

ANDREW LANSLEY SPEECH 8 JUNE 2010

Thank you all for being here, and for giving us the opportunity to show that patients are at the heart of our plans to improve the NHS.

There was a moment, after six and a half years as Shadow Secretary, when the thought, “many a slip twixt cup and lip”, came back to me.

Between the verdict of the electorate and the uncertainties of coalition-building, there were reasons to be cautious. But the people voted for change, and in relation to health and social care, we were readily and quickly able to bring together a Coalition Programme – one, I think, which promises, not just change, but a clear, consistent, coherent strategy for our health and social care services.

May I just tell you, between ourselves, that there was of course that moment in the Cabinet Room, with the Prime Minister. As I sat down, I recalled a day, fifteen years ago, when David and I, who had worked together in the Conservative Research Department, were talking to George Osborne, who was leaving the Department.

I said to David and George, “when you two are running the country” – we always knew they had it in them – “I want a job”. They gave me what my mother would call an ‘old-fashioned look’, “What job?” they said. So, I replied “I want to be the Governor General of Bermuda, with the shorts, the hat, especially the feathers – the lot!”.

I’m happy to say the Prime Minister didn’t remember.

Because over these years, as Shadow Secretary of State, I have shaped a personal ambition.

An ambition rooted in the commitment to the core values of the NHS – of a comprehensive service, free at the point of use, based on need, not ability to pay.

But an ambition beyond that. Beyond achieving equity and the social solidarity of access to a National Health Service. My ambition is that we can achieve health outcomes – and quality health services – as good as any in the world. That we can achieve a unique combination of equity and excellence, including for the most vulnerable. An ambition for excellence. I’m buoyed by the knowledge that we have medics, nurses and scientists as good as anywhere in the world, I know that we can achieve this.

It is my passion. To back the NHS. To put my heart and soul into achieving success for the NHS, and for, you, the patients.

Over the last six years the key changes that will enable us to realise this ambition, have become increasingly clear.

These now represent our priorities for government:

First, that patients must be at the heart of everything we do, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about us, without us.

Second, that if we are to seek to achieve continuously improving outcomes, then that is what we must focus on. Not politically-motivated process targets, not simply measuring inputs or constant changes to structures, but a consistent, rigorous focus on outcomes – achieving results for patients.

Third we must empower professionals to deliver. This is the only way we can secure the quality, innovation, productivity and safe care, all of which are essential to achieving those outcomes.

Engaged and empowered professionals will deliver results. Disempowered, demoralised and demotivated staff will not.

Fourth, we must, as a society, do much better on the health and well-being of our families and our communities. Only by prioritising health and well-being and by preventing ill-health more effectively, can we achieve the overall health outcomes we seek, not just good health services but good population-wide health outcomes, and reduce the inequalities in health, which so blight our society.

Fifth, we must see the many links and connections between health and social care, seeing care in its wider aspects. Whether provided by their families, by carers, by support workers or by health professionals, all are part of a spectrum of care for those in need. Health and social care should be integrated more. And so we need to reform social care alongside healthcare, so that we can support and empower people – not least as individuals – to be more safe and secure and, themselves, to be able to exercise greater control over their care.

These will be our priorities. We will act across the breadth of health and social care to deliver these priorities and, in doing so, we will establish and embed the consistent, sustainable strategy for reform, which will give our services the long-term stability they have so desperately needed for so long.

The Coalition Programme is a programme for a five year Parliament. My intention is to deliver a strategy as early as possible, so that people have a sustainable framework with within to work, and not just for five years but for longer.

I will not today set out all the aspects of that strategy. I don't want begin by talking about structures, funding or processes. I want to focus on the first priority – to put patients at

the heart of all that we do. And for that reason I am delighted to be here at the Bromley-by-Bow Centre.

Sam Everington and I have several times discussed what you do here. And it's great to see how you bring together all aspects of health, wellbeing and community in one place. Health is an holistic experience; it is more than simply the absence of, or treatment of, disease.

