Essays collected by the Associate Parliamentary Health Group in association with The King's Fund

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Associate Parliamentary Health Group

The King's Fund

HEALTH POLICY PRIORITIES FOR PARLIAMENT

‘HEALTH IS AN INTRINSICALLY INTERESTING POLICY AREA AND AS PARLIAMENTARIANS, OUR ENGAGEMENT WITH IT IS ESSENTIAL’

Baroness Cumberlege, APHG Chair
Lord Hunt of Kings Heath, APHG Parliamentary Officer

CONTENTS

FOREWORD

Health is an intrinsically interesting policy area and as Parliamentarians, our engagement with it is essential. In order to effectively formulate and scrutinise health policy, represent constituent concerns and hold healthcare providers to acount, all Members of Parliament must acquire an understanding of the NHS and the health policy agenda. However, the complexity of the health service and the rapid pace at which it evolves can make this challenging, rendering health as one of the more daunting subject areas for parliamentarians to get to grips with.

It is on this basis that in 2001, we and other parliamentary colleagues helped establish the Associate Parliamentary Health Group (APHG) as a forum through which to provide MPs and Peers with high quality, impartial information about health issues. Focusing on local as well as national issues, the APHG is dedicated to disseminating knowledge and generating debate on topical health issues in a cross-party setting.

For the most part we achieve this by holding regular seminars on the Parliamentary Estate addressed by expert panelists drawn from the health sector. Since the group's inception, we have been fortunate to have been addressed by some of the most senior voices on health including Secretaries of State, Chief Executives of key NHS and regulatory bodies, senior civil servants and leading academics. In our mission to open up the health policy debate to the broadest parliamentary audience possible, we have enlisted the support of a distinguished panel of advisors who, alongside our fellow Parliamentary Officers, determine the group's activities. Full details about the individuals involved in the group and the services provided by the APHG can be found on page 28 of this booklet.

As we embark upon a period of substantial reform for the health service, and in the context of a challenging financial climate, parliamentary participation in the forward health debate will be paramount. To help orientate new and returning MPs and Peers on the shape of the health policy agenda, we are delighted to present this collection of short essays in partnership with The King's Fund on some of the central issues that will dominate the health policy agenda over the course of this Parliament.

Contributed by key health sector figures and commentators, each essay provides essential information on a particular policy priority, exploring its development and the ways in which it can be addressed and advanced in the coming years.

We would like to offer our thanks to all those who have contributed to this publication for lending us their time, insight and expertise and our partners in this project, The King's Fund, for their valuable input and support. We hope very much that, collectively, the essays will encourage colleagues to initiate, resume or continue their engagement in health policy and that the APHG will act as a useful forum through which to develop and enhance your understanding of this fascinating policy area.

Baroness Cumberlege
APHG Chair

Lord Hunt of Kings Heath
APHG Parliamentary Officer

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COMMISSIONING

Professor Chris Ham
Chief Executive, The King's Fund

Commissioning in the NHS is the process by which population health needs are assessed, decisions are taken on how best to meet these needs, services are procured through contracts and other means, and performance against contracts is reviewed to ensure value for money. Ever since the introduction of the internal market in the 1990s, successive governments have sought to develop the role of commissioners to enable them to negotiate on equal terms with hospitals and other providers. Most recently, this has been done through the world class commissioning programme which was put in place by the previous government to strengthen the role of primary care trusts.

The Coalition Government's plans envisage GPs taking full responsibility for commissioning from April 2013 when primary care trusts are replaced by GP commissioning consortia. The aim of these plans is to bring the clinical knowledge of GPs and primary care teams to bear in decisions on how to use resources within the NHS in the belief that this will be more effective than commissioning led by managers in primary care trusts. While GP commissioning builds on previous initiatives, such as practice based commissioning and total purchasing, it goes much further in requiring all practices to be involved and devolving responsibility for around 80% of NHS expenditure to commissioning consortia.

Research into primary care-led commissioning in the NHS has highlighted its potential to contribute to improvements in performance, especially in increasing responsiveness to patients accessing planned care and delivering more care closer to home. On the other hand, there is little evidence that primary care-led commissioning has made a significant impact on secondary care services or on moderating demand for unplanned care. Evidence from the United States where medical groups have taken on capitated budgets suggests that GP commissioning will depend critically on developing capable GP leaders and providing adequate budgets to enable consortia to buy in management support, among other things.

