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DAYS OUT IN THE NHS: LISTENING TO NHS STAFF

When I was appointed, both you and the Prime Minister asked me to consider developing a strategy for better engagement with staff on our programme of reform of the NHS.

As you know, I decided that the only way to address this task was to get out and listen to staff. So, throughout the second half of 2006, I conducted a series of work-shadowing days in different jobs across the NHS.

It has been a refreshing and inspiring experience, both reassuring and challenging in equal measure.

It was reassuring because all of the staff I met spoke of considerable progress in the National Health Service in recent years. But it was challenging because staff have a sense of uncertainty about the future and real concerns to which we need to provide answers.

The NHS is changing, but the structures to help staff through changing times have not kept pace. If the transformation of the NHS that we seek is to succeed, we must do better at taking our staff with us.

Below, in the attached annex I make some suggestions for how we might achieve that.

I hope you agree that this represents a sensible basis for action.

ANDY BURNHAM

My report - Days out in the NHS: Listening to NHS Staff - gives my observations and conclusions on my workshadowing exercise. On the back of this, I have tried to draw the threads together and reflect upon how staff can be better engaged and involved in the necessary process of reforming services. My main conclusion is this: we need to learn from the last year in the NHS and put in place stronger and permanent structures to help staff negotiate changing times.

There follows a number of practical ways in which this could be achieved.

1. Patient and public expectations

There is a clear case for giving a much higher priority to encouraging more responsible use of NHS services by patients and the public. It is a message that increasingly needs to counter-balance calls for a patient-led service providing services to the individual's convenience. Rising expectations are changing the working environment for NHS staff and placing them under more pressure. This changing behaviour could also have long-term implications on the viability of a service free at the point of use.

We will develop a clear set of proposals to encourage patient responsibility, in particular by informing the public of the actual value of the NHS services they are using.

Within this context, it is right to consider whether NHS staff at different levels need extra powers or responsibilities. For instance, should paramedics be expected to carry all patients from 999 calls to A&E, or should they have the ability to refuse because of the minor nature of the condition? We need to build upon the vision set out in the Ambulance Review and ensure that paramedics and other front-line ambulance staff are being fully supported to make the decision to leave patients at home if, after assessment or indeed treatment, they feel that this is safe and that the patient doesn't need to go to A&E. I know that this is what the ambulance service and the Department want to see and that up to a million fewer patients could be taken to A&E. Getting this right will also depend upon each ambulance service developing clear protocols for the direct referral of patients to more appropriate primary care professionals if they deem that is the right course of action as an alternative to A&E and continued work to ensure that staff training and education supports this shift. There is also a case for considering whether A&E staff need more clearly-defined powers to refer patients on to more appropriate providers as part of the initial triage process although we also need to be careful not to pass patients around the system as they have told us they find this frustrating, and therefore the increased use of co-location of service may provide a solution and needs to be looked at. The Department's forthcoming Urgent Care Strategy will look at how we build on the areas where some of this is already happening and ensure we maximise opportunities to spread this practice for the benefit of patients and staff.

2. Workforce issues

In 2006, concerns about the strength of workforce planning in the NHS came to the fore in response to financial pressures in parts of the system. In general, the right direction of travel for the NHS is to take more decisions at local level. But the important thing about a national health service is knowing where it makes more sense for regional NHS bodies to act together and co-ordinate requirements. Workforce planning and support falls into this category.

Going forward, we will learn from 2006 by establishing structures for stronger collaborative action between NHS bodies in addressing these important issues and creating better systems of practical support for staff experiencing change.

Graduate employment

A particular concern has emerged about the position of graduates. In some parts of the country, graduates in certain disciplines such as physiotherapy have found it hard to find work. While many of the problems are of a temporary nature, the impression created is of a system not using its human resources to best effect.