And I am so pleased to be able to address the Patients' Association and National Voices, who I have worked with in the past and who have brought us here today, as well as representatives from the Local Involvement Networks. Each of you, in your respective ways, speak for patients – and I hope I will too. Because I believe that we must see everything that we do through the eyes of patients, as well as with the objective view of the clinical evidence – both are necessary if we are to fashion a service which is truly of the highest quality.

In this way, I hope I can escape from one of the enduring frustrations of my predecessors. As the BMJ said in a review of Richard Crossman's diaries: "All Ministers of Health were in the unenviable position of being regarded as the agents of government by the health professions and as agents of the professions by their ministerial colleagues".

I do not propose to be caught in that trap. I serve the public. I know too how committed health professionals are to the cause of their patients. Politicians and professionals in service of public and patients – that is our common ground.

And so to put patients first, we need a cultural shift in the way the health service works.

We need to put priority on the things that matter most to patients. We need to see the service from the patients' point of view, to listen to patients, to shift power down through the system – and, where possible, to put power and control into the hands of patients themselves.

So let me tell you some of the things that patients have told me matter most to them. They most often say: 'Mr Lansley, I'd just like to tell you that the care I received from the NHS was fantastic; the staff couldn't have been more wonderful or more helpful.'

That is the most common thing I hear – and nothing I say today should detract from that. So I want to say to NHS staff: I know how often you get it right. You know I want to support you to get it even more right, even more often. And when things go wrong, I want to help you to put it right.

So, the first principle must be 'do no harm'. When it goes wrong in the NHS, patients suffer and patients die. Safety for patients is at the heart of quality care and of the professional responsibility of nurses and doctors. So there is no trade-off between safety and efficiency. Good care is safe care. Unsafe care costs more, in lives and in

cash. High levels of infection, VTE, emergency readmissions, falls, pressure sores. They all lead to more suffering and more cost.

So I will not countenance a “production line” approach to healthcare which measures the volume but ignores the quality. Patients expect their care both to be safe and high quality.

I will back every effort to put patient safety first in the NHS. For patients, they need to know who is providing quality, safe, effective, accessible services. Information will drive higher standards. It’s not just about choice, although patients value choice, even if the choice they make continues to be to go to their local practice and their local hospital. The combination of information and choice will hold people to account and drive up standards.

So our vision must be of an information revolution across the NHS. Shared decision-making between patients and professionals at every stage. With rapid progress in identifying the evidence base for quality standards, which will be the basis of comparative information on quality and performance, enabling patients to be confident both of the service they should receive and the quality of the hospital or other healthcare provider they are actually receiving.

Putting the information out there – accessible to everyone – is a catalyst. It drives comparison and performance.

Sir Bruce Keogh and the cardiac surgeons have led work in this country, publishing and benchmarking in depth information on their performance and results. The result has been very encouraging – as their 2008 National Cardiac Database reported, “Despite the fact that the risk profile of patients has increased, mortality has fallen dramatically”.

That is one specialty in this country. Where they lead others can follow. But in the spirit of benchmarking, let’s remember Sweden has 69 National Quality Registers.

Information for patients must embrace all that goes to make up quality – including access, waiting times, cleanliness, infection rates, quality of clinical care, results for patients, access to same sex accommodation and single rooms, cancelled operations, emergency readmissions, discharge arrangements, numbers of complaints, patient experience and patient-reported outcomes.

That sounds pretty forbidding perhaps. But most of this data already exists – it’s just that you can’t access it. So, as I began to do last week, we will continue to put information out there, where patients can see it. Where people such as “I Want Great Care”, Dr. Foster, CHKS, and others can enable patients to see who is doing well and badly; putting patients in the driving seat.

I simply don't believe that in an open information culture of that kind, the scandalous failings that took place in Maidstone and Tunbridge Wells and then at Stafford Hospitals could have gone unchallenged for so long.

But I will take no chances. I will not let a culture of "don't ask, don't tell, don't complain" persist.

At Mid-Staffs there was clearly a sense among some of the professionals, and indeed the public, that the hospital had problems, but that was just the way things were. Well that's not good enough. We can never allow this sort of situation to develop again. And I will be saying more about how we can learn the lessons from and about Mid-Staffs in the next few days, and about the relationship of the whole healthcare system to a hospital like Mid-Staffs.

