ABPI Exam Unit 1 – NHS Structure and Function: March 2016

NHS Structure and Function

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1.2.1 Introduction

The health and care system must keep evolving in order to deliver a service which responds to the nation’s changing health and care needs. Today’s population has very different needs and expectations to the population of 1919, when the Ministry of Health was first created, or to that of 1948 which saw the establishment of the NHS.¹

In this exam unit we will provide an in-depth look at the NHS in England as well as an overview of the devolved nations – Scotland, Wales and Northern Ireland.

We will take you on a journey that will cover the following sections:

- An overview of the NHS – where did it start and where is it now
- The current structure of the NHS in England
- The organisations across the system including:
  - The Department of Health
  - NHS England
  - Clinical Commissioning Groups
  - Provider Organisations
  - Monitoring and regulation in the system
  - Data and evidence
  - Training and development
- Planning in the NHS including
  - Funding allocations
  - Key documents
- Incentives across the system including:
  - Quality Outcomes Framework
  - CQUINS
  - Premium Quality
- Prescribing in the NHS
- Joint working – industry and NHS
- Devolved nations

The NHS is a large and complex organisation, so this exam unit aims to give you a basic understanding of what the NHS looks like today, where it came from and what the current direction of travel is. Throughout the unit we will provide you with key learning points for each section.
1.2.1.1 Overview of the National Health Service (NHS)

The NHS was launched in 1948. It was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth – a principle that remains at its core. With the exception of some charges, such as prescriptions and optical and dental services, the NHS in England remains free at the point of use for anyone who is a UK resident.²

The NHS in England now employs over 1.3 million people and the system deals with over 1 million patients every 36 hours. It covers everything from antenatal screening and routine screenings such as the NHS Health Check and treatments for long-term conditions, to transplants, emergency treatment and end-of-life care.² Funding for the NHS comes directly from taxation. When the NHS was launched in 1948, it had a budget of £437 million (roughly £15 billion at today’s value).² For 2015/16, the overall NHS budget was around £100,360 billion with an increase in 2016/17 to £105,836 billion.³

Responsibility for healthcare in Northern Ireland, Scotland and Wales is devolved to the Northern Ireland Assembly, the Scottish Government and the Welsh Assembly Government respectively.²

UK Healthcare³,⁴,⁵,⁶,⁷,⁸
Most modern healthcare systems, within the UK and across the globe, are facing similar challenges which include:

- Ageing population
- Rise in long-term conditions
- Advances in treatment/discovery of new drugs
- Higher patient expectations

All of which are underpinned by the need to deliver high quality care in times of great austerity. Changing demographics and the environmental challenges highlighted above mean that a radical change to the system is needed to ensure sustainability in the long term.

Jeremy Hunt, Secretary of State for Health, recently stated that:

“The NHS is a truly remarkable institution. Made up of over 8,300 separate organisations and served by more than 1.3 million staff, it sees more than a million patients every 36 hours. It has been independently rated as the fairest and most patient-centred health system in the world,”

Since its inception, the NHS structure, and the way in which it has met the healthcare needs of the population, has undergone continuous change, but over the last two decades this has been substantial and far reaching.

The government has set NHS England some ambitious objectives for the next five years to drive the changes that are needed and to see an NHS that has evolved and responding to the challenges that it now faces. Jeremy Hunt continued to say:

“Extra investment from taxpayers must come with serious reform, so we have asked NHS England to make rapid progress on tackling the unacceptable variation in the standard of weekend services, focusing on transforming weekend provision of urgent and emergency care.

“We are also continuing to back and fund the NHS’s own plan for the future, the Five Year Forward View. This blueprint for the transformation of out of hospital services achieved an extraordinary level of consensus across the NHS, and next year (2016/17) we will see those plans coming to fruition.... We anticipate real progress in patient outcomes across these transformation areas, including a reduction in emergency admissions, and improvement in accident and emergency performance to ensure that standards are met.”

Key Learnings:

- The NHS was launched in 1948 however the guiding principles remain unchanged - good healthcare should be available to all, regardless of wealth.
- We now see four independent healthcare systems across the UK
- The Government is calling for radical changes to the structure and how care is delivered to drive sustainability of the NHS in England
1.2.1.2 Structure of the NHS in England

The Health and Social Care Act 2012 saw a statutory change in the structure of the NHS in England with the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) along with the introduction of Clinical Commissioning Groups (CCGs).

