

Essays collected by the All Party
Parliamentary Health Group

All-Party
Parliamentary
health
Group



A GUIDED TOUR OF THE NEW NHS

**Parliamentarians
must hold the
NHS to account
by shining a light
on failures and
providing a voice
for patients and
the public.**

Baroness Cumberlege, APHG Chair

Lord Hunt of Kings Heath, APHG Treasurer

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PREFACE

A new landscape?

As we reflect upon the changes recently introduced into the NHS we are struck simultaneously by a sense of upheaval and a sense of continuity: upheaval in the structures of the NHS; continuity in the scale and nature of the challenges which the whole system must tackle.

The Health and Social Care Act introduced a localised clinician-led commissioning structure, a greater role for local authorities in public health and Health and Wellbeing Boards, and the creation of various new national bodies. Yet there remain serious challenges which the system and its new leaders must grapple with: a tight financial environment; pressure from growing demand; a culture driven by targets which puts providers under pressure; and a renewed focus on quality and safety in light of events at Mid Staffs and elsewhere.

In responding to these challenges we must remember that the staff of the NHS are vital to its success. We must encourage the professionalism which so many NHS staff show in their daily work and, at all costs, we must avoid the insidious infiltration of a blame culture among the workforce.

The role for Parliament

One of the aims of the Health and Social Care Act was to depoliticise the everyday running of the health service. As a result of the Act many of the key bodies, such as NHS England, have now become one step removed from the political sphere. Politicians need to find their place within this new system because healthcare will always remain an area of public interest, and the public will rightly expect their representatives in Parliament to continue taking an interest in this topic.

The All Party Parliamentary Health Group aims to provide parliamentarians with a space in which they can enhance their understanding of the health service and hold the system's leaders to account. We hope that this guide will provide a useful introduction to the different bodies within the new NHS and will help to explain their roles and responsibilities. Through our regular seminar programme we also offer the chance to engage with these figures in more detailed discussions about specific policy areas.

The role for parliamentarians, and especially MPs, within these new structures is to listen to their constituents and hold the NHS to account by shining a light on failures and providing a voice for patients and public.

The challenges ahead

Both politicians and NHS leaders must be under no illusions: when it comes to reforming our healthcare system for the 21st century the hard work is still to be done. The challenges we face today are not just quantitatively, but qualitatively different from those faced by earlier generations.

We no longer require large numbers of acute beds to accommodate people for short periods of ill health; we need a system which can look after large numbers of people as they enter old age with increasing numbers of long term, non-communicable conditions.

There will be challenges in pursuing this agenda to conclusion: it will require reform of both secondary care and primary care.

We shall need to build capacity elsewhere in the system if we wish to move care out of acute hospitals: this will mean fundamentally reshaping GP services, investing in models of community care, and focusing across the system on prevention and early diagnosis. There is also an absolutely vital role for social care and the third sector in meeting these challenges: the NHS must ensure it works with all relevant parties to deliver a seamless, integrated care experience for patients.

In spite of these challenges which remain we believe there is reason for optimism: the challenges outlined are not insurmountable and in tackling them we can build a system which excels at keeping people well and preventing them going into hospital - which is exactly what the public want from their health service. The APHG will play its part in helping politicians to understand these challenges and to hold the key players to account for delivering on them.

Baroness Cumberlege and Lord Hunt

Baroness Cumberlege is Chair of the All Party Parliamentary Health Group and a Conservative Peer. She was a Minister in the Department of Health from 1992-97.

Lord Philip Hunt is Treasurer of the All Party Parliamentary Health Group and Labour spokesperson for Health in the House of Lords. He is Chair of Heart of England NHS Foundation Trust.

INTRODUCTION

The NHS passed its 65th birthday in July this year. That occasion prompted much comment about the NHS and whether it had a future. In a collection of essays from key figures published by the Nuffield Trust ‘The Wisdom of the Crowd’ⁱ there were some consistent messages.

First, the NHS should continue as an overwhelmingly tax-funded, free at the point of use, comprehensive service available to all citizens.

Second, the NHS would be under more pressure in the next 10 years than at any other time since 1948. The most significant pressures being the short to medium term financial constraints on health and social careⁱⁱ, the background rising demands due to ageing and ill health, and in the short term widespread organisational reforms in health care in England.

Third, as well as pressures there are also significant opportunities to improve care. It is easy to overlook the fact that overall the quality of health care is improving across the UK (insofar as we can measure it) despite recent scandalous lapses in quality such as at Mid Staffordshire NHS Foundation Trust. For example, new treatments become available, there are better data to measure quality, and better communication technology can transform the way care is delivered. Budget constraints also can stimulate significant innovation in service delivery out of necessity.

Fourth, a recognition that there needs to be significant transformation of care for it to be affordable from the public purse in the future. In particular the need to reconfigure the hospital sector, boost out-of-hospital care which reassures the public in particular of good quality emergency treatment when they need it, expand preventive and public health, and achieve better integration of care within the health sector and between health and social care.

Fifth, a recognition that patients and the public, and care staff, need to be heavily involved in helping to create new and sustainable forms of care.

The reforms brought about by the Health and Social Care Act 2012 were in part designed to address these points, especially the fourth and fifth. This collection of contributions outline the anatomy of reform – the main national bodies created and their broad functions. Viewed at this level there is some coherence (some have said ‘terrible beauty’) to their respective and collective rationale and objectives. They also appear to move the NHS away from being directed from Whitehall (via the Department of Health and the NHS headquarters) towards a wider set of bodies including regulators – from government to governance.

But how this greater plurality of stewardship will work in practice to help create the right conditions for transforming care is the acid test of these reforms. Put bluntly, will the leaders collaborate, will they

have the staff and information, bravery and political cover to make the right decisions at the right time? An obvious place to start could be in tackling intelligent reconfiguration of hospitals. As former Secretary of State for Health Patricia Hewitt remarked recently ‘The inability to make decisions that are in the interests of patients is frankly shocking, just shocking’ⁱ. But no less important is to improve the quality of out-of-hospital care and to develop integration. How to do this, with the public involved, is the debates which should be live at present, not whether or not competition between providers should be pursued.

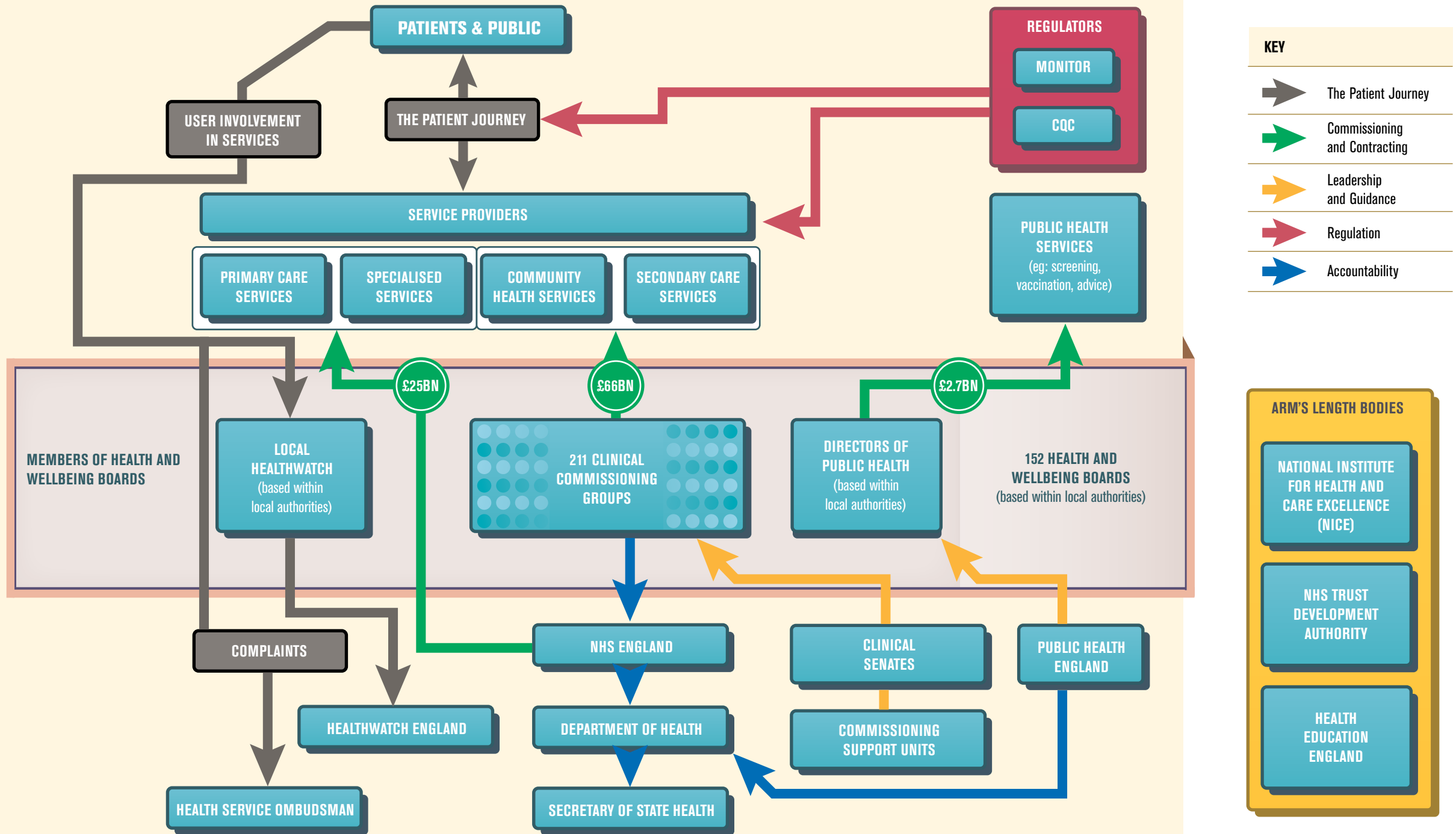
So while we now have the new anatomy in place, it is the physiology of the system that will matter. The challenge is set, let’s now see if we have the intelligent leaders we need to meet it.