We need to develop a culture of active responsibility. So that everyone – GPs as local commissioners, LINKs, local authorities and others – will all be empowered to ask, to challenge and to intervene. Those who are charged with managing the care of patients, and purchasing services, must be commissioning for quality.

The standards that will drive quality accounts and benchmarks of performance, must also be linked to payment, so that we're not just paying for activity – but for performance and results.

And there's a specific point I want to tackle here. Over the last ten years emergency readmissions have increased by over 50 per cent. Not, it seems, primarily because patients have become more frail, although some may have, but because hospitals have been incentivised to cut lengths of stay and send patients home sooner – process targets creating risks for patients.

So in addition to getting rid of targets that have no clinical justification, we're going to ensure that hospitals are responsible for patients not just during their treatment but also for the 30 days after they've been discharged. It will be in the interests of the hospital for patients to be discharged only when it is ready and safe for them to do so.

And if a patient is readmitted within those 30 days the hospital will not receive any additional payment for the additional treatment – they will be focused on successful initial treatment and reablement and support for people as they return home.

The outcome for the patients is the only outcome that matters – and so we are sending a clear message to the NHS that patient care doesn't end when they walk out of the hospital door. This will have the added benefit of driving the further integration of hospital and community services where it most matters. Patients don't talk about 'primary' and 'secondary' care, they see it simply as treatment and care for the problem they have, whether at home or in hospital.

Within hospitals and across the health service the culture must also be one of patient safety above all else.

I remember hearing about what a safety culture in the NHS could be, from a pilot called Martin Bromiley. He tragically lost his wife because of an error in an operating theatre. As a pilot, he knew what it means to be in a 'high reliability' organisation, where an undetected human error can lead to deaths. And now he, and his colleagues in the Clinical Human Factors Group, tell NHS staff about building a safety culture.

Reliability, consistency of operating procedures, and a culture of challenge are all required. A culture where the offence is not to make a mistake – to err is human – but the offence is to ignore an error or, even worse, to cover it up.

So we will work with NHS staff to embed a safety culture across the NHS where instead of thinking of 'whistle-blowing' as going outside the organisation, we see challenge of that kind as integral to the safety and improvement within the organisation.

And in the same way, instead of seeing complaints as a burden, or a distraction or something to be dealt with outside the mainstream of service provision, we must see complaints as integral to the improvement of the service we provide.

Think about it – learning from our mistakes, listening to complaints, comparing what we do, evaluating our performance and constantly seeking to improve our quality – these are the features of the best-performing organisations in every sector – and they are there in the best-performing NHS organisations already.

I am determined to make the best become the norm; and excellence become everyone's expectation.

Let me give you some further examples of how I want to take these principles forward.

On safety and on infections. Last week, I began this process by requiring the publication of weekly data on MRSA bloodstream and C Diff infections. I have spent too long with too many people who have lost loved ones to healthcare-associated infections, not to be determined to act on this.

Five years ago, at the Royal Berks, I saw them taking what they described as a 'zero-tolerance' approach on infections. The then Government was calling for a 30% reduction. How can you target a 30% reduction in infections? The only acceptable strategy is a zero tolerance strategy. There is no tolerable level of preventable infections.

The NHS in the South East has set the task of eliminating preventable healthcare associated infections by next year. I welcome that ambition – that is an outcome I support. And if they can do it, so can others.

We will be signalling to the service that a zero-tolerance approach to infections will be our strategy.

And what about the relationship of information to choice? The expectation of choice has been a feature of maternity services going back to Julia Cumberlege's 1993 report, "Changing Childbirth". But choosing between a home delivery, a midwife-led service and an obstetric delivery is a limiting concept of choice.

Mothers-to-be should have information about the different aspects of maternity care including choices of location, but also issues like pain-relief, choice of providers as well as risk assessments – because not all choices will be appropriate or safe for all women. They should have the ability not only to compare key aspects of care, like continuity of midwifery support and one-to-one midwifery support in labour; but they should also be able to see what other mothers' experiences have been and to hear their views of the safety and quality of care.