Learning from recent experience, there is a case for introducing a better system of how we bring through new graduates into jobs. We have discussed this and agreed to ask the Social Partnership Forum to look at whether one SHA area could pilot a scheme to offer a short-term employment guarantee on graduation to nursing, midwifery and allied health professions graduates, whereby they commit the first period of their working career to the NHS after training. The local healthcare providers in that SHA would work together on a voluntary basis to reach an agreement on the number of jobs - for perhaps six months or a year - that they could offer these graduates in order to help them onto the career ladder.

Of course, nobody can expect a job for life, health service staff included, and it is essential that the NHS continues to take every opportunity to improve productivity and value for money. But there may be sound planning reasons to test a system of this kind. First, the very existence of the commitment may encourage a better dialogue between educational organisations and the NHS and earlier workforce planning. It may help prevent the system training more staff than are needed. Second, it may help create a better culture of staff progression and personal development within health service organisations, as positions will need to be freed up at the lower-level entry grades. Thirdly, it could help more hospitals reduce the use of expensive agency staff by creating a 'bank' of staff who can be used flexibly, for example to provide cover for someone who is ill.

Help to move from hospital to community

I have met a number of staff who have recently transferred from hospital to community settings and are finding their new role rewarding and liberating. Yet we must recognise that it is a major step for many hospital-based staff to take. **Given that the clear direction of travel set out in the *Our Health, Our Care, Our Say* White Paper is to see more care delivered in the community, we need to consider a more structured programme to help staff to make the transition from secondary care settings to the community and to get the help they need.** We need to ensure that the right incentives and training are available in all parts of the country. Current employers of staff (hospital trusts) may have no incentive to offer staff such training and support. In addition, it may not be easy for staff interested in making such a switch to access training. These issues will be explored, including the development of a national training module and the possibility of offering it to all staff facing redundancy from hospital-based roles.

National jobs system

NHS Employers have been working to develop better systems whereby people can access information about job vacancies around the NHS. This system needs to be built up and expanded to include all opportunities in primary care, social care and other health settings.

Pay

Most staff recognise the significant additional investment that we have made in pay under Agenda for Change. But some mentioned to me residual implementation issues and the need to keep the pay of the lowest-paid under review. The NHS Staff Council (co-chaired by NHS Employers and the Trade Unions) is responsible for reviewing the implementation of Agenda for Change and I believe this should continue. **However, we will ask the NHS Staff Council to provide an annual report to ministers on its progress including an assessment of whether there is more we could do to realise the full potential of Agenda for Change to support individual development for the mutual benefit of employees, employers and particularly service users. This report should be made available to Parliament.** It could also review the equality impact of the new pay policy. The Department will continue to ensure that the benefits built into the new system by effective use of the NHS Knowledge and Skills Framework – the

second tool in the new pay system to support career and pay progression – are realised. In particular, for staff at the lower end of the pay system, it should maximise individual potential and development delivering positive benefits for both staff and patients.

Cleaning and portering services

When NHS workforce issues are considered, it is all too easy to focus on the terms, conditions and career development of clinical staff to the exclusion of others. We give insufficient attention to the lowest-paid staff such as cleaners and porters who perform a vital role on behalf of us all.

Agenda for Change has brought all our non-medical staff onto a single pay system. We need to ensure that the NHS goes further in bringing together its workforce by taking the opportunity to break down the divide between clinical staff, cleaners, porters and other support staff. While it would be wrong to raise expectations of staff of an immediate pay increase, we will ask NHS Employers to review how Agenda for Change is benefiting the lowest-paid workers in terms of pay and access to training, and to what extent this has kept pace with other grades.

Back in the 1990s, a view gained currency that cleaning and portering services were peripheral to the running of the hospital. Having spent time working alongside both, it is clear to me that this view is mistaken. Today, the quality of cleaning services arguably has an equal bearing on the reputation of a hospital as its clinical services. In a world of more choice in healthcare, it will only become more important.