Various studies in the last twenty years have described commissioning as the weak link within the NHS. The challenge for the Coalition Government will be to ensure that history does not repeat itself and that the leadership and management are put in place counter the power of providers in order to deliver benefits for patients and the public.

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COMPETITION WITHIN THE NHS

Dr. Jennifer Dixon
Director, The Nuffield Trust

Historically, across the political spectrum, there has been consensus that a competing private sector should supply goods such as pharmaceuticals, capital equipment or indeed buildings. In the 1980s and 1990s under the Conservative Government many formerly NHS-supplied non-clinical services had been put out to competitive tender, such as cleaning, laundry, and catering. After initial opposition mainly by the unions, this arrangement was eventually accepted. Allowing competition for clinical care was more controversial for a number of reasons. For example: the incentives inherent in competition might taint or pervert the altruism of clinical staff; private sector suppliers might offer a poor service and cream off profits to shareholders rather than to taxpayers; and the costs of developing and maintaining a market would be high.

But sometime near 2000, the New Labour Government concluded not only that extra (private) supply of care was needed to reduce waiting lists, but more fundamentally that competition for clinical services could potentially be beneficial, and more autonomous facilities might offer greater innovation. Hence the initial 'concordat' with the private sector signed by then Secretary of State for Health, Alan Milburn, the national contracts between the Department of Health and independent treatment centres (ISTCs), the policy of foundation trusts (squeezed through Parliament with a majority of only 5) which conferred greater freedoms on NHS Trusts, and policies to promote patient choice of hospital. Patients were given freedom to choose the hospital of referral, from 2007 from any willing provider. The competition/choice policy notably did not extend to other providers, and not to commissioners, such as primary care trusts. Alongside these policies should be considered other 'market mechanisms' introduced, such as the introduction of fixed prices for hospitals under 'Payment By Results', and more latterly guidance from the NHS Competition and Cooperation Panel.

Several years later there is an emerging body of empirical evidence on the impact of these measures. First, there is still little market for clinical care outside major conurbations such as London, Birmingham and Manchester. Second, in hospitals facing the greatest competition, management appears to have improved and mortality rates for heart attack patients reduced - but it is not yet clear whether this relationship is 'association' or 'causation'. Third, patient satisfaction with elective care in ISTCs was greater than that in NHS facilities, but it is not yet clear if the NHS facilities were treating more complex patients. Fourth, despite some (albeit mixed) encouragement, there have been disappointingly few new entrants to the 'market'. Fifth, patients are choosing, but in most cases stay local.

On this basis, the results look tentatively encouraging, at least to stick to the broad policy direction of travel. However, the unit of competition – the hospital or elective care facility – is not optimal for the big priorities of caring for older people and those with long term conditions. Here integrated care is needed spanning home to hospital – but this is too often viewed as anti-competitive by economists used to theorising about the behaviour of firms. We should now seriously consider how competition between vertically integrated networks of providers might be encouraged.

Finally and related, a lot of health policy has been oriented to what might be done to challenge providers from without to improve performance (eg competition, regulation, directive) and not on what type of 'intra' provider environment might be created to increase performance. For example using information, peer review of performance, aligned financial incentives, clinical leadership, and involving patients/communities to provide the 'disruptive innovation' from within. This is surely the arena ripe for development over the next decade. If the last decade has taught us anything, competition, regulation and directive can only go so far – and too much leads to failure.

NHS FINANCES AND PRODUCTIVITY

Professor John Appleby
Chief Economist, The King's Fund

Following the Spending Review, there seems to be some confusion about the financial future for the NHS and what the Department of Health's push to improve productivity will mean for the service, staff and patients. So what are the facts?

On funding, since 2006/7, the English NHS budget increased by nearly 19% in real terms. But over the next four years the planned real rise will be 0.34% - or just 0.083% a year on average. This slow down in funding growth in fact started this year, with a real rise of just 0.7%. Part of the NHS settlement also includes an average annual amount of £950 million earmarked for joint spending between the NHS and social care.

Whether the NHS actually receives a real increase by 2014/15 depends on the accuracy of the forecasts for the GDP deflator - the measure used by the Treasury to estimate inflation; an error of 0.1% a year could more than wipe out the small real increase. And whether NHS purchasing power increases in real terms will depend on future inflation as experienced by the NHS. The staff pay freeze to 2012/13 will keep NHS inflation in line with the GDP deflator - but what might happen in the last two years of the spending review?