Dr Jennifer Dixon is the Chief Executive of the Health Foundation. She was previously Chief Executive of the Nuffield Trust and she is a visiting professor at the London School of Economics, London School of Hygiene and Tropical Medicine, and Imperial. She is an advisor to the All Party Parliamentary Health Group.

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ii. The Age of Austerity. Nuffield Trust, 2012.

THE NHS IN 2013: AN OVERVIEW



NHS ENGLAND

Sir David Nicholson, Chief Executive, NHS England

The main aim of NHS England is to improve health outcomes for people in England.

Central to our ambition is to place the patients and the public at the heart of everything we do. We are what we want the NHS to be – open, evidence-based and inclusive, transparent about the decisions we make, the way we operate and the impact we have.

We encourage patient and public participation in the NHS, treat them respectfully and put their interests first. We empower and support clinical leaders at every level of the NHS through clinical commissioning groups (CCGs), networks and senates, within NHS England itself and in providers of NHS services. We help them to make genuinely informed decisions, spend the taxpayers' money wisely and provide high quality services.

In the new system, 211 CCGs hold providers of NHS services to account through contracts, and CCGs are accountable to NHS England for how well they meet their population's needs. NHS England funds, oversees and supports the commissioning system at a national level. We are accountable to the Secretary of State for Health for the performance of our functions and the delivery of the Mandate, which sets out the government's objectives for the NHS. Overall, NHS England has a budget of £95.6 billion to deliver the mandate. Within this overall funding, we have allocated £65.6 billion to local health economy commissioners: that is, CCGs and local authorities.

Although GPs and other local health professionals commission most NHS services, some services are not appropriate to be commissioned locally. At NHS England we commission services which are more appropriate to commission at a national level. These include specialised services (such as those for rare diseases), offender healthcare and some services for members of the armed forces. NHS England is also responsible for commissioning primary care, including GP services.

NHS England works nationally with a single operating model, employing approximately 6,000 staff.

In addition to commissioning services itself, NHS England also has responsibility for ensuring the overall system of commissioning NHS funded services works well. This involves working on plans to improve commissioning for specific conditions (e.g. dementia) or patient groups (e.g. children's services). NHS England provides information and resources for CCGs, and holds them to account for how they carry out their commissioning activities and improve the health care outcomes that matter locally. NHS England also looks at how well CCGs operate within their budgets, engage with their local populations, and deliver the pledges, rights and values in the NHS Constitution.

The NHS, like many international healthcare systems, is under increased pressure from the demands of an ageing population and an increase in the number of people with long term conditions. If the NHS is to preserve the values that underpin a universal health service free at the point of use and ensure NHS England's vision of 'high quality care for all, now and for future generations' then there need to be fundamental changes to how we deliver and use health and social care services.

To get the best outcomes and experience for patients we need commissioners who secure quality today and lead the transformation of services for tomorrow. This means clinically-led local commissioning and professional, high quality commissioning support. Lean and patient focused CCGs can draw on evidence-based practice to deliver services that offer the best outcomes for patients, adding value through effective local clinical leadership and engagement.

At NHS England, we practice what we preach. By working collaboratively and building coalitions with partners everywhere we can achieve great things together and deliver the best patient service not only in England but in the world.

FACTSHEET

About NHS England

NHS England is the Executive Non-Departmental Public Body responsible for overseeing the running of the NHS. It aims to improve the health of people in England by working in an open, evidence-based and inclusive fashion, keeping patients at the heart of everything they do.

NHS England's key functions include:

- Supporting clinical commissioning groups and the wider commissioning structures.
- Direct commissioning of specialised services and primary care services.
- Supporting the delivery of the targets outlined in the Government's Mandate to NHS England and the NHS Outcomes Framework.
- Supporting emergency and resilience preparations to deal with urgent and unexpected challenges
- Building partnerships between NHS, voluntary and private providers of care to improve quality for patients.
- Providing long-term, strategic leadership for the NHS.



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MONITOR

David Bennett, Chief Executive, Monitor

Monitor has changed substantially since the NHS reforms were introduced. When we were set up in 2004, we had a narrow remit overseeing NHS foundation trusts. Today we are a health services regulator with wide and varied powers affecting the whole NHS landscape and with a new primary duty to patients. We are responsible for the economic regulatory aspects of the NHS, such as competition and cooperation, and the payment system. We also issue the new licence which, from 2014, all organisations providing NHS-funded services must have.

We can step in at individual trusts where we have concerns about their governance or financial sustainability, and we are also involved in their clinical sustainability. We work particularly closely with the Care Quality Commission, the quality and safety regulator, and its Chief Inspector of Hospitals. When they establish that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed. When the problem is really serious we send in external administrators to ensure the continuity of services for local populations.

We describe our aim as “making the health sector work for patients”. We know the NHS needs to change to meet the challenges of the future and that, as the sector regulator, Monitor must facilitate that change. This means we encourage new ways of delivering care and use the tools we have, such as pricing incentives, to encourage innovation.

Our aim is to be pragmatic and flexible in applying rules. We are not pre-disposed to any particular solution to the challenges facing the NHS; instead our decisions and actions are based on the available evidence. Where relevant evidence is scarce, we will commission research to establish the facts.

What matters to us is that all our work helps to improve the quality of services so they are clinically effective, safe and provide a positive experience for everyone who uses them. In all our decisions, we are guided by one simple principle: we will do whatever is ultimately in the best interests of patients.

In the coming year, we will support change among providers and commissioners of NHS care to ensure a sustainable, high quality NHS. We will adapt our models for assessing applicant foundation trusts to evaluate applicants that have not long operated in their current configurations. We will also support the leadership and governance of NHS Trusts in making changes in what is likely to remain a tough financial setting.

To reassure people that they will continue to receive essential services, we must be able to spot where organisations are getting into serious difficulties that they cannot fix themselves, step in quickly and ensure essential services are protected. We will concentrate our financial monitoring of providers on identifying early signs of increasing risk.

Through our new role in developing the national tariff for NHS-funded care, we intend to bring stability to the whole NHS pricing and payment system and ensure that it incentivises improvements in the quality and efficiency of care. We will work for the benefit of patients by making sure that procurement, choice and competition play an appropriate role in bringing about necessary change in the sector.

We recognise that NHS care is the result of interactions between numerous varied and complex organisations. So we will proceed with care as we seek to help them improve. This is particularly relevant to the better integration of care which is now rightly seen as significant to the future of the NHS.

FACTSHEET

About Monitor

Monitor is the sector regulator for health services in England. Their job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Monitor exercises a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences they issue to NHS-funded providers.



Dr David Bennett
Chief Executive

Monitor's key functions include:

- Making sure public sector providers are well led so that they can provide high quality care to local communities.
- Making sure essential NHS services continue if a provider gets into difficulty.
- Making sure the NHS payment system rewards quality and efficiency.
- Making sure choice and competition operate in the best interests of patients.

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CARE QUALITY COMMISSION

David Prior, Chair, Care Quality Commission

Politics and healthcare are inextricably intertwined and so long as the NHS and adult social care are substantially taxpayer funded, they will remain so. This must be right; there has to be democratic accountability for taxpayers' money.