The process for the introduction of the Health Act is outlined below:

- 2010: The White Paper, Equity & Excellence: Liberating the NHS was published
- 2012: Health and Social Care Act gained royal assent
- 2013: 1st April the Health Act was implemented seeing a more clinically led NHS

The Health and Social Care Act introduced a number of key changes to the NHS in England. The changes include:

- Giving groups of GP practices and other professionals – clinical commissioning groups (CCGs) – 'real' budgets to buy care on behalf of their local communities
- Shifting many of the responsibilities historically located in the Department of Health to a new, politically independent NHS England
- The creation of a health specific economic regulator (Monitor) with a mandate to guard against 'anti-competitive' practices
- Moving all NHS trusts to foundation trust status
Current structure of NHS in England showing key organisations

The structure looks complicated however you can view it as six interconnecting sections of the NHS:

<table>
<thead>
<tr>
<th>Central Government</th>
<th>Commissioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers</td>
<td>Monitoring and regulation</td>
</tr>
<tr>
<td>Data and evidence</td>
<td>Training and development</td>
</tr>
</tbody>
</table>

Each organisation within the system has roles and responsibilities that it must undertake and all are ultimately accountable to central Government through the delivery of the NHS Mandate and within the parameters of the NHS Constitution.

Key Learnings:

- The introduction of the Health and Social Care Act 2012 saw the drive for a more clinically led NHS with the abolition of PCTs and the introduction of CCGs.
- The structure of the NHS can be divided into six interconnecting sections including commissioning organisations and providers of healthcare.
1.2.2 Organisations within the System

The Secretary of State for Health has overall responsibility for the work of the Department of Health (DH). The DH provides strategic leadership for public health, the NHS and social care in England.

1.2.2.1 Department of Health

The Department of Health provides strategic direction for the NHS and the wider health and care system by creating national policies and legislation, providing the long term vision and ambition to meet current and future challenges. The Department is ultimately accountable to Parliament and the public for the quality of care provided, but since April 2013 the role of the DH focuses on leading, shaping and funding healthcare in England rather than on delivery of healthcare through the NHS, social care and public health systems.¹

The DH acts as a steward for the health and care system to ensure it delivers the right things for patients, service users and the public. ¹

1.2.2.2 NHS England

NHS England is an independent organisation, which is at ‘arm’s length’ to the government. Its main aim is to improve health outcomes and deliver high-quality care for people in England by: ¹¹

- Providing national leadership for improving outcomes and driving up the quality of care
- Overseeing the operation of CCGs
- Allocating resources to CCGs
- Commissioning primary care and directly commissioned services (specialised services, offender healthcare and military healthcare)

NHS England is a clinically led organisation. It has a budget of over £100 billion. Within its overall funding it allocates over £65 billion to CCGs and local Authorities, which commission services locally for patients. The remainder is allocated to direct commissioning activities (primary care services) and to operational costs. NHS England’s responsibilities are discharged through four regional offices (NHS North, NHS South, NHS London and NHS Midlands and East). ¹¹

1.2.2.3 Clinical Commissioning Groups (CCGs)

CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. CCGs members include GPs and other clinicians such as nurses and consultants.

They are responsible for about 60% of the NHS budget and commission most secondary care services such as: ⁴

<table>
<thead>
<tr>
<th>Planned hospital care</th>
<th>Urgent and emergency care</th>
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<tbody>
<tr>
<td>Rehabilitative care</td>
<td>Most community health services</td>
</tr>
<tr>
<td>Mental health and learning disability services</td>
<td></td>
</tr>
</tbody>
</table>

¹ Source: Department of Health
¹¹ Source: NHS England
⁴ Source: NHS England
CCGs can commission any service provider that meets NHS standards and costs. These can be NHS hospitals, social enterprises, charities or private sector providers. However, they must be assured of the quality of services they commission, taking into account both National Institute for Health and Care Excellence (NICE) guidelines and the Care Quality Commission’s (CQC) data about service providers. Both NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission.

CCGs have the flexibility within the legislative framework to decide how far to carry out these functions themselves, in groups (e.g. through a lead CCG) or in collaboration with local authorities, and how far to use external commissioning support. However, a CCG will always retain legal responsibility for its functions.