Overall, despite what will be an unprecedented run of very low real growth, the NHS can perhaps count itself fortunate compared with equally unprecedented real cuts in most other departments.

But the NHS will not be exempt from the challenge to improve its productivity. The monetary value of meeting increasing demand from a growing and increasingly ageing population and, crucially, improving the quality of its services has been variously estimated by the Department of Health and joint analysis by the King's Fund and researchers from the Institute for Fiscal Studies to be between £5 billion and £7 billion a year.

These are broad estimates and depending on decisions about, for example, future pay rises, whether or not to invest in further waiting times reductions and infrastructure improvements suggested by Sir Derek Wanless in his 2002 review of future NHS funding needs, the value of the productivity challenge could be less - of the order of £3 billion to £5 billion a year.

If the productivity challenge can be met, then for patients it will mean better services and more of the things they value - fewer hospital infections, more operations, higher quality care. The task for the NHS is not to fixate on the cost side of the equation - saving money or making cuts - these are not improvements in productivity. Rather, it needs focus on the benefits side to find new ways of providing services that increase the value of care to patients.

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THE NHS WORKFORCE

Dr Peter Carter
Chief Executive, Royal College of Nursing

After the recent Comprehensive Spending Review, overall spending on the NHS will increase by 0.4% in real terms over the life of this Parliament. In reality however, this is will not keep up with a growing demand on services and an ageing population. Put simply, the NHS will still have to do more with less.

The NHS workforce has to respond to unprecedented challenges, particularly those outlined in the recent NHS white paper. Such ambitious changes in the way healthcare is delivered will require multidisciplinary support, including from those on the frontline of care. Despite this, the white paper mentions 'nursing' only once.

Staff are facing a two year pay freeze, pension reforms, changes to ways of working, and the ever-present prospect of cuts in jobs and services. The Royal College of Nursing (RCN) is aware that staff are already dealing with deep efficiency measures, the inappropriate reconfiguring of skill mixes and the down-banding of salaries. All are deeply unsettling. It isn't very surprising, therefore, that a study by the RCN earlier this year showed that these factors are causing heightened levels of anxiety among staff; particularly regarding job security and the ability to provide high quality care.

The RCN has said clearly that the workforce needs to work in new and innovative ways to increase productivity, reduce waste and eliminate inefficiency. Through our *Frontline First* campaign, we have been asking our 400,000 members for examples of the nurse-led innovations that lead to better and more efficient care. Good nursing is that which embraces the richness and the possibilities of care and I would urge trusts to engage more readily with staff.

The support of nursing staff is essential to any changes in healthcare - especially if the workforce is expected to cope with such a difficult financial climate. To help deliver the change, trust boards will need to be pragmatic and engage with the workforce and with trade unions; they are part of the solution not the problem.

Having a healthy workforce is vital. The 2009 Boorman Report, NHS Health and Well-being, emphasised the importance of staff achieving physical, mental, and social health. As the report outlined, the NHS could reduce its rates of staff sickness absence by a third and, in so doing, create an additional 3.4 million available working days, saving an estimated £555 million per year. The evidence of a link between staff well-being and patient experience is not only credible, but proven.

The workforce needs to be healthy, empowered and innovative. In the difficult times, both now and ahead, these are the only ways that quality patient care, and by extension good nursing practice, will flourish.

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PATIENT EXPERIENCE

Jeremy Taylor
Chief Executive, National Voices

Health will loom large in this Parliament and much time will be spent on the Government's funding and reform plans for the NHS in England. National Voices is the coalition of national voluntary organisations promoting stronger patient and citizen influence. For our members there is also a wider agenda: persistent health inequalities; the health impacts of austerity; and ever-rising demands for care. Our challenge to parliamentarians in this time of flux and financial stringency is to maintain a focus on the needs of individuals and communities, particularly the most vulnerable. What does this mean in practice?

Firstly, we need to get robust about public health. If we are to become a healthier nation we will all need to take greater personal responsibility. But politicians also need to shape the climate in which personal health decisions are made, for example by having the bravery to further deter the use of alcohol and tobacco. Nor should the focus be on individual decisions alone. Healthy lives are lived inside healthy communities. Physical and mental health are damaged by poverty, unemployment, poor housing, poor education and lack of social cohesion. Strategies for supporting communities, including the most marginalised communities, must be central to the public health agenda.