But there must also be independent inspection of health and social care. There can be no reliance on the market because it is too imperfect; and a failure in care can result in death or a ruined life neither of which can be remedied. We have seen at Winterbourne View, Morecambe Bay and Mid Staffordshire Hospitals the consequences of a catastrophic failure in care quality. There is no doubt in my mind, that these examples are the tip of an iceberg. In domiciliary care, in residential care homes, in primary care, in mental health settings and in acute hospitals far too many people are suffering poor quality and sometimes dangerous care.

This is why we need an effective, independent regulator. We have set out, in the aftermath of the Francis Report, a new approach to the way we inspect hospitals and we have learned a great deal from Sir Bruce Keogh's inspections of the 14 hospitals with above expected mortality levels. We will be asking five key questions about services:

Are they Caring?

Are they Safe?

Are they Effective?

Are they Responsive?

Are they Well Led?

Our inspection teams will comprise experts including senior and junior clinicians, patients and trained inspectors. They will use their collective judgement in making their assessment; we are determined not to fall into the compliance trap of ticking the box and missing the point. Our judgement will be informed by both hard intelligence, for example mortality and hospital acquired infection rates, and soft intelligence, for example staff and patient surveys.

Our role is to hold up a mirror and to shine a light into some of the dark places in the health and social care system. We will expose unacceptable variations in care quality and give a rating for all the organisations we inspect. We are unequivocally on the side of patients, and those hospitals, care homes and other providers who deliver a great service. It is only by being transparent and honest that we can restore public confidence in a sector in which there is so much good and excellent care.

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About the Care Quality Commission

The Care Quality Commission (CQC) is the quality and safety regulator for health and adult social care in England. The CQC is responsible for identifying Trusts where quality standards are not being met. Responsibility for intervening in failing trusts lies with Monitor and the Trust Development Authority, not the CQC.

The CQC's key functions include:

- Setting the fundamental quality standards expected of all service providers.
- Inspecting and monitoring service providers to ensure they meet the standards set.
- Maintaining the register of approved service providers across the NHS, private and voluntary sectors.
- Protecting the rights of people detained under the Mental Health Act
- Working with Monitor, NHS England, and the Trust Development Authority to develop recovery plans for failing providers.



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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Sir Andrew Dillon, Chief Executive, NICE

It may seem that in contrast with the major changes happening elsewhere in health and social care, a slightly different name and a new status are the only changes to the National Institute for Health and Care Excellence (NICE) as a result of the Government's reforms. It's true that to many NICE has seemed the one constant fixture in the system, but these changes reflect a significant departure for us as we take on new responsibilities that support a more integrated and joined up health and social care service.

Our new name, the National Institute for Health and Care Excellence reflects our new responsibilities in producing guidance and quality standards for, and with, the social care community. Our new status, as a non-departmental public body (NDPB) puts us on a surer legislative footing for the future and consolidates our permanence in the health and social care landscape.

Our aim in social care is to apply the same rigour and evidence-based processes that we are renowned for in our clinical and public health work, to improve the long term and on-going social care and support for adults, children and young people.

The Health and Social Act 2012 requires NHS England and clinical commissioning groups to have due regard to our quality standards as they fulfil their duties. NICE quality standards provide a clear description of what high-quality health and social care should look like. Commissioners and providers can use them to design and deliver effective care and, more importantly, patients and service users can use them to find out what sort of care they should be getting.

Another change in the Act has been the transfer of public health to local government. Coupled with our move into social care, this means our guidance and standards can be used by councillors and those working in local authorities to improve the health and wellbeing of the communities they represent and work for, and it can also inform the work town halls are leading on with the £3.8bn integrated care fund, announced in the recent spending review.

We are working with partners in social care and in local government to develop new products and have already published social care quality standards for dementia and looked after children. In the months ahead we will publish guidance for care homes and home-based care and last year we launched our new local government briefings for town halls to plan how they will improve health and wellbeing of the people they serve.

The changes outlined here, together with other national initiatives we are involved in around innovation, value-based pricing, new medical technologies and the benefits of evidence-based policy, mark a new chapter in the story of NICE. Evidence combined with a rigorous and transparent approach continues to be at the heart of everything we do.

We and our partners featured in this collection all have a vital role to play in ensuring that the people who work in frontline health and social care can be confident that they are delivering high quality services and that their patients, service users and public are receiving safe, effective care that is good value for money.

FACTSHEET

About NICE

The National Institute for Health and Care Excellence (NICE) provides guidance on best practice in health, social care and public health, and assesses the clinical and cost effectiveness of specific drugs and interventions.

NICE's key functions include:

- Producing evidence-based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for providers and commissioners of health, public health and social care services
- Assessing the clinical and cost effectiveness of health technologies, such as new pharmaceutical and biopharmaceutical products, new procedures, and new devices.
- Providing recommendations for indicators to be included in the Quality Outcomes Framework incentive scheme for GPs.
- Developing measurements and indicators for Clinical Commissioning Group performance and outcomes.
- Providing access to reliable information and guidance on best practice for health and care professionals.



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HEALTHWATCH ENGLAND

Dr Katherine Rake, OBE Chief Executive, Healthwatch England

The Healthwatch network was born at a time of great change in health and social care. The Health and Social Care Act 2012, and the Care Bill currently passing through Parliament, aim to put those who use services at the centre of a modern and responsive new system. This is a powerful ambition and one of the reasons we were created.

Health and social care is important to us all. At some point, everyone needs treatment or care and millions of us use services every day. Whether it's going to the doctor, hospital, pharmacist, or receiving care and support in our own homes, we all need high quality services that help us to manage our health and improve our independence.

But for too long the public's experiences and engagement with services have been marginalised within the system. This led to the terrible events at Mid Staffs, Morecambe Bay and Winterbourne View. Healthwatch is part of the solution. We are the consumer champion in health and social care, and we are here to ensure that people's experience, opinions and ideas shape the way that local services are designed, commissioned, delivered and scrutinised, and the way that national policy is made. This is why we were given statutory powers to ensure the voices of people using services and the wider public are heard in national decision making.

As the consumer champion we must always start with people and their experience. We know the public are proud of the NHS and because they know our doctors and nurses are stretched they are reluctant to criticise health and social care services. But people want a change; they want services that are more tailored around their lives and more responsive to their needs.

We believe it is time to do things differently. The health and social care system should be clear with people about their rights and actively involve them in decisions that affect their lives and those of people in their community.

This will be a challenge, as the public and health & social care professionals alike are still trying to navigate the complex new structures in health and social care. Healthwatch will play an important role in showing a path through the maze of the NHS as well as speaking out for consumer interest to make sure no one is left behind or falls through the gaps.

It is early days for Healthwatch England and our local colleagues, but we are passionate about championing people's experience and ambitious about the power of people's collective experience to shape services. Now is the time to stop talking about change and take action to revolutionise health and social care. Over the next twelve months, the Healthwatch network will not only be at the heart of that revolution but help ensure that those commissioning and delivering services put the public voice at the heart of decision making now and for the future.

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About Healthwatch England

Healthwatch England (HWE) is the national champion for consumers and users of health and social care services in England. Their remit covers children, young people and adults.

It is a national body, with full independence to report on the issues and trends it believes are relevant and important to consumers. They will develop oversight of the national issues and trends in healthcare by gathering evidence from:

- The views and experiences of people who use services
- The evidence gathered by local Healthwatch
- The evidence from providers, commissioners and regulators across the health and social care system, as well as from charities and those who support vulnerable people

HWE will use this evidence to influence national policy and provide advice to Monitor, NHS England, the Secretary of State, English local authorities and the Care Quality Commission. The Secretary of State for Health has a duty to consult with HWE in producing the mandate for NHS England.

By connecting national trends and issues with the views and experiences of local communities, Healthwatch England and local Healthwatch will together give children, young people and adults who use health and social care services a powerful voice locally and nationally.



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HEALTH EDUCATION ENGLAND

Professor Ian Cumming, Chief Executive, Health Education England

Health Education England (HEE) exists for one reason only: to help improve the quality of care patients receive. To do this we spend nearly £5bn a year on undergraduate and postgraduate education and training to ensure that the whole health and healthcare sector in England, including the NHS, the independent sector and public health have the most highly qualified new professionals in the world.

We currently have around 160,000 students at various stages of their education, from junior doctors in our hospitals (we pay their salaries) to the first tranche of potential student nurses joining our innovative pre-degree care experience programme in response to the Francis Inquiry.

HEE is the product of the idea that the education and training of the health and healthcare workforce should be planned and delivered as close to the patient as possible, whilst making best use of public money by ensuring that patients have access to the right people with the right skills, attitudes and behaviours in the right place at the right time in the right numbers across the whole country.