CCGs are designed to be clinically led and responsive to the health needs of their local populations. They are membership bodies made up of GP practices in the area they cover. The law requires that members appoint a governing body who oversee the governance of the CCG and which must have at least six members including:

<table>
<thead>
<tr>
<th>CCG Chair</th>
<th>A registered nurse</th>
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</thead>
<tbody>
<tr>
<td>Deputy Chair</td>
<td>A secondary care specialist</td>
</tr>
<tr>
<td>CCG’s Accountable Officer</td>
<td>Two lay members</td>
</tr>
</tbody>
</table>

**1.2.2.4 Provider Organisations**

Once commissioned, NHS services are delivered by a number of different organisations called providers.

**Primary care** services are delivered by a wide variety of providers including general practices, dentists, optometrists, pharmacists, walk-in centres and NHS 111. There are more than 7,500 general practices in England providing primary care services.

**Acute trusts** (NHS Trusts & Foundation Trusts) provide secondary care and more specialised services. The majority of activity in acute trusts are commissioned by CCGs. However, some specialised services are commissioned centrally by NHS England.
Differences between NHS foundation trusts and NHS trusts:

<table>
<thead>
<tr>
<th></th>
<th>NHS foundation trust</th>
<th>NHS trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government involvement</td>
<td>Not directed by Government, freedom to make strategic decisions</td>
<td>Directed by government</td>
</tr>
<tr>
<td>Regulation: Financial Quality</td>
<td>Monitor CQC</td>
<td>Trust Development Authority CQC</td>
</tr>
<tr>
<td>Finance</td>
<td>Free to make own financial decisions according to an agreed framework set out in law and by regulators. Can retain and reinvest surplus</td>
<td>Financially accountable to government</td>
</tr>
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</table>

**Specialist tertiary care centres**

Tertiary care refers to the third and highly specialised stage of treatment, generally provided in a specialist hospital centre, accessed through referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment.  

**Ambulance trusts** manage emergency care for life-threatening and non-life threatening illnesses, including the NHS 999 service. In some areas the ambulance trusts are also commissioned to provide non-emergency hospital transport services and/or the NHS 111 service.

**Mental health trusts** provide community, inpatient and social care services for a wide range of psychiatric and psychological illnesses. Mental health trusts are commissioned and funded by CCGs. Mental health services can also be provided by other NHS organisations, the voluntary sector and the private sector.

**Community health services** are delivered by foundation and non-foundation community health trusts. Services include district nurses, health visitors, school nursing, community specialist services, hospital at home, NHS walk-in centres and home-based rehabilitation.

**Commissioning Support Units** (CSUs) support commissioners (both CCGs and NHS England) by carrying out functions that they may not wish to take on directly themselves; for example contract negotiation, medicines management, service redesign or healthcare procurement. Commissioners can decide what support they require and are free to select the CSU provider to deliver it. CSUs are still evolving and are likely to develop their own speciality services.

**Non NHS Providers:** A range of other non-NHS providers provide health services, including social enterprises, local authorities, charities and community interest companies.
Key Learnings:

Within the core of the NHS there are commissioning organisations and provider organisations:

1.2.2.5  Public Health England (PHE) & Health and Wellbeing Boards

Public Health England (PHE) is an operationally autonomous executive agency of the Department of Health and was established in April 2013. 11

PHE provides national leadership and expert services to support public health, and also works with local government and the NHS to respond to emergencies.4

PHE: 4

- co-ordinates a national public health service and delivers some elements of this
- builds an evidence base to support local public health services
- supports the public to make healthier choices
- provides leadership to the public health delivery system
- supports the development of the public health workforce
Public Health England and Health and Wellbeing Boards have the remit to protect and improve the nation’s health and to address health inequalities.

