior member of staff on my mind. She asked why we didn't set out a clear vision for the NHS – perhaps in a statement or constitution – and then stand back and allow more freedom at local level. I replied that it is politicians who always pick up the flak from the public for failings and so need to be able to control things. But she had made a valid point.

In the afternoon, I went to the trust's day-case unit to witness the afternoon session of day surgery. One of the surgeons assisting with this session had been on the morning ward round with me eight hours earlier. As working days go, it is hard to imagine another as long and as intense as this one.

Day 7: GP, Devon

On 18 May, on the train on the way home after a long week, a letter in *The Times* caught my eye:

> 'Sir, I am a GP. Today I arrived at my surgery at 8.10am; read a dozen hospital letters, actioned and filed my pathology results (blood tests and X-rays), made two phone calls to patients and discussed some management decisions before seeing my first patient at 8.30am. A non-stop surgery followed, seeing a patient every ten minutes until noon, while teaching a fourth-year medical student.
>
> After more phone calls and dictating referral letters, I visited two patients at home. The second required four liaison phone calls and faxed letters to arrange urgent residential care. I was ten minutes late for a lunchtime prescribing meeting at 1.10pm. I started my antenatal clinic at 2pm for an hour and a half, followed by 30 minutes to complete an insurance form, read the second batch of hospital letters and results, answer queries at reception and sign repeat prescriptions. Evening surgery was another 12 patients from 4pm until 6pm.
>
> This was an average day. I left at 6.10pm and arrived home to a glass of wine and the paper, only to read the Thunderer describing me as a lazy 'jack of all trades' useful only for referring to specialists or signing prescriptions for drugs that my patients request but which I couldn't have heard of. Carol Sarler, you have no idea.'

I like to think I had some ideas of a GP's day before I went to shadow Sarah, the GP who wrote this letter. But the benefit of having spent time with Sarah is that I can verify its content as an accurate summary of her day and probably that of the vast majority of GPs who are similarly conscientious.

In some ways, this was the least surprising of all my shadowing days in that it confirmed what I thought to be true. But it was a valuable first-hand reminder that some of the biggest strides forward in the health service in recent years have been in primary care – a fact that is often overlooked by politicians like me and the media as we overly concentrate on the performance of hospitals.

With Sarah at her surgery

When I arrived around lunchtime, Sarah had already spent the morning carrying out a surgery for students at the practice's new premises at the university. She described how younger people would turn up for appointments with the most trivial of ailments.

I then sat through an afternoon surgery. It was great to witness the strength of the relationship between Sarah and her patients. They clearly felt extremely comfortable in her company and trusted her advice. Sarah's father had run the inner city practice where we were for many years before Sarah took over. Many of the patients felt a personal connection to Sarah and the practice and it made the service they provided to local people very valuable. This is without doubt a major strength of British general practice and it will be important in making a success of any move towards self-care and remote consultations using new technology.

Spending the day at this excellent practice in the South West, I got the impression that we are still only scratching the surface of what primary care and general practice can do to deliver services and promote better health. With the support of their PCT, and the extra funding in the system, this multi-GP practice was doing more and more and had a large team of clinicians and support staff. It was all a far cry from primary care in the 1970s and 1980s. Sarah told me how her father provided an excellent service but operated alone with no support staff. Part of the problem with the controversial debate about moving services out of hospitals and locating them in the community is that many members of the public still think of general practice as it was then and may not be aware of what the best are doing. Rather than flinching from that debate, we must work harder to explain the positive changes that are possible.

One of the frustrations that Sarah expressed was that the systems supporting the new GP contract prompted her to do things that she would have done as a matter of course and as part of good patient care. I took the point on board and feel sure that these issues of unnecessarily bureaucratic or formulaic procedures can be ironed out as the contract evolves. It is important that we do this, as in the future more and more will be delivered in primary care settings and the contract has to support that. The new contract aims to ensure that the standards of the best GPs, like Sarah, are available to patients everywhere. The trick is to achieve that improvement without frustrating those who are already the best.

The new GP contract, and the rewards it brings, have of course put Sarah and her colleagues under the media spotlight and into the gaze of the columnists. GPs are under more scrutiny than ever before but then they are also doing more than ever before. Just half a day in this practice confirmed to me that the best of British general practice is truly brilliant.

Reflections

Seven days out of the office is not much; there is a limit to what you can see. But it was enough to bring home to me the sheer scale of the NHS and the fact that it can look very different depending on your vantage point and where you work within it.

When I set out, I was well aware of the danger of this exercise being seen as a gimmick. People will have to make their own judgement about it, but I know I have gathered insights in seven days that are simply not available in seven months of Whitehall meetings.

Such is the value of work-shadowing to someone in my position that I intend to make it a regular event. In 2007, I will continue by shadowing a health visitor, dentist, pharmacist and senior consultant. By posting an entry on the Department of Health website after each visit and inviting reaction, I hope to keep a focus on workforce issues. Suggestions for other shadowing days from staff in any part of the NHS would be welcome.

Overall, I feel I have succeeded in my two main aims: first, to see a good part of a 'normal' working day in eight different NHS jobs; second, to get a clearer idea of what staff are thinking about their jobs and the NHS in general.