For the first time all responsibility for education and training is in one organisation, a single organisation on the national and international stage led by providers (the organisations who actually employ the students when they graduate) locally through our Local Education and Training Boards (LETBs). Every corner of England is covered by a LETB, which are committees of the HEE Board, ensuring that local decisions, local issues and local conditions are as core to commissioning student numbers as government priorities and a national overview are.

As I write, at the beginning of September, we are already making a difference to how we educate and train which will make a difference to the quality of care for patients.

- From this September every university in England will, for the first time, interview all prospective medical students to ensure that we are recruiting for the right values as well as academic excellence;
- We are piloting pre-degree care experience to give potential nurse students experience of working as a healthcare assistant to test their values and behaviours as well as helping them make the right choices before we spend tax-payer's money putting them through university;
- We are leading work on how to ensure we have the right number of GPs in the future, and changing the way they are educated, as well as piloting a number of ideas at making a career in Emergency Medicine more attractive, and therefore, helping to solve staffing problems in A&Es;
- We are working towards launching a programme designed to attract school children into health and healthcare across the full range of clinical specialities.

This, and much more, can be found in the Mandate to HEE from the Government that was published in July this year. From recruiting the best and brightest from our schools; to reforming medical and non-medical education programmes to include quality improvement science; to working with NHS Employers to ensure that each and every job in the NHS - from Chief Executive to porter - carries a values-based assessment of candidates, we are making a difference to patients. We are taking a lead role in delivering on the Francis Inquiry recommendations now and planning for an NHS into and beyond its 100th year.

I am confident that HEE will be a success story, delivering higher quality outcomes for patients whilst also making the best possible use of taxpayer's money.

FACTSHEET

About Health Education England

Health Education England (HEE) is the national NHS body providing system-wide leadership and oversight of workforce planning, education and training.

HEE is responsible for improving the quality of health outcomes for the people of England, through recruiting for values and behaviours, and - with providers - delivering the best training, education and lifelong learning opportunities for the health and healthcare workforce.

The Health Education England's key responsibilities include:

Providing national leadership in planning and developing the healthcare and public health workforce;

- Promoting high quality education and training that is responsive to the changing needs of patients and communities;
- Ensuring security of supply in the health and public health workforce;
- Holding Local Education and Training Boards to account for local delivery and leadership of workforce planning, education commissioning and provision;
- Allocating and accounting for NHS education and training resources and the outcomes achieved.



Sir Keith Pearson
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TRUST DEVELOPMENT AUTHORITY

David Flory, Chief Executive, NHS Trust Development Authority

2013 is a significant year for the NHS. Healthcare structures have changed with new national and local bodies now in place; the publication of the report into the serious failings at Mid-Staffordshire NHS Foundation Trust has rightly brought both the quality of care the NHS provides and the accountability for its delivery into a sharper focus; and the economic climate we all operate in means delivering value for money is more important than ever before.

Within this challenging environment it is crucial that there is a common focus. In creating the NHS Trust Development Authority, we asked senior leaders from across the NHS what that common focus should be, in order to help us design how we would operate. One clear theme emerged from those discussions; the overwhelming desire to create an environment where NHS Trusts can deliver high quality, sustainable services for the patients and communities they serve.

The NHS Trust Development Authority is here to do precisely that. To support all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow.

The landscape we inherited is varied on every level: the range of services NHS Trusts provide covers the entire spectrum of healthcare from ambulance services through to community services; the size of organisation varies from very small providers through to some of the largest providers in the NHS, and therefore each Trust has a set of unique challenges.

Due to this variation, we recognise that there is not going to be a 'one size fits all' solution to the challenges Trusts face. Our goal is first and foremost to help each and every NHS Trust to improve the services they provide for their patients.

This support can range from helping NHS Trusts to implement innovative solutions to the wide-spread pressure they have faced in their A&E departments; to working directly with the five Trusts named in the Keogh Review to make the necessary improvements to the care they provide.

It is by improving the quality of services all NHS Trusts offer, and ensuring that offer is sustainable for future generations, that they will achieve Foundation Trust status. Ultimately, the environment that we intend to create will help to deliver the government's stated aim of achieving an all Foundation Trust provider sector in the future.

We do not underestimate the size of this task. It is clear that along this journey we will need to ensure that prompt action is taken when concerns about quality in NHS Trusts are raised. We take pride, therefore, in working closely with other national bodies to make sure that patients see real improvement where it is most needed.

Our task is also a hugely exciting prospect. For the first time there is an organisation with the sole responsibility for the NHS Trust sector. This allows us to work together with each NHS Trust to improve services for patients. We can share what is working well across the length and breadth of the country.

We can embed a patient-centred culture of care, compassion and improvement in our organisation and work with the leadership teams in all NHS Trusts to ensure they do the same. We can create the systems and structures to make sure these improvements can be sustained for future generations. And we won't lose sight of the most important issue of all; improving the standard of NHS care available for patients.

FACTSHEET

About the Trust Development Authority

The Trust Development Authority (TDA) is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers. This includes 103 NHS Trusts, providing around £30bn of NHS funded care each year.

The TDA will oversee the performance management of these NHS Trusts, ensuring they provide high quality sustainable services, and offering guidance and support in their transition to Foundation Trust status.

The Trust Development Authority's key functions include:

- Monitoring the performance of NHS Trusts, and providing support to help them improve the quality and sustainability of their services
- Assurance of clinical quality, governance and risk in NHS Trusts
- Supporting the transition of NHS Trusts to Foundation Trust status
- Overseeing non-executive appointments to NHS Trusts
- Working with Monitor to oversee the intervention regime for failing NHS Trust and to ensure a continuous, high quality service for patients



Sir Peter Carr
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PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

Dame Julie Mellor, Ombudsman

NHS reform and the Parliamentary and Health Service Ombudsman

With many new NHS organisations coming into being with the introduction of the Health and Social Care Act, we have a vital role to play in ensuring that these new organisations learn from mistakes they may make in order to improve the services they provide to everyone.

For the majority of people, their experience of care within the NHS is very positive and greatly valued. As we've seen recently however, when things go wrong, how concerns and complaints are dealt with determines whether patient or carer confidence in the health service is restored. In the worst cases we are seeing a "toxic cocktail" within some hospitals, where patients and their carers' reluctance to complain is combined with a culture of defensiveness and a failure to listen to feedback.

We have conducted research into how to address this toxic cocktail, making recommendations to produce a step change in complaint handling from the ward to the Board. This includes supporting early intervention on the ward to ensure concerns are addressed before they become formal complaints.

This could be achieved by patients and carers being given the name of a senior person to turn to with their concern or questions, who has the authority to act swiftly to put things right.

Information and support for the public about how to raise a complaint should also be available 24/7, with good advocacy services accessible locally to support people when complaining.

It is also critically important that NHS hospital boards take responsibility for shifting the culture within their organisations to one that is open to feedback and learning, with a focus on remedy not retribution. It should therefore be a priority for boards to regularly find out what people liked within their trust, and what their concerns were.

Improving and learning

We are committed to supporting the NHS to learn from mistakes by continuing to improve the service we provide. Our strategic priorities set out our plan to ensure we achieve this vision. These priorities are:

1. To make it easier for people to find and use our service

This includes raising awareness of our work for everyone and helping people who find it hard to complain to contact us.

2. To help more people by investigating more complaints and to provide an excellent service for our customers

This includes using different ways to investigate and resolve different types of complaint and setting high standards for the service we provide.

3. To work with others to use what we learn from complaints to help them make public services better

This includes sharing information about what went wrong with different organisations so that mistakes can be avoided in the future. We will help Parliament find out the reasons for mistakes and how services can be improved.

4. To lead the way to make the complaints system better

This includes working with Parliament to help make it easier for people to complain. We will also share information about the way in which public services respond to complaints to help them do it better.

5. To develop our organisation so that it delivers these aims efficiently and effectively

FACTSHEET

About Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) is the final stage in the NHS complaints process in England. The Ombudsman listens to individual complaints and, where things have gone wrong, helps to get them put right. Of the 162,000 complaints to the NHS in 2012-13, 15,944 came to the Ombudsman either because complainants were dissatisfied with the local outcome or because they needed help to understand the complaints process.

The Ombudsman's key responsibilities include:

- Assisting patients and the public to understand the complaints process
- Investigate complaints where individuals have been treated unfairly or have received poor service from the NHS in England, or other public organisations or government departments.
- Producing reports on their findings to recommend how mistakes can be put right.
- Sharing information about large or repeated incidents with regulators to help them do their job.
- Helping MPs in their role of scrutinising services.



Dame Julie Mellor
Ombudsman



Helen Hughes
Chief Operating Officer

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PUBLIC HEALTH ENGLAND

Duncan Selbie, Chief Executive, Public Health England

Public Health England's (PHE) mission is to protect and improve the nation's health and to address inequalities. PHE is an operationally autonomous executive agency of the Department of Health.