Secondly, people need help to look after themselves better. People want to be in control, yet many of us, including the growing numbers of people with long term conditions and disabilities, have more contact with health services than we want or need, and spend too much time in hospital. The traditional medical model of care - highly paid experts doing more and more things to passive recipients – is wasteful, paternalist, not always effective, and no longer affordable. Modern care needs to support greater health literacy and better self management. It needs a more democratic style of clinical practice. It needs services closer to home, with better coordination between health promotion, social care and NHS care, and more support for carers. Hospitals are important but need to be put in their place. Parliamentarians should not automatically resist proposals to take services out of hospitals.

Thirdly, we need to get real about patient and public involvement in service decisions. The importance of involving people is generally accepted, but practice is too often formulaic and tokenistic: questionnaires rather than collaborations. The very acronym "PPI" - which makes me wince - is indicative of this mindset. We know that decisions made in partnership between service providers and citizens are more likely to be the right decisions and more likely to build confidence and support. To make a reality of that partnership approach needs different behaviours and attitudes. It means, for example, doctors coaching rather than instructing. At the collective level it means commissioning becoming far more democratic, and public servants reaching out to excluded communities.

Radical reform of services at a time of austerity risks creating a perfect storm. It will also generate opportunities for doing things better. I hope that parliamentarians will seize their opportunities to secure a better deal for patients, carers, families and citizens.

PUBLIC HEALTH

Professor Steve Field
Former Chair, Royal College of General Practitioners

As a practising GP working in a busy inner city area, I work at the heart of a community, providing lifelong care to our patients and their families. But the public's health is everybody's business, not just healthcare professionals'.

I have seen at first hand the problems of health inequalities, and as Professor Sir Michal Marmot said in Fair Society, Healthy Lives: "There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health" and in particular focus on six objectives:

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

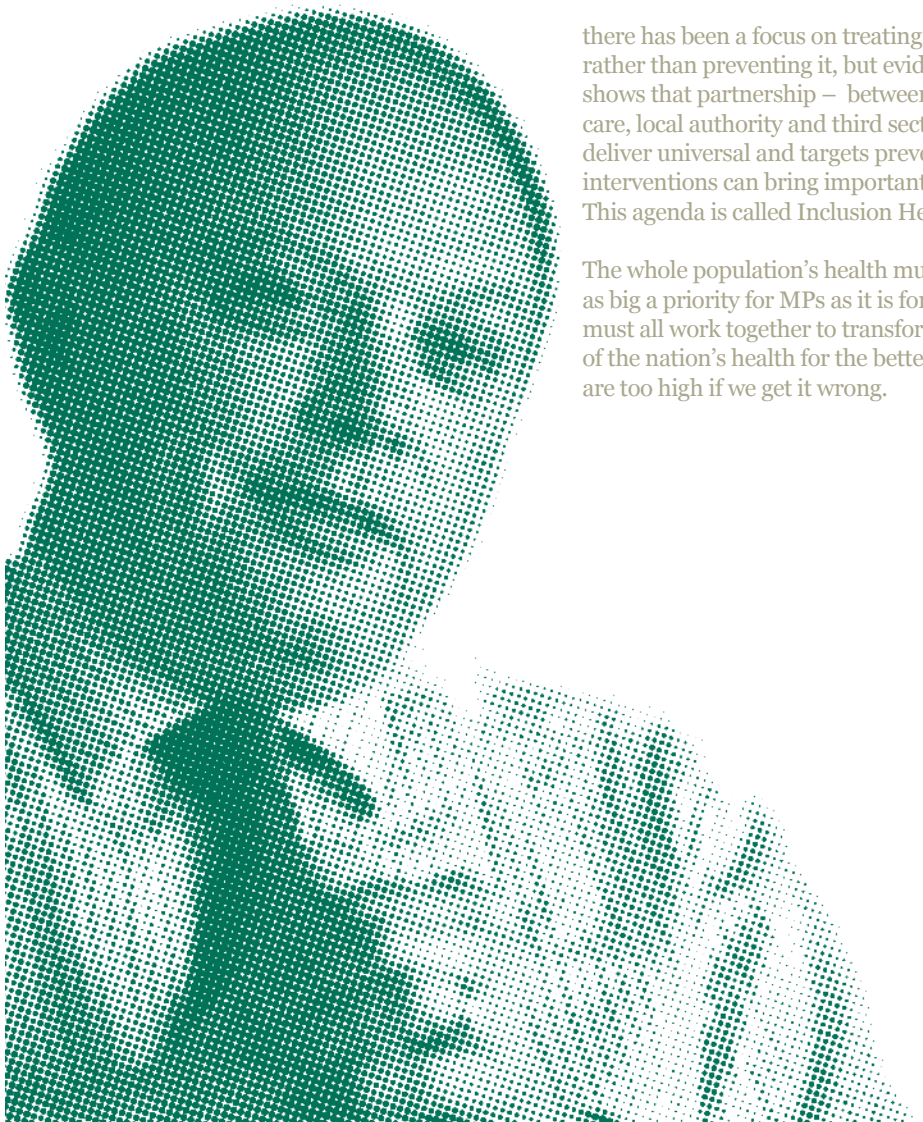
Public health is a sensitive issue; there is a fine line between promoting good health and a nanny state that tells people how to live their lives. At the heart of the agenda should be the principle that prevention is better than cure and the need for a legitimate public health service that exists not just to patch people up when they are ill but that prevents them from becoming ill in the first place.