But some of the old culture and thinking remains in some places; there is too much of a divide between clinical staff and cleaners and porters. The vast majority of cleaning and portering staff want to feel part of the same hospital team and they do the job they do because of a commitment to the NHS.

It is for hospital trusts to decide how best to organise these services – and that should remain the case. Many contracted-out services provide good value, innovative services and integrate closely with the rest of the hospital team. But, however these services are provided, it is important that cleaning and portering staff are consulted on a regular basis and fully involved in the work of the hospital. **Going forward, I believe the views of all staff should be sought when decisions are being taken about the provision of cleaning and portering services.**

3. Consultation at every level

Experience over the last year has shown the need for better arrangements for regular and on-going dialogue with staff representatives at national, regional and local levels. We have had positive discussions with the TUC and trade union colleagues on this issue and, as a result, will strengthen our existing Social Partnership Forum. It will meet on a monthly basis, chaired by a minister. **This principle of tri-partite working between the Department of Health, NHS employers and trade unions should be replicated at SHA and local levels with senior representation at those levels.** The strengthening of the Social Partnership Forum will link in to the creation by the Health Secretary of the new Stakeholder Forum and together provide a coherent set of arrangements for dialogue and debate.

4. Staff leading change

By the end of 2008, the NHS will be in a position of fundamental strength. Waiting lists as we have known them will be all but gone and patients will be free to choose the services of any provider that meets NHS standards and NHS quality. When we reach that point, it will represent a remarkable transformation in the patient experience since the government published the NHS Plan in 2000. The challenge then will be to make these major improvements self-sustaining.

On my travels, I made a specific point of asking all staff about their views on government targets. I heard A&E staff, for instance, talk about how the four-hour target was instrumental in changing the way that their hospitals worked. It had boosted their bargaining power with other departments and had improved the management of the whole hospital. Infection control staff spoke about how the introduction of the Government's target to cut MRSA had taken their voice from the periphery to the heart of the hospital's decision-making structure.

It is clear to me that national targets have worked and were right for their time. Together with national standards (for example, National Service Frameworks, Healthcare Commission standards and NICE guidance) they brought focus to a failing system, provided a clear articulation of the public's priorities and successfully guided new investment. **It is vital that all existing targets must be kept in place until they have been achieved. At that point, they should be held as an operational standard below which performance should not fall.**

But it is important to say that I also heard staff talk of their frustration about the top-down nature of the NHS system and the inflexibility of its culture. Like Gerry Robinson, I came to the conclusion that the NHS is not good at giving its front-line staff a sense of empowerment. People with good ideas do not feel that they can easily put them into action; there is a prevailing sense that those decisions are taken by somebody else.

But that said, the time is right to look ahead to an era beyond 2008. When the 18-week target has been met, there will be less need for performance-managed top-down targets. They will have done the job they were intended to and the NHS will be performing at a significantly higher level. But we now need to articulate a vision of how the next decade might look – and, to my mind, it should be characterised by bottom-up empowerment of not just patients, but staff too.

Our 18-week target presents an opportunity to provide a pathway towards this new way of working and a bridgehead to a new era in the NHS. By setting a broad end-to-end goal, the challenge is laid down to staff at all levels in all localities to agree their own way of getting there. Now is the time for trust management to empower staff to lead those changes.

For these reasons, this target holds the potential to rise above political and professional tensions. It will only be delivered with strong clinical leadership and a drive to make sure that it brings forward the best of today's clinical practice. All staff have a role to play in this and in deciding how barriers to success can be identified and overcome.

We are planning a campaign to engage staff on the 18-week challenge and use the target as a means of empowering staff. Some NHS organisations are already using innovative systems – such as the LEAN management system – to equip staff with the skills to lead change in their area. Changes instigated and developed by staff are more likely to succeed.