We aim to work transparently, proactively providing national and local government, the NHS, MPs, industry, public health professionals and the public with evidence-based professional, scientific and delivery expertise and advice. PHE ensures there are effective arrangements in place nationally and locally for preparing, planning and responding to health protection concerns and emergencies, including the future impact of climate change. PHE provides specialist health protection, epidemiology and microbiology services across England.

Improvement in the public's health has to be led from within communities, rather than directed centrally. This is why every upper tier and unitary local authority now has a legal duty to improve the public's health. PHE supports local authorities, and through them clinical commissioning groups, by providing evidence and knowledge on local health needs, alongside practical and professional advice on what to do to improve health, and by taking action nationally where it makes sense to do so. PHE in turn is the public health adviser to NHS England.

For years we have all focused more on treatment and illness than on prevention and resilience. That focus has often occurred when illness is already well advanced.

This is not where we need to be. We need to focus much more on prevention and early intervention, helping people to help themselves and their communities to be as healthy as they can be and for as long as possible, and intervening before conditions become unmanageable. We all need to take responsibility for our own health and wellbeing, but for many it is more difficult than it should be.

We know the most significant factors that lead to poor health: smoking; high blood pressure; obesity; poor diet; lack of exercise; and excessive alcohol consumption. Beyond these the wider determinants of health (poor early childhood experience, poor education, lack of work and poor environments) that lie behind the marked health inequalities between the richest and the poorest.

It is at least as important to tackle major non-medical causes of ill health, like social isolation, homelessness and worklessness.

Our role is to understand the causes and consequences of poor health; be clear about what works; and encourage the adoption of effective interventions at scale and pace. This is not about spending more money, it is about making sure we get the best impact for the money already spent – focusing on prevention and early intervention to avoid the high financial and societal cost of crises and failure.

Local action will drive sustainable change in the public's health, but we are committed to taking action on a national scale where it makes sense, and when it is needed. We will focus our energies on five priorities:

1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol
2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency
3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics
4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme
5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives

To underpin these, we will promote the development of place-based public health systems and seek to develop our own capacity and capability to provide the professional, scientific and delivery expertise to support our partners and improve the nation's health.

FACTSHEET

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address health inequalities.

Public Health England is responsible for:

- Improving the public's health by encouraging discussions, providing advice and supporting action across local and national government, the NHS, and other public bodies.
- Supporting the public so they can protect and improve their own health.
- Protecting the nation's health through the national health protection service and preparing for public health emergencies.
- Sharing information and expertise with local authorities, industry and the NHS, to help them make improvements in the public's health.
- Researching, collecting and analysing data to improve understanding of health and come up with answers to public health challenges.
- Reporting on improvements in the public's health so everyone can understand the challenge and the next steps required.
- Helping local authorities and the NHS to develop the public health system and its specialist workforce.



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Public Health
England

CLINICAL COMMISSIONING GROUPS

About CCGs:

Clinical commissioning groups (CCGs) are one of the main components of the new health and social care system. In April 2013, 211 clinically led CCGs replaced primary care trusts as the commissioners of most services funded by the National Health Service (NHS) in England, and now control around two-thirds of the NHS budget. They are responsible for deciding what range of services are needed for their local population and making sure that the specifications for those services will deliver what is needed in terms of quality and cost.

Contact:

Most clinical commissioning groups should provide contact details on the internet. Alternatively, NHS England should be able to put you in touch with your local CCG.

Dr Amit Bhargava, NHS Crawley CCG Chair

Commissioners do three things annually. We plan, we buy and then we monitor. We are currently in the planning phase for next year's contracts.

Clinical Commissioning Groups (CCGs) are building on the work done by Primary Care Trusts but focusing heavily on localism, clinical leadership (management enabled) and patient/population centeredness.

The Crawley Clinical Commissioning Group is a local membership organisation. Our first loyalty is to our 125K population. We have been clear from the outset that the £142.4 million commissioning pot belongs to the people of Crawley, with the CCG as expert stewards working in partnerships to get maximum benefit from this resource. Through joint responsibility with the public comes full involvement in co-production and co-ownership. We are working together to define and promote good health citizenship.

The patient and population representatives supported by our organisational structure are integral in all decisions we make, they have access to all CCG data and also have equity of power with the clinicians.

The key functions of a Clinical Commissioning Group include:

- Buying services, and working closely with NHS England area teams to improve services
- Responsible for monitoring the success of commissioned services.
- Working with local partners across the NHS to design services which meet the local population's needs
- Working with Health and Wellbeing Boards to assess and provide services which meet the needs of the local community
- Providing access to information and materials to improve public health outcomes

What are the principles driving our CCG?

- Culture: The culture of our organisation is 'Transformational'. Reflection on the Office of Business Responsibility report predicting the next 50 years for the NHS highlights the demographic changes, shifting needs of the population and changes in the partner and stakeholder organisation. CCGs have to be transformational to deliver their purpose. Business as usual or incremental change is not a realist option. How we transform and the speed is dependent on our legacies and stakeholders.
- Clarity of purpose: The vision statement created by Crawley CCG members is "improving the health and wellbeing of you and your community". Our organisation is clear that the clinician and supporting organisations, will not only treat the patient and customise their care, but will also think about the whole population and the impact of individual decisions. The purpose is for the CCG to deliver better care from prevention to intervention. The narrative that will support the delivery of this purpose also has to be clear and compelling to our partners. How we deliver this will change with circumstances, partners and issues, but the purpose is clear and constant.

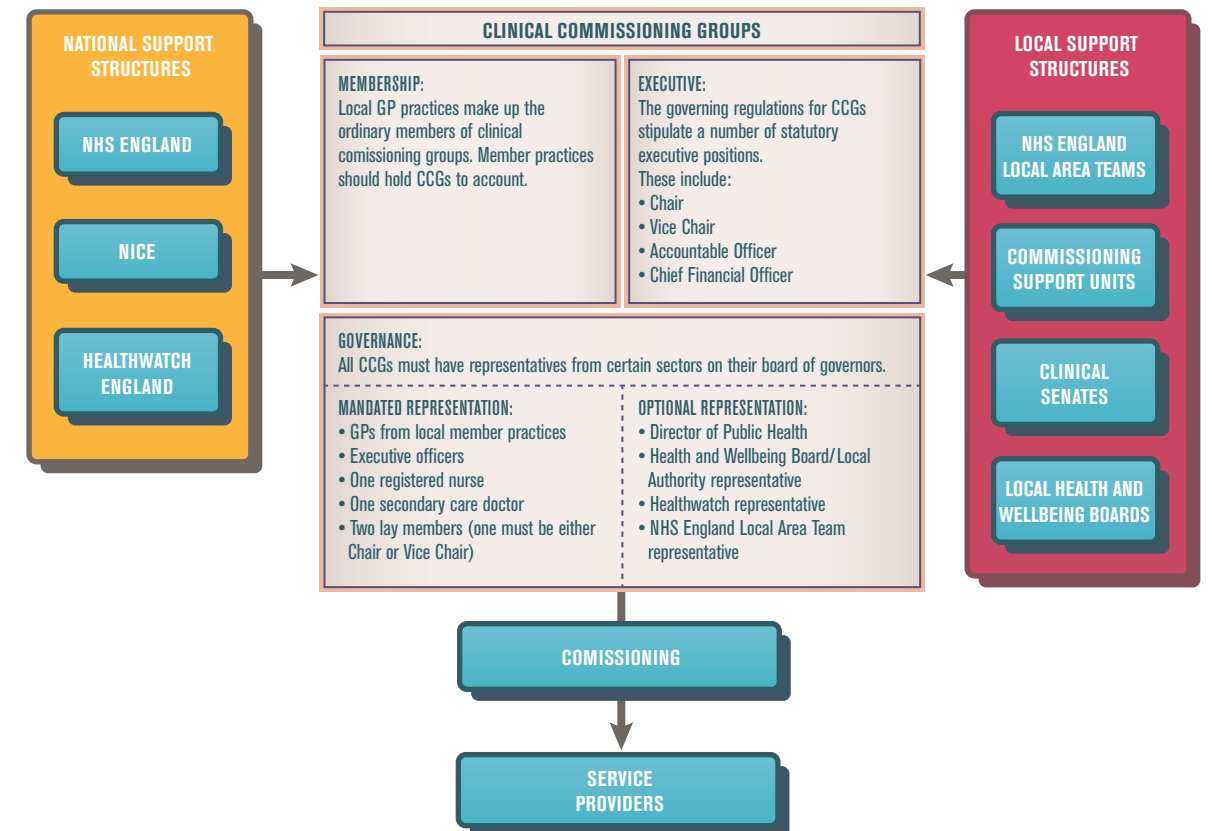
- Social value and impact: Whatever services we commission must have a positive impact that adds value to the person/patient with clinical improvement, but should also have a positive effect in their social and work environment. An example of social value could be – 'is the orthopaedic surgeon in the hip replacement business or the dog walking business? The patient wished to be pain free from their hip to be able to walk their dog, whereas the surgeon is good at putting in brand new hips. If the patient can take their dog for a walk painlessly then the operation had social value.' Measuring social value and impact is key to measuring our success along with building physical and emotional resilience in our communities.
- Collective impact: With the complexity and seriousness of the future challenges, there is no way any one organisation can find all the solutions. There is no single silver bullet. Collective impact only works when there is a commitment of local important players with a shared fate, to find a solution to the population-based problem in a systematic way, using the five principles of collective impact.