I welcome the establishment of a new public health service; clearly public health is about more than healthcare provision, and local government is its natural home. I believe our society needs to move from a top-down 'shove' mentality to a freer 'nudge' mentality; of course with freedom comes responsibility, and the state must create an environment where people can take more responsibility for their health.

It's not about telling people what to do, or worse, ratifying a nanny state through law. It is about promoting an agenda that informs and persuades the public to make informed choices that will lead to longer , more productive, healthier lives. In making public health a priority, Parliament has the opportunity to right the real public health injustices that continue today – the health inequalities gap perhaps above all others – and it is an opportunity too important to waste.

The public health is everybody's health, and this includes a small but significant number of people who are generally socially excluded. These include the homeless, street sex workers, asylum seekers and those with learning difficulties. In the past there has been a focus on treating harm, rather than preventing it, but evidence shows that partnership – between primary care, local authority and third sector – to deliver universal and targets preventative interventions can bring important benefits: This agenda is called Inclusion Health.

The whole population's health must become as big a priority for MPs as it is for GPs. We must all work together to transform the state of the nation's health for the better. The stakes are too high if we get it wrong.



SOCIAL CARE

Richard Jones
President, Association of Directors of Adult Social Services

The facts almost speak for themselves. Over the next 15 years the number of people aged over 85 will double. Within 20 years some 1.7 million more people (older people and disabled working age adults) will have a potential care need than do today. In the period of the spending review 370,000 more people will require care and support.

Social care provided through councils is supporting 1.7 million people but increasingly people are having to fund their own care costs. Adult social care spend on older people is around £8bn but is only a small component of public expenditure on over 65's, where social security benefits amount to £83bn and NHS spend to £50bn.

The challenge is how we increase the level of resource into the care and support pot. Andrew Dilnot's Commission on Care Funding will need to come forward with a clear option for a sustainable, resilient and fair settlement. It will need to be a settlement that recognises the level of informal support, estimated at a value of £87bn, significant levels of unmet need and helps the public understand that a partnership approach will be needed between individuals/families and the state as we move forward. We need people to understand that they have a 1:4 chance of receiving residential care in their later years and a 65% risk of receiving community based support with a huge costs working out at £40,400 for women and £22,300 for men.

The challenge for social care in the short to medium term is about building a reform agenda based on 3 key principles.

- Increasing choice and control through personal budgets - by the end of March 2011, 300,000 people will have more control of their care and support through a personal budget. We want to see people increasingly pooling their own resources with public funding to develop different and flexible responses to their needs, building on their strengths and working them as active citizens. In order to achieve personalisation we need to see a care and support market which is diverse and vibrant with new entrants offering different services.
- A focus on prevention across health and social care is needed to keep people independent and responsible for themselves. We know investment in good information and advice is crucial to help people make good decisions. Early intervention, crisis support services, telecare and the wider use of IT, end of life services, good support for dementia patients and home based healthcare can all help to improve outcomes and save money in acute interventions.
- A radical realignment and integration of budgets and commissioning towards community based interventions, improved outcomes for people and reduced duplication of visits. We need to build different partnerships which are aligned to secure shared goals and understand the interdependency of health and social care.

The challenge is to deliver significant productivity gains through a major programme of reform. More of the same won't work.