Mothers must have this information not only to exercise choice when originally booking their maternity care, but to be able to be in control of their childbirth, exercising safe choices at each stage.

Because, like that process of choice, listening to patients is at the heart of what we should be doing.

And listening to patients – asking, reporting, and learning from patient experience – will be of great importance in designing and improving services, including achieving greater efficiency. Just look at the high levels of patient-reported satisfaction in productive wards.

But the NHS too often asks insufficiently penetrating questions, insufficiently often, of too few patients.

Patient Access Surveys in General Practice miss the point of whether patients are doing well and if they have good outcomes, if they required treatment or advice. Access is not as important as outcomes.

And the NHS Patient Survey, asking if patients were satisfied with the care they received, is too much like asking patients whether they were grateful.

I have seen other hospitals asking more immediate questions, with more relevant and particular questions, like, "when you pressed the call button, was the response what you expected, better than you expected or worse than you expected?". That's how you get real answers about the care that's being provided.

Such questions, done frequently and disaggregated to ward-level where possible, give a management focus on what is happening in a hospital; and can be the basis of a much

more informed and interactive relationship, with the population that is served by the hospital.

I know there will be some, including in the medical profession, who regard this with alarm. They will imagine that patients' wishes and wants are insatiable and unjustifiable; that their needs are susceptible only to the evidence-based judgement of clinicians.

Well, I would just invite those who think this to take a look at the evidence. Engaged patients are more likely to manage self-care and more likely to be compliant with treatments. Informed patients, expressing choice, are less likely to seek unnecessary intensive and invasive treatments. Informed patients are more likely to have a good patient experience and a better outcome.

With individual patients, doctors expect to listen to them, to understand their needs and expectations, they know that patients are the experts about themselves, that they have the greatest knowledge about their own experience, and that they have a right to informed choice. Why shouldn't the NHS as a system do at least as much?

Frankly this isn't about money, it's about raising standards and quality. As the Health Foundation said in a recent report, quality can save money. Because that's where we need to be – a service which is being supported to meet rising demands. But one which must deliver continually improving quality. Actually the focus on quality and outcomes will enable us to deliver more from the resources we currently deploy. And as we are supported by the taxpayer with a rising budget we must do more with what we already have.

So we will empower patients and we will empower health professionals. That means we will have to disempower someone. And I think it might be me! I know that others know better about their care and are better placed to make certain decisions.

So we will disempower the hierarchy, the bureaucracy, the Primary Care Trusts and the Strategic Health Authorities. I don't want the whole of the NHS to wait to hear from me. I want it to listen to patients, and to take responsibility for action.

Action to give patients and care-users more control, to exercise choice – from choice of GP to choice of treatment, all the way through to personal budgets.

Action to empower patients collectively in thinking about what quality standards and commissioning guidelines should look like, as well as patients and the public locally, impacting on decisions about access and design of local services to meet local needs.

Action to empower patients through access to information, from a plurality of information providers, with the ability to hold their own patient records, to interact more readily with their clinicians. To be able to use this new information ecology, to secure the quality of care and service we want as patients – and collectively, to drive an improvement in standards and outcomes.

I began today by talking about my ambition: for health outcomes and healthcare services in this country to be as good as any in the world.

I know it won't happen by creating more process-driven targets, by demanding more data returns, by issuing more Department of Health circulars, pursuing more structural upheavals, increasing the number of administrators in PCTs, nor even just by supplying more money, important as resources are.

I know these things either don't work or even work against improving outcomes, despite the best efforts of NHS staff, because they have been the approach of the last Government over 13 years.

Reform has stalled. Targets have trumped quality. On too many key areas our health outcomes lag behind our European neighbours.

We need change. We need to set the service free to deliver high-quality care, based on evidence of what works. Accountable for results. Answerable to informed and engaged patients. Focussed on what matters most to those patients – safe, reliable, effective care. The best care for each patient and the best outcomes for all patients.

That is my ambition, and I have been delighted today to be able to share it with you.

Thank you.