Our local transformation board has been having monthly meetings for three years, it brings together commissioners, providers (including social care and third sector) and patients. Applying the five principles of collective impact we have an agreed common agenda, one 'version of the truth' and measurement, partners working together to have mutually reinforcing activities, an agreed communications plan and a single programme management office. This is having measureable incremental improvement.

As local Clinical Commissioning Organisations the first few months have been illuminating and mainly positive. There is much to do and the country, its politicians and its policy makers have to work together to create the environment in which good industrious people can do the right things. The rhetoric has to be followed by principled actions. That is the challenge.

Dr Amit Bhargava is Chair of NHS Crawley CCG and a member of NHS Clinical Commissioners leadership group.

Clinical Commissioning Groups in context:



HEALTH AND WELLBEING BOARDS

About Health and Wellbeing Boards:

Health and Wellbeing Boards have been established as a result of the Health and Social Care Act 2012. In England there are 152 Health and Wellbeing Boards functioning as statutory committees within local authorities. They exist to bring together local health and care commissioners and patient representatives in order to plan and develop a better integrated approach to the delivery of local services. Boards provide the strategic framework that health and social care commissioners will use to guide their future policy, service planning and investment.

Contact:

To contact your local Health and Wellbeing Board you should speak to your local authority.

The key functions of a Health and Wellbeing Board include:

- Identifying the health and wellbeing needs of the local population through the Joint Strategic Needs Assessment (JSNA).
- Developing a Joint Health and Wellbeing Strategy (JHWS) to outline how local needs will be met, and how improvements will be achieved. CCGs must take regard of the JHWS when commissioning services.
- Contributing to the performance management of CCGs through NHS England's annual assessment of commissioning groups' performance.
- Investigating ways to pool budgets and resources through joint commissioning and integration of local services.

Health and Wellbeing Boards in context:



Councillor Teresa O'Neill, Leader Bexley Council

Recent health reforms have placed Health and Wellbeing boards at the heart of the new local health infrastructure. The boards bring together public health and local government with a membership comprised of locally elected councillors, commissioners, clinical commissioning groups, directors of public health, adults and children's services, local Healthwatch (to represent the public) and NHS colleagues, all within one statutory body.

These Boards bring a new and important democratic legitimacy to decisions about the commissioning and delivery of local health and social care services, through the involvement of elected representatives and patient representatives (via local Healthwatch). In Bexley we hold our Health and Wellbeing Board meetings in public, providing a forum for challenge, discussion, and the involvement of our residents.

The creation of the Bexley Board has provided some exciting opportunities to use our collective experience and expertise to shape local services and do things differently. The Board has taken a lead role locally in overseeing proposals to reconfigure hospitals in south east London, so that Bexley's Queen Mary's Hospital continues to deliver services that residents value and which meet local health needs. It has also overseen the development of integrated care pathways for older people's services, which are critical to reducing demand in our acute hospitals whilst allowing residents to receive good quality treatment in the community.

Joint commissioning and budget sharing arrangements are also moving forward under the auspices of the Board.

These developments reflect our Board's joint strategic aims, which are to tackle the borough's health priorities - childhood and adult obesity, tobacco control, dementia and diabetes – whilst rebalancing our local health

economy, establishing Queen Mary's as a thriving local hospital, improving primary care, and focusing on prevention of ill health.

There is a recognition that over the next few years public services in general will continue to change way beyond the recent health reconfigurations. Health and Wellbeing boards will be central to responding to, and delivering those changes locally.

The acid test of the success of any local board will be its ability delivering tangible changes at the frontline that local residents value, whilst at the same time making significant efficiency savings across the public sector. Getting the balance right in terms of local health and wellbeing priorities, national demands and managing resident's expectations will be crucial.

Councillor Teresa O'Neill is leader of Bexley Council and Chair of Bexley Health and Wellbeing Board. She is also Executive Member for Health on London Councils.

THE ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES

About ADASS

The Association of Directors of Adult Social Services (ADASS) represents all the directors of adult social services in England as well as senior managers who report to them. Members are responsible for providing or commissioning, through the activities of their departments, the wellbeing, protection and care of hundreds of thousands of elderly and disabled people, as well as for the promotion of wellbeing and protection wherever it is needed. There are around 1.5 million people employed directly and indirectly in adult social care - more than the total staff employed in the NHS.

Current issues in adult social care:

The adult social care sector currently faces major pressures due to reductions in funding and increasing demand. Over the five year period from 2007-08 to 2012-13 expenditure increased by 12 per cent in cash terms, but this was a decrease of 1 per cent in real terms ⁽¹⁾.

As the diagram on the opposite page shows, demand is projected to continue to increase based on current trends in population growth and ageing. The graph also shows the additional cost of the Dilnot proposals to cap the cost of social care for individuals.

Sandie Keene, President of ADASS

In Adult Social Care the *raison d'être* is supporting individuals to live independent, safe and fulfilled lives. The challenge for us all is to ensure that a changing economic and organisational climate does not inhibit enabling the most vulnerable people to live well and play their own part in contributing and shaping the society we live in.

Funding and legislation control virtually everything we do. The Care Bill offers a ground-breaking opportunity to clarify individuals' rights and entitlements, extend the reach of state support to carers and set a new, well-defined level for individual financial contributions for care.

The state's responsibilities towards supporting individuals' health and wellbeing are consolidated in new requirements for information and market-shaping, giving more support for those who will continue to fund their own care. The financial pressures to deliver this and the overarching concerns for improving quality in a low-wage sector are fundamental national issues of the day.

Finding a single key to unlock multiple doors into the NHS and social care is a challenge which has perplexed many – politicians, professionals and public alike. Successive reforms have made little difference to public access and routes in to the system. Far from providing a single key, the reforms have created the additional complexity of potential fragmentation of responsibilities and decision making, the acceleration of competition, and the inevitable turbulence of change as systems bed down.

However, what the latest reforms are achieving positively is decision-making closer to local level; GPs engaging with and leading commissioning, and the NHS and local government taking real, shared decisions about health priorities.

Whether change is helped or hindered by restructuring is a subject many will debate for years to come. Adult social care has been a partner in delivering services throughout many NHS restructures. Systems adapt and re-form and care continues to be delivered. However, these latest reforms present the best opportunity in years for community-based care delivery in partnership with primary, community and social care services finally to come together in a purposeful manner.

1. Personal Social Services: Expenditure and Unit Costs, England 2012-13, Provisional Release, Health and Social Care Information Centre, September 2013

Redesigning services around people and the communities in which they live, driven and informed by the people who use them, will be the necessary step to resolve the significant issues of those with long-term and multiple conditions. Addressing health inequalities through a stronger voice for public health in local government will hopefully begin to craft the single key we need. Regrettably, the key to unlocking the remaining barriers of changing financial flows and redesigning the interface between acute, secondary and social care is still hidden. We will need to find it before the system can truly move forward to address the 'Nicholson Challenge'.