QUALITY

Dame Jo Williams
Chair, Care Quality Commission

The Care Quality Commission (CQC) was established in April 2009. It was formed from three predecessor organisations: the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission. CQC has built on the expertise of those organisations but operates within a different legislative framework (Health and Social Care Act 2008). Our emphasis is on outcomes for people, ensuring that whatever the service is, it focuses on the individual and is responsive to each person's particular circumstances.

We define quality as safety, appropriate clinical interventions or care and an experience that the individual values because it enhances their general wellbeing. We have 16 essential standards of quality and safety within a single framework that applies to all services we regulate.

We monitor compliance against these standards using a combination of feedback from people who use services, their families and carers, staff in hospitals and care homes, and other local groups (including Local Involvement Networks (LINks) and the voluntary sector). We also look at data to see if we can identify worrying patterns. If concerns emerge CQC is empowered to take action to require improvement and if necessary can apply restrictive conditions to reduce the risk of harm to people. In extreme situations, this can lead to service closure.

The current financial climate presents a real challenge to commissioners and providers, who need to ensure they maintain quality in services while achieving greater efficiencies cuts. In addition, the transition period of change within the NHS will potentially lead to a lack of focus on quality; many of the NHS' 'early warning systems' are being dismantled and reformed – strategic heatlth authorities and primary care trusts have an important role in tackling poor quality care and their mantle needs to be picked up. The regulator will play its part but everyone working in the sector needs to be vigilant and be prepared to question and challenge if they see poor practice.

We are beginning to detect a need to do things differently in order to meet the challenges the financial climate is giving rise to. As a regulator we want to support, not stifle innovation and we are discussing these issues with providers and commissioners.

Combining services and back-office functions is one way savings may be achieved to protect front-line services. Herefordshire council plans to form a joint venture organisation in April 2011 with NHS Herefordshire and Hereford Hospitals Trust. By sharing and jointly running HR, IT, finance and legal services, significant savings are forecast, which will be reinvested in essential services.

Westminster, Hammersmith & Fulham, and Kensington & Chelsea councils intend to go even further, with plans to share every council service between them to deliver more for less while protecting front-line public services.

For people using services, it is essential for the right information to be available in an accessible format to inform their choices. People must also be involved in decisions about their care, in line with the Health Secretary's pledge of, 'no decision about us, without us'. This has a huge impact on the quality of people's experience. A 'do with' rather than a 'do to' attitude must prevail amongst care professionals.

Quality can be enhanced through a focus on prevention, getting it right first time and, for example, reducing hospital re-admissions. Investment in the right reablement services is money well spent if it ensures people have appropriate and timely support to recuperate in their own homes. The lack of such support is likely to lead to higher costs and poorer long term outcomes.

REFLECTIONS

Lord Hunt of Kings Heath
APHG Parliamentary Officer

The NHS is never far from the thoughts of politicians at Westminster. This session is no exception as we await the NHS Bill which will implement Andrew Lansley's reforms.

The intended outcomes of the white paper are difficult to argue with. Most of us would like a patient centred service, more control over our own treatment and choice of doctor. It was a strong theme of Labour's approach to the NHS.

Interestingly, the response of the NHS and patients organisations to the Government's plans has been pretty unenthusiastic. Concerns over unintended consequences and the potential de-stabilisation of the Service have been a consistent theme of their representations.

The key feature is the abolition of primary care trusts and strategic health authorities and the creation of GP consortia to commission £90 billion worth of health care from providers. Hospitals will operate in a much more competitive market under the mantra 'any willing provider'. Anti-competitive practices by providers will be policed by an economic regulator like OFGEM.

So why is the Secretary of State so willing to entertain such an upheaval? From various comments he has made to parliamentarians, it is striking the emphasis he places on the funding difficulties so many health systems find themselves in.

As he sees it, patients make demands which clinicians are happy to respond to because the costs will be met by someone else. He makes the point that GPs incur most of the expenditure of the NHS in terms or prescribing and referrals, but don't have the responsibility for seeing how the management of care is best reconciled with the management of resources.

Apart from the question of whether GPs collectively want to take on the responsibility of commissioning, it's a moot point as to whether they really will be prepared to police fellow doctors who are unable to control demands on services.

Of more immediate concern, is whether the NHS can withstand the disruption caused by the setting up of a completely new system, when the current management bodies are on the way out and funding pressures are rising?

The NHS may have a ring-fenced budget, but it has to make £20 billion of efficiency savings in the next few years. On top of that, they will have to compensate local authorities for adult social care cuts given the huge financial hit local government is taking.