Health and Wellbeing Boards (HWBs) promote co-operation from leaders in the health and social care system to improve the health and wellbeing of their local population and reduce health inequalities. The boards, which sit within local government authorities (LGAs), bring together bodies from the NHS, public health and local government, including Healthwatch as the patient’s voice, to plan how to meet local health and care needs, and to commission services accordingly.11

Who sits on a Health and Wellbeing Board? 11

<table>
<thead>
<tr>
<th>Locally elected representatives</th>
<th>Director of Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthwatch representative</td>
<td>Representative of each CCG</td>
</tr>
<tr>
<td>Director of Adult Social Services</td>
<td>Other invited persons to provide specific expertise</td>
</tr>
<tr>
<td>Director of Children’s Services</td>
<td>(CQC)</td>
</tr>
</tbody>
</table>

1.2.2.6 Monitoring and Regulation

<table>
<thead>
<tr>
<th>Monitoring &amp; Regulation</th>
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<tbody>
<tr>
<td>Monitor</td>
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<tr>
<td>As the sector regulator, Monitor’s job is to make the health sector work better for patients.2 Monitor ensures foundation hospitals, ambulance trusts, and mental health and community care organisations are run well, so they can continue delivering good quality services for patients in the future. To do this, Monitor works closely with the Care Quality Commission (CQC).2 Monitor is responsible for regulating payments made by commissioners to providers for all NHS services, to make sure every pound of taxpayers’ money spent on health goes as far as it can and results in the best possible care for patients.2</td>
</tr>
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NHS Trust Development Authority (TDA)  

The TDA is responsible for ensuring that non-foundation trusts develop the capability to achieve independent foundation trust status. Key functions of the TDA include: 11

- Monitoring performance
- Assurance of clinical quality
- Transition into Foundation status
- Appointment of chairs and non-executive members to the trust

Care Quality Commission (CQC)  

CQC is the independent regulator for health and social care in England.2 It registers and inspects hospitals, care homes, GP surgeries, dental practices and other healthcare services. If services are not meeting fundamental standards of quality and safety, CQC has the powers to issue warnings, restrict the service, issue fixed penalty notice, suspend or cancel registration, or prosecute the provider.11
Healthwatch England

Healthwatch has been set up as an independent consumer champion for health and social care. Its purpose is to represent the public’s view on health and social care at both local and national levels. 

Every local authority in England has a healthwatch. It is hoped that through the healthwatch network the voices of people who use the NHS will be heard. Healthwatch will gather these views by conducting research in local area, identifying gaps in services and feeding into health commissioning plans.

1.2.2.7 Data and Evidence

Data and Evidence

<table>
<thead>
<tr>
<th>National Institute for Health and Care Excellence. (NICE)</th>
<th>The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care. It also advises on ways to promote healthy living and prevent ill health.</th>
</tr>
</thead>
</table>
| | NICE’s role is to improve outcomes for people using the NHS and other public health and social care services. They do this by: 

- Producing evidence based guidance and advice for health, public health and social care practitioners.
  - **NICE guidelines** make evidence-based recommendations on a wide range of topics, from preventing and managing specific conditions, improving health and managing medicines in different settings, to providing social care to adults and children, and planning broader services and interventions to improve the health of communities.
  - **Technology appraisals** guidance assess the clinical and cost effectiveness of health technologies, such as new pharmaceutical and biopharmaceutical products, but also include procedures, devices and diagnostic agents.
  - **Medical technologies and diagnostics guidance** help to ensure that the NHS is able to adopt clinically and cost effective technologies rapidly and consistently.
  - **Interventional procedures guidance** recommends whether interventional procedures, such as laser treatments for eye problems or deep brain stimulation for chronic pain are effective and safe enough for use in the NHS.

- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services. |
| **Quality Standards** | are concise sets of statements, with accompanying metrics, designed to drive and measure priority quality improvements within a particular area of care. These are derived from the best available evidence. 

**Quality Outcomes Framework (QOF).** NICE undertakes the development of an annual menu of potential indicators for inclusion in the clinical component of the QOF, the quality element of the contract the NHS has with General Practitioners. 

**Clinical Commissioning Group Outcomes Indicator Set (CCGOIS).** A framework for measuring health outcomes and the quality of care (including patient reported outcomes and patient experience) achieved by clinical commissioning groups (CCGs). 

- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care. 

**NICE Evidence** an online search engine that identifies relevant clinical, public health and social care guidance. 

**British National Formulary (BNF) and British National Formulary for Children (BNFC),** published jointly by the Royal Pharmaceutical Society and the British Medical Association. For a number of years, NICE has been responsible for providing NHS access to these publications, including recently through the use of smartphone apps. 