The public, rightly, does not care about organisational design: people judge us by their experience. That, really, is the single measure which drives the current acceleration of service integration. This is supported by the belief (not yet substantially proven) that avoiding

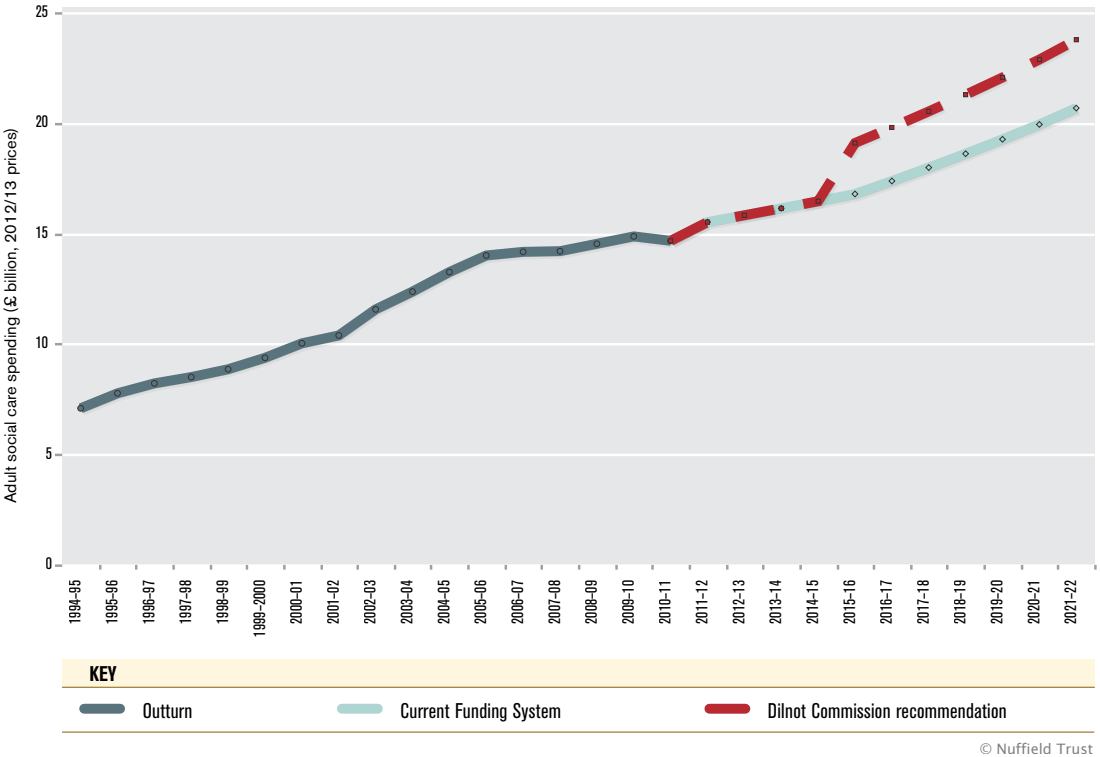
duplication, better joint information and financial planning, along with engaging individuals in their own decision making will make the differences we are looking for financially as well as qualitatively.

The reforms bring a renewed profile to the role of GPs and the importance of that first contact in times of crisis or ill health. By developing multi professional teams within and around primary care, a whole-person approach to improving health and wellbeing can be achieved. With 95 applicants for the no more than 15 authorities to be awarded Pioneer status for integration, there is clearly a large appetite in localities to develop new ways of working within the new architecture of health service reforms.

Let's hope that renewed system leadership will support the cultural change necessary to really make a difference this time!

Two social care funding scenarios for England (real terms)

Source: NHS Information Centre, Commission on Funding of Care and Support



Source: <http://www.nuffieldtrust.org.uk/data-and-charts/future-funding-scenarios-adult-social-care-England?gclid=CLSTtLGu6bkCFZMbtAodJkcACA> (Reproduced with permission from the Nuffield Trust)

REFLECTIONS: HAVE WE EMPOWERED PATIENTS?

Jeremy Taylor, Chief Executive of National Voices

In Chinese Premier Zhou Enlai's famous (if possibly misunderstood) judgement it was still too early to assess the implications of the French revolution. In similar vein, we will need to wait a while longer to judge the impact on patients of the Coalition Government's health reforms. But are they paving the way to a transformed experience for patients?

The 2010 White Paper *Equity and Excellence: Liberating the NHS* promised to put patients at the heart of the NHS. We would have more choice, control and information, there would be shared decision making with "no decision about me without me" and a powerful new "consumer" champion Healthwatch would stand up for our interests.

What would this mean in practice? It was never very clear. Were we primarily consumers of services, who would be empowered through greater choice of services and better information to inform those choices? Were we better seen as partners in care, making joint decisions with clinicians and managing our own health and health conditions? Where was the voice of patients in service design, if the rationale for putting GPs in charge of local commissioning was that they understood patients best? Why was Mr Lansley so down on targets when they addressed things that really mattered to patients like waiting times? And so on.

In truth, the White Paper lacked a radical and coherent vision for the role of patients, families and communities. Despite the rhetoric about "putting patients at the heart"; its starting point was the organisation of the service. Mr Lansley's primary goal was to "liberate" the NHS, not the patient.

Then things moved on. The politics of marketisation became the central political issue during the passage of the enabling legislation. The full scale of a reorganisation famously "visible from space" according to Sir David Nicholson, became clear. On the anvil of coalition politics the Lansley plan was reshaped. A new but ill-defined theme of integration was added in as a

counterweight to competition. Centralism and localism, managers and clinicians, the Secretary of State and the NHS chief executive stood in uncertain balance, and patients still floated ethereally at the heart.

Above all, reality intruded into the theoretical and context-free world of the White Paper. The central puzzle of the original Lansley plan was: What is the problem to which these reforms are meant to be a solution? In the real world there has been no shortage of problems. Money is short, more and more of us have complex care needs and disabilities; the pattern of care, with its overreliance on emergency interventions and hospitals, is no longer fit for purpose. The reorganisation itself has caused problems; draining money, time and attention from front-line care, unpicking long-standing arrangements and relationships, bleeding talent and causing confusion.

Hence we are seeing something approaching a crisis in the quality and availability of social care; people unable to get appointments with GPs; hospitals under severe pressure; problems with staff morale; families fighting to get a decent, joined up package of care for vulnerable relatives. In many ways the system is bearing up very well and sustaining many of the impressive improvements of recent years, but the signs of strain are everywhere.

Reality has also intruded in the shape of high profile failure. The scandals of disastrous care in Stafford, Winterbourne View and in other places have changed the national conversation about the NHS and the shadow of Robert Francis has loomed darkly over decision makers in health.

So the Government has had to adapt and evolve its policies. In this new phase of reform, two views of the patient have come into sharper relief. One is the patient as victim or potential victim of harm; a vulnerable person deserving of compassion and respect; needing to be heard louder; needing honesty and effective redress when things go wrong, and relying on a new breed of

high profile inspectors to enforce standards of care. The other is patient as customer – needing good information to make choices, including greater transparency about quality, and the opportunity to give feedback, rate their service, and have their experience valued. Both these views of the patient are important and the actions that flow from them could add value. But they are far from sufficient. In particular, the "protect and inspect" reflex is double-edged, putting the emphasis on the helplessness rather than power of the patient.

In 2013, as in 2010, our national decision makers still seem to lack a transformative vision of patient power. For inspiration, they could do worse than to look at the opening line of the NHS Constitution which stirringly reminds us that "the NHS belongs to the people". It is worth pondering what our systems of health and care would look like if the citizens genuinely acted as owners and shareholders of the enterprise.

We might see this, for example:

- Rapid access to a GP as standard, online, by phone, or face to face.
- Patients taking informed decisions about their care and treatment, with health professionals trained to coach and facilitate.
- Information and support for self-management as standard.
- All those with complex needs having a personal care plan, a named care coordinator, wrap-around out of hospital care and support for their family carers.
- Complaints handled swiftly and no fault compensation standard.
- Health organisations – providers, commissioners, clinical reference groups and so on – which are lay led and with a lay majority. Major investment in patient and lay leadership. Patients and service users playing a central role in service redesign.

- Voluntary organisations and communities playing a key role in designing and delivering care, including non-medical, practical and emotional support, and ensuring that the needs of all groups are met.
- Politicians and policy makers only launching new health initiatives after extensively road-testing them with front line practitioners, patients and patient leaders.

Ask yourself how close we are to these things happening and you have a measure of the distance between the rhetoric and the reality of "putting patients first".

In other areas of life the notion that ordinary citizens can be trusted to do important things is not controversial. We have had centuries of trial by jury; young men in their millions have been expected to fight and die for their country. But in the worlds of health and care ordinary citizens still struggle to be taken seriously and to take control. Instead of people power we have the baggy notions of patient and public "involvement" and "engagement". Commissioners' legal responsibilities to share power with communities go no further than the duty to inform and consult, activities which the theorist Sherry Arnstein, in her famous ladder of participation dismissed as tokenism.

The germs of a transformation can be seen in some of the reforms still being implemented and in things that are beyond the reforms, for example the development of online patient communities. But it's all taking too long. A fellow patient champion is fond of saying: "Haven't you heard of the patient revolution? Well, I'm a revolting patient". We need more revolting patients.

Jeremy Taylor is Chief Executive of National Voices, a coalition of health and social care charities in England.