Another worry is the potential return of post-code prescribing with the decision to remove the mandatory nature of NICE's guidance. GPs will get more discretion in prescribing but inevitably they will come under tremendous pressure to fund drugs which NICE will have ruled against on cost-effectiveness terms.

Another question will be the role of Ministers. Mr Lansley is keen to step back and hand over the money and commissioning responsibility to a new NHS Commissioning Board. But can Ministers absolve themselves from responsibility? If things go wrong, it is inevitable that MPs will want answers from the Secretary of State rather than some remote quango.

All in all, the NHS will provoke endless debate and analysis in which MPs and Peers will play a full part.

REFLECTIONS

Mark Simmonds MP
APHG Parliamentary Officer

The National Health Service is rightly a key priority for the Coalition Government. Our health outcomes are still poor when compared to other developing countries whether it be cancer survival rates, stroke mortality or cardio-vascular outcomes.

Whilst retaining a service which is taxpayer funded and free at the point of delivery, the Government needs to refocus NHS resources to frontline patient care and put clinicians at the heart of the NHS whilst shifting the emphasis of the NHS and concentrating on making the patient, the user of the service, central to everything that happens within the service.

Firstly, this requires a relentless focus on outcomes not processes. Clinically evidence based outcomes should drive decision making in the planning, management and allocation of valuable resources. This will make is easier to compare and contrast provider performance and inform genuine patient choice.

Secondly, there needs to be a complete change in commissioning with GPs leading the purchase of services on behalf of their patients. Giving clinicians who understand the patient best a greater responsibility for budgets has to be correct.

However, there also needs to be a great deal of thought given to working with specialists and others to ensure integrated services for patients, particularly in the context of an ageing population and the growing importance of community services.

Thirdly, much greater and more easily accessible information for patients must be provided to enable patients to have genuine choice both about where they receive their treatment and about what type of treatment they get for their individual ailments. These decisions should be based upon an understanding of the potential outcomes of a patient's choice.

I see no reason why in an 'any willing provider' service, information should not be comparable. This will not only drive outcomes but also standards of safety and quality of care as publically accessible information ratchets standards upwards in a virtuous cycle.

Fourthly, I would like to see greater understanding, support for and innovation in public health and prevention, this all important and too often sidelined part of healthcare. Independent sector organisations should be incentivised to deliver improved public health in targeted areas particularly where health inequalities are wide. Much greater use of mapping and analytics should be put in place to target resources to deliver the maximum impact.

Finally, the focus must be on improvement in health outcomes and patient's experiences. We must move away from arguments about the delivery mechanisms and focus on quality of care.

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ABOUT THE APHG

The Associate Parliamentary Health Group (APHG) is an all-party parliamentary subject group dedicated to disseminating knowledge, generating debate and facilitating engagement with health issues amongst Members of Parliament. The APHG comprises parliamentarians of all political parties and both Houses, provides information with balance and impartiality and focuses on local as well as national health issues.

The APHG was launched in November 2001, on the basis that Members of Parliament need as much high quality and impartial information as possible to fulfil their crucial role in the UK's health programme. With the knowledge and expertise of senior figures from both Houses of Parliament, the NHS and the public, private and voluntary sectors, we aim to provide this and further encourage this involvement.

We inform and engage parliamentarians through two major avenues:

- The organisation of briefings, seminars and conferences under Chatham House Rule addressing and providing information on the major developments in health and the health service
- The provision of comprehensive web-based resources, including a unique site that compares local hospital trust performance on a constituency by constituency basis, a weekly Parliamentary monitoring update and a daily media bulletin service

The APHG's agenda is set by its all-party team of elected Parliamentary Officers in consultation with its distinguished Advisory Panel, and delivered by a dedicated secretariat.

The group is supported by an Associate Membership of 25 of the UK's leading organisations working in the health sector, which as well as providing an independent source of funding, offer a valued insight into present developments occurring within wider the healthcare community in the UK.

By acting as a forum for discussion and a vehicle for the dissemination of information, we enable parliamentarians, policy makers, healthcare professionals, suppliers, purchasers, universities, voluntary organisations and charities all to play their part in the delivery of the national health programme.

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Lynda Hamlyn	Chief Executive, NHS Blood & Transplant

ABOUT THE KING'S FUND

The King's Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

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Ideas that change health care

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