FIVE LESSONS FOR REFORM

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Last Friday I visited the heart failure ward at Glenfield Hospital in my constituency.

Jan Kovac, one of the consultant cardiologists who showed me around, came to Leicester from Poland 20 years ago. He told me about the huge changes he's seen since then: not just the phenomenal technological advances but the kinds of patients he now treats. They're much older and frailer, with multiple physical and mental health conditions that can't be treated in isolation from one another.

Ellen Brightling, the senior sister, and Louise Clayton, the specialist heart failure nurse, explained how a large part of their role is giving patients and their families emotional support to cope with knowing that they can't be cured, but can be helped to manage their condition.

Ian Loke, another consultant cardiologist, told me that known heart failure patients can get direct access to the ward, bypassing the Emergency Department, which makes a real difference to the quality of their care.

He said the biggest difficulty they face is there aren't enough services in the community to help keep people living well at home, or to get them back out of hospital quickly after an admission, which is putting huge pressure on the ward and their budget.

What I saw at Glenfield encapsulates the huge challenges facing the NHS.

Providing high quality care in the 21st century requires a single, seamless system that supports the 'whole person', rather than continuing to treat people's physical, mental or social needs in separate silos.

Some care must be delivered in specialist centres, with a decisive shift in many other services out of hospital, into the community and towards prevention.

Patients need far more help to manage their own conditions, and families - who provide the vast majority of care in this country - must be properly supported too.

And all this must be done within extremely tight budgets, whichever Government is in power in 2015.

At this point you're probably thinking "Tell me something I don't know, we've been talking about these issues for years".

So the question is how do we make the changes we all want to see, in every part of the country, so our care system is fit for the future?

Today I want to share with you some of the lessons I've learnt from my work before becoming an MP and from the services I've visited in this country and abroad as the Shadow Minister for Care and Older People.

The first is that structural reorganisations rarely, if ever, make the financial savings or service improvements that successive Governments have claimed. At best they're distracting and at worst they're damaging, as vital expertise is lost and relationships disappear.

That's why this Government's NHS reorganisation was a real mistake, wasting precious time, effort and resources at the worst possible time.

So Labour has been very clear – if we're elected in 2015, we will not have another top-down reorganisation.

When we asked Sir John Oldham to chair an Independent Commission on Whole Person Care, this was explicit in its terms of reference. And the Commission's proposals to turbo-charge integration can all be achieved without centrally driven structural change.

The second lesson is how we pay for services really matters.

Local councils and the NHS are constantly urged to join-up services and shift them into the community. Yet the vast majority of health and care budgets remain separate and are held to account by different central Government departments. The way we pay for NHS services actively incentivises episodic treatment of individual conditions and hospital admissions.

All this must change.

That's why the Oldham Commission recommends payment by results should be replaced by a new capitation or 'year of care' tariff, initially for people with multiple long-term conditions and frailties, to drive the right care, in the right place, at the right time.

The third lesson is you can't separate the quality of services from the staff that provide and manage them.

Achieving excellent quality requires NHS and social care staff with the right skills, attitude and training, working together as one team. This won't happen by magic. It needs to be actively designed into workforce planning, education, training, practice, research and leadership development.

I've seen some fantastic examples - like Worcester University, where patients and families help interview students, and design and deliver the courses, so the next generation of nurses and healthcare assistants really understand what matters to service users.

Jonkoping in Sweden – a real pioneer of integration – invests a huge amount of time and effort in their staff. This includes establishing a Masters in Quality Improvement and Leadership: a multi-disciplinary programme, which gives doctors, nurses, social workers and finance staff the skills they need to put continuous quality improvement into their daily practice.

The Oldham Commission makes a number of important recommendations to ensure changes like these are spread throughout the NHS and social care**.**

The fourth lesson is that whilst effective regulation is essential, regulators can't be everywhere all the time. Our goal must be to prevent problems from happening in the first place. That means ensuring openness and transparency are hardwired into the system.

When the last Labour Government published data on heart and stroke services for the first time, it was initially very controversial but ended up driving real changes in quality because when clinicians compared their outcomes to those of their peers, they wanted to improve.

Alongside publishing more information on outcomes, we need much more powerful ways of putting the patient and user experience at the heart of local services.

I welcome the Friends and Family test, as far as it goes. But it only asks whether patients would recommend an NHS service to others. It doesn't explain the reasons for patients' views or provide the detailed, real time feedback on their experience of individual services, which patients want and staff need to improve care standards.

'TripAdvisor' style services like Patient Opinion and I Want Great Care allow people to share their experience of services online, in writing or on the phone. This gives users a voice and staff a powerful incentive to improve in a simple and cost-effective way. Realtime feedback must become a major driver of change across all health and social care services in future.

The final lesson – and perhaps the biggest challenge of all - is that we must give more power, say and control to the people who matter most: users, families and local communities.

That's not just about ensuring people can choose which GP or hospital they use, and when – vital though this is. It's about making sure people have the power to shape their care and support and get the results that matter to them, as individuals and members of their local community.

For me, this is a matter of principle but it's also about getting better results.

There's clear evidence that patients who are actively involved in making healthcare decisions and in managing their own health have better outcomes than those who are passive receivers of care.

Personal budgets and Direct Payments in social care have already transformed the lives of many disabled people. The early evidence from the pilots of personal budgets for people with long-term health conditions is encouraging too, which is why I think they should be expanded in future.

Communities must also have a real say in designing local services.

Too often the NHS still comes up with proposals for service reconfigurations behind closed doors, without involving patients and the public from the start. Service changes will always be controversial, but the only way we can make them happen is by properly involving local communities at every stage of the process.

None of this will be easy. NHS and social care staff feel battered and bruised by the huge number of changes that have taken place in recent years.

Risks are inherent whenever changes are made. Politicians – both national and local - always find it difficult to give power away.

It can also be extremely difficult when professionals who have developed an extensive body of knowledge are challenged by users' views about what they really want and need, and by the changes that inevitable come when power is shared with others.

However, the risks of not doing things differently are equally great. No change is not an option.

Bill Clinton once said 'those who believe in government have an obligation to reinvent government to make it work', not least because it is those without power and wealth who bear the brunt when the state and public services fail.

This is the challenge now facing us: to offer a real alternative and genuine hope that the health and care services we rely on can be sustained for future generations.

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