REFLECTIONS: THE LONG TERM FINANCIAL CHALLENGES FACING THE NHS

Professor John Appleby, Chief Economist at the King's Fund

If the next 50 years follow the trajectory of the past half century, then the United Kingdom could be spending nearly one-fifth of its entire wealth on the public provision of health and social care.

The Office of Budget Responsibility's 2012 projections for health care suggest public spending could increase from around 7% now to nearly 17% in 2062...and long term care could increase from around 1.3% to 2.5%.

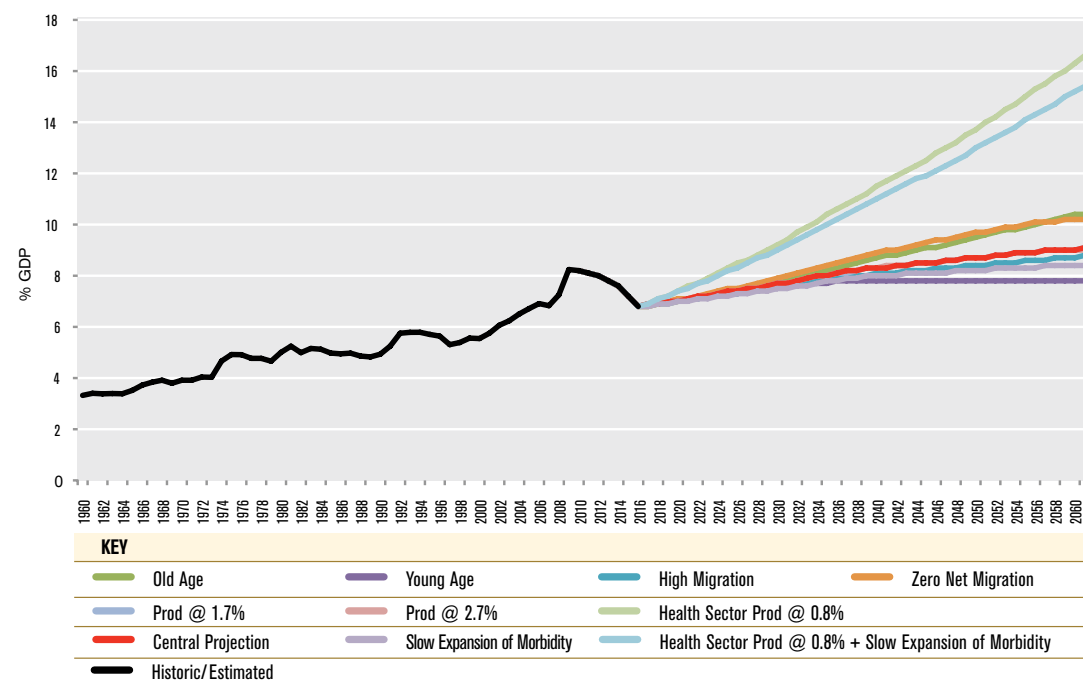
Together this is equivalent to one pound in every five in the economy - around double what we spend now and just a little bit more than the US spends now, just on health care.

This could be seen as a burden. But higher spending on health and social care is not solely a financial debit.

It is also a credit: higher spending would improve the population's health, well-being and quality of life. It would also have wider positive impacts on economic activity and productivity, too.

Moreover, spending nearly one-fifth of the United Kingdom's entire GDP on health and social care over the next 50 years could be affordable - and would allow increased real spending on all other areas of the economy - if projections for a trebling in real GDP are achieved. Clearly, this would not be the case if growth is more sluggish. However, all other things being

Figure 1: Long term health spending projections 2016/7 to 2061/62



Source: OBR (2012) Fiscal Sustainability Report. TSO, London <http://budgetresponsibility.org.uk/wordpress/docs/FSR2012WEB.pdf>

equal, such spending would consume around half of all government revenues and, despite allowing an increase in the real level of spending, would mean reducing the proportion of government spending in non-health and social care areas from around 80 per cent in 2016 to around 50 per cent by 2061.

There are of course many uncertainties surrounding very long projections. Different analyses produce widely differing results. However, history - and not just in the UK - together with analysis of what drives health and social care spending suggests all the pressures are to spend more.

For example, the historic trends in most OECD countries are clear: In terms of what really drives increased spending, other research confirms that a wide range of factors include national income, user behaviour, technological progress and demographic change. But the key factors are income and technology. Demographic pressures such as an ageing population are much weaker drivers than most people think. Given what we know drives spending and what we expect in the future it seems very likely that the pressure will be to spend more and it's clear that important decisions lie ahead.

Although improvements in productivity should enable more value to be squeezed out of whatever level of funding is deemed to be affordable, it is likely that a gap will open up between the resources made available by government on the one hand, and the demands arising from population increases, rising national wealth, and medical advances on the other. The question that arises is how this gap might be filled given the evidence summarised here. The answer is as much political as technical.

A great deal depends on how we view the role of the state and the individual, and how the balance might change over time.

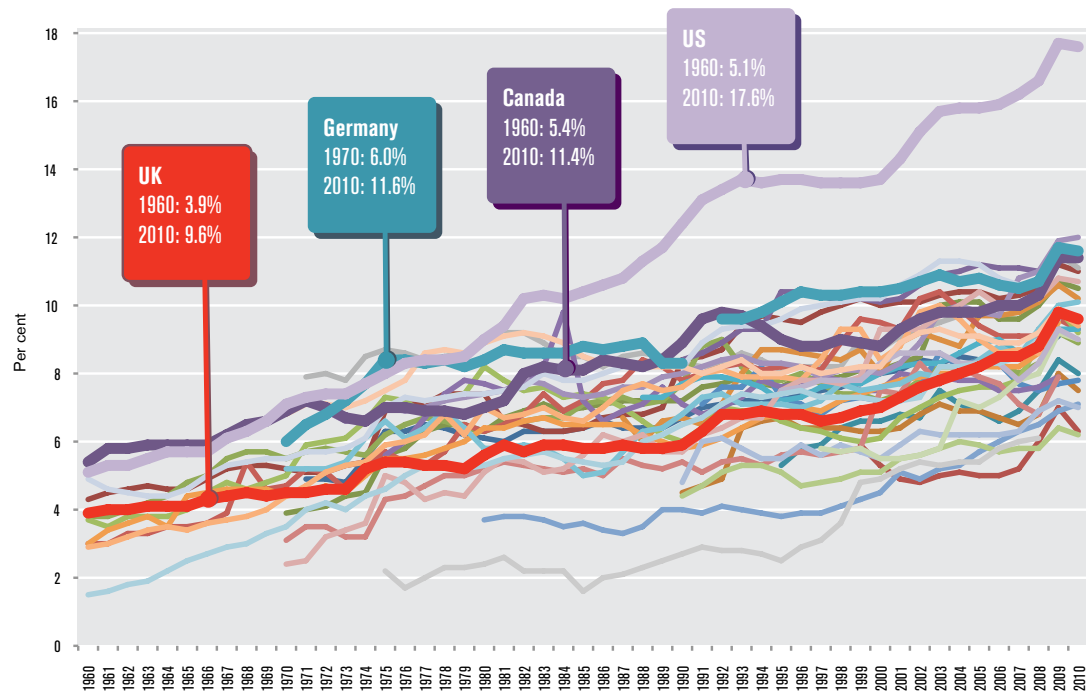
- Will people be willing to pay the same or indeed increasing levels of taxes in order to fund public services?
- Might the government be willing and able to increase borrowing to ensure the sustainability of valued public services such as health and social care?
- Or will there be a backlash against the role of the state, and an expectation that people should take greater personal responsibility?

There is nothing inevitable about spending on health and social care continuing to rise in line with historic trends, so we need to think much more long term about the difficult choices we face. In June this year, The King's Fund launched its Commission on the Future of Health and Social Care in England, which is asking whether the post-war settlement - which established the NHS as a universal service, free at the point of use and social care as a separately funded, means-tested service - remains fit for purpose.

Questions about the balance of funding are central to this. It is crucial that the public are engaged in these debates, as the key questions are ones which chime with economists and the public alike: is it worth spending so much more on health and social care, now and in the future? And what will we get for our money?

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Figure 2: Total (public + private) health spending as a percentage of GDP: 1960-2010: OECD countries



Source: OECD (2012) Health Data OECD 2012 - Frequently Requested Data. OECD, Paris <http://www.oecd.org/els/healthpoliciesanddata/oecdhealthdata2012-frequentlyrequesteddata.htm>

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ABOUT THE APHG

The All Party Parliamentary Health Group is a 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 focusses 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 system. 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 involvement.

We inform and engage parliamentarians through the organisations of briefings, seminar and conferences under the Chatham House Rule addressing and providing information on the major developments in health and the health 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 20 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 the wider healthcare community in the UK.

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