My objective in preparing this report for the Prime Minister and the Health Secretary is not to offer a string of detailed policy answers. Rather, it is to respond in the right way to a challenging year by listening, learning and, as a result, suggesting options for a better way of doing things.

My overall conclusions are as follows: first, that now is the right time to put in place stronger structures to help staff negotiate changing times; second, front-line staff need to be much more involved in the process of deciding change in the NHS; and, third, a stronger framework is needed around the NHS values that staff hold dear.

People had much to say about their jobs, good and bad. I have not tried to filter out the bad but to give an honest assessment of what I found.

All of the people I shadowed felt there had been real progress in the NHS in recent years. The level of resources available had improved considerably, as had the quality of the working environment. While pointing out the limitations of targets, many of the people I met acknowledged their role in achieving this progress. From what I could see, people are

ready to embrace different ways of working, to improve productivity and work to eliminate waste. They want to be accountable for the service they provide.

On the other hand, everybody indicated in different ways that they were working under more pressure today than ever before. Many spoke of colleagues' concerns about job security. All shared a degree of uncertainty about what the future holds for the jobs that they do and the NHS as a whole. While there has been significant change, the individual pieces of the reform programme had not yet fallen into place to provide a clear vision of the NHS of the future.

These were my detailed conclusions:

1. **Staff members are motivated by what the NHS stands for, and have a strong sense of commitment to its values and principles and to helping others.** This may seem a statement of the obvious, but it is important to say it. It is a fact that people working in the NHS feel a sense of loyalty beyond that you would find in other workplaces. It matters to them that they work for the NHS.

2. **If left unchecked, rising public expectations could place staff under increasing pressure and represent a growing threat to a service free at the point of use.** It is common to hear staff speak of rising expectations as a good thing. But they also say the availability of medical information over the internet is changing the patient–professional relationship. The worry is that rising expectations are leading to demands bordering on the unreasonable. If we want an NHS that is able to cope with future demands, funded and provided on the same basis as it is today, we need to do more to balance discussion of a patient-led NHS with efforts to encourage more responsible use of services. Too often, the latter is given insufficient emphasis.

3. **Staff are not opposed to changes in the way services are delivered, but want more explanation at an earlier stage and more involvement in their development.** Having done this exercise, I now understand more clearly how the top-down management structure of the NHS can make the process of change feel different to that in other public services and private industries. Over time, the process of handing down instructions becomes disempowering. Change can sometimes feel imposed and, consequently, inspires less support and ownership. For people on the front-line, there is a sense that good ideas are hard to put into action. Our 18-week referral to treatment target offers a real opportunity to change these perceptions and put staff in more control of change.

4. **After ten years of major change in the NHS – and huge improvements as a result – we need to reflect on how talk of reform is perceived at the front line.** We call for reform because we want the NHS to succeed. The change has put the NHS in a strong position in terms of public support, and calls for alternative funding systems have diminished. But it would be a mistake to assume that talk of reform is always seen in this context. To some, it may come over as a frustration or dissatisfaction with the NHS, even a wish to turn it into something fundamentally different. More than once, people said to me that they were uncertain about where the NHS was heading in the long-term. This is a complex question but we need to understand it and respond in the right way. It cannot mean slowing down the process of change – indeed, change is vital if the NHS is to succeed in the long term – but it does mean finding better ways of taking people along on the reform journey.

5. **Targets and top-down performance management have served a clear purpose, and were right for the time, but as the NHS moves into a different phase the time is coming for a re-assessment of the emphasis on them.** I asked all of the staff I shadowed for their views on targets. It always drew a mixed response. There was an acceptance that targets had brought focus, improvements and were a clear expression of public priorities. It was surprising to hear staff in A&E ask that they be maintained because of the ability they gave them to negotiate with other parts of the hospital. They have ended the chaos that was common in A&E departments and have led to better internal planning of patient flows right across the hospital. But there was a sense of weariness and frustration with their inflexibility. People spoke of the potential for conflict with professional priorities. In response, we need to acknowledge that what was right for the last ten years may not be right for the next decade. As we near the point where key targets are being achieved and sustained – in A&E, cancer and, further down the line, MRSA and 18 weeks – we need to allow much greater priority setting at a local level.

By identifying these important issues, it will help inform thinking within the Department as we set out our plans for the future. However, in the more immediate future, I have agreed a work programme arising from my conclusions with the Health Secretary and the Chief Executive of the NHS. I will be writing to the Health Secretary to set out some detailed points on how we may respond to the challenges I have identified.

It is my hope that the vision that the letter sets out – a decisive move to locally-determined services backed by a binding NHS Constitution – is one that patients, NHS staff and politicians alike will feel is right for the times. The next decade in the NHS – 2008 to 2018 – will need a different way of doing things.

Supporters of the NHS have made the argument that it is the fairest way to deliver a high-quality comprehensive health service to a whole population. The time now is right to set out a shared course for a new era and cement the achievements of the last decade. I hope that the proposals outlined here will go some way to building a new consensus. They represent the beginning of a debate on that and by no means the last word.

I would welcome comments and feedback on this report. I can be emailed at andyburnham.workshadowing@dh.gsi.gov.uk.

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Minister of State for Delivery and Reform
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