In the future, when basic waiting guarantees have been standardised, it will not be necessary to performance manage every stage of the patient journey. Instead, what should be measured is the quality and safety of what every NHS organisation is providing. Overall, from 2009, there should be fewer national targets and the inspection regime should focus on placing clear and authoritative information before the public that will be relevant to the choices they make, including patient satisfaction results for each NHS organisation. Targets and priorities should be set locally wherever possible, within national service frameworks and national standards such as those set by NICE.

One of the problems at the current time is that we are in a period of transition where the NHS is facing both top-down and bottom-up pressure as choice becomes an increasing reality. That pressure from both ends may be sending out confusing signals about the future direction.

In this new NHS, PCTs will be the focal point of the system as they work with GP practices to commission the very best services to meet local needs. In exercising this role, it is vital that we explore ways of improving the local democratic legitimacy and accountability of the PCT. There are a number of potential models to achieve this goal and we should bring forward proposals for consultation, including proposals to improve staff representation within the PCT decision-making process.

The NHS sometimes finds itself in a sterile argument which suggests that the only thing that can improve services is evermore money. NHS staff know that this isn't true. They know how much of their time, which could be spent caring for patients, is wasted through duplication, missing information and outdated processes. To transform this we need to engage the enthusiasm and ideas of all our staff.

5. An NHS Constitution

Most staff appreciate how the NHS needs to change and move with the times if it is to keep pace with modern expectations. As the internet generation gets older and becomes more regular users of healthcare, they will test the NHS's ability to provide convenient services.

But, despite an acceptance of the need for change, there is a feeling of nervousness amongst NHS staff about being on a journey without knowing what the end point is. That strikes me as a good summary of how many feel at the present time. Some are concerned that the values of the NHS are in some way up for grabs.

While many people can articulate what we might call the founding values of the NHS – universal, comprehensive, free at the point of use, based on need not ability to pay – they are not set down in legislation. As we look forward to an era where more power is devolved to a local level, and where we encourage innovation, difference and diversity in the way services are provided, that is a growing weakness that will need to be addressed.

In the last ten years, supporters of the NHS have made the case that this system is the fairest and most cost-effective way of delivering a high-quality healthcare service to a whole population. As we approach the 60th anniversary of the NHS, the time is right to cement that new consensus and give NHS staff more certainty about the future.

One way of doing this would be to adopt a formal Constitution for the NHS.

An NHS Constitution could provide a clear expression of what is unchanging about the NHS and what we hold in common. It would set down and protect the values of what is a precious and unique British institution. It would provide a more secure framework within which debates about change can take place. In itself, it would be an important symbol that what is special about the NHS is not its buildings or services but its values and principles.

Any Constitution could do much more than express core values. It could, for instance, prioritise the promotion of good health within the NHS mission. It could talk of the critical role that the NHS should play in the future in facilitating clinical research and making the best of science available to all.

But exactly what it should say should not be decided top-down by the Government; that would be to defeat the object. Its precise content and status should be subject to a wide-ranging and inclusive process of debate and discussion with patients, staff and the wider public, led by the new Stakeholder Forum that the Health Secretary recently established. Indeed, the Forum should advise on whether the idea of a Constitution itself has merit. The NHS Chief Executive David Nicholson has already begun a process of consultation with staff about NHS vision and values; that important work will help inform and support this process.

If successful, this work could lead to the adoption of a new Constitution for the NHS in 2008, its 60th anniversary year, setting out a direction for the next decade.

Any changes to the way services are delivered would have to be judged against this shared statement of aims and values. All commissioners and providers would have to abide by the letter and the spirit of the Constitution. It could also set out the baseline offer to the public. By 2008, patients will have free choice of any provider that meets NHS standards and NHS quality, and a guarantee of hospital treatment within 18 weeks. Moving forward, those advances forward should be maintained as standard.

If handled correctly, a Constitution could seal a generational consensus around the NHS model that would help defuse the ideological and political wrangling that staff find destabilising. Like the BBC Charter, it could prompt a periodic public debate about what the NHS is and should seek to do, a process that would be healthy and renewing.