**Medicines and prescribing support:** information and new pharmaceutical products and information about the use of particular products outside the scope of their licensed indications. This includes Medicines practice guidelines to support best practice in medicines management, including practical advice on developing and maintaining local medicines formularies.

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**Patient Access Schemes:**

When assessing new drugs and treatments - to decide whether they represent good value for the NHS - NICE looks at evidence on how well the treatment works compared with available alternatives, and the cost of treatment.

Drugs or treatments that are expensive and do not have a significant benefit over existing treatments are unlikely to be approved by NICE for use in the NHS.

Patient access schemes are special ways pharmaceutical companies can propose to enable patients to gain access to high costs drugs.
Health and Social Care Information Centre (HSCIC) | HSCIC are the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. HSCIC is an executive non-departmental public body, sponsored by the Department of Health.

1.2.2.8 Training and Development

<table>
<thead>
<tr>
<th>Training and Development</th>
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<tr>
<td><strong>Health Education England (HEE)</strong></td>
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1.2.2.9 Other Networks within the NHS

<table>
<thead>
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<th>Other Networks within the NHS</th>
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<tbody>
<tr>
<td><strong>Strategic Clinical Networks (10)</strong></td>
</tr>
<tr>
<td><strong>Clinical Senates (12)</strong></td>
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1.2.3. Planning in the NHS and Key Documents

The following section outlines the key documents that set out the direction of travel for the DH and NHS England for 2016/17 and looking forward to 2020/21.

Key Learnings:
- Public Health England and Health and Wellbeing Boards have the remit to protect and improve the nation’s health and to address health inequalities
- Monitor is the economic regulator whilst CQC is the inspector for quality and safety
- NICE’s role is to improve outcomes for people using the NHS and other public health and social care services.
- Other networks include strategic clinical networks, clinical senates and academic health science networks

1.2.3.1 The NHS Constitution

The NHS was founded on a common set of principles and values, and the NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. It also sets out responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.
Seven key principles guide the NHS in England in all it does. They are underpinned by core NHS values:

1. The NHS provides a comprehensive service, available to all
2. Access to NHS services is based on clinical need, not an individual’s ability to pay
3. The NHS aspires to the highest standards of excellence and professionalism
4. The NHS aspires to put patients at the heart of everything it does
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
6. The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources
7. The NHS is accountable to the public, communities and patients that it serves

The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions, are required by law to take account of the NHS Constitution in their decisions and actions. The Handbook to the NHS Constitution provides guidance on the rights, pledges, duties and responsibilities established by the Constitution.

Pledges go above and beyond legal rights. With regard to access to medicines the Constitution states that patients and the public have the following rights:

- You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.
- You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.
- You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.

1.2.3.2 The NHS Mandate

The NHS Mandate between the government and NHS England sets out the ambitions for the health service for the given financial year. The mandate to NHS England sets out the government’s objectives for NHS England, as well as its budget.

In doing so, the mandate sets direction for the NHS, and helps ensure the NHS is accountable to Parliament and the public. Every year, the Secretary of State must publish a mandate to ensure that NHS England’s objectives remain up to date. The Mandate for the year April 2016 – March 2017 was set in December 2015.

For the first time, the objectives in the mandate are underpinned by specific deliverables to be achieved in the short term, for the year 2016-17, and to be achieved in the long term, by 2020 or
beyond. The mandate must be refreshed each year and laid before Parliament, to ensure the objectives and requirements are up to date and to agree new annual deliverables.\textsuperscript{9}

The Mandate clearly sets out seven overarching objectives for NHS England and have assigned measurable goals to each objective. The majority of these goals will be achieved in partnership with the Department of Health, NHS Improvement and other health bodies such as Public Health England, Health Education England and the Care Quality Commission.\textsuperscript{9}

The table below details the objectives and goals for 2016/17: \textsuperscript{9}

<table>
<thead>
<tr>
<th>Objective</th>
<th>Goals</th>
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<tbody>
<tr>
<td>1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities</td>
<td>CCG Performance: Consistent improvement in performance of CCGs against new CCG assessment framework</td>
</tr>
<tr>
<td>2. To help create the safest, highest quality health and care service</td>
<td>Avoidable deaths and seven-day services Patient experience Cancer: Deliver recommendations of the Independent Cancer Taskforce,</td>
</tr>
<tr>
<td>3. To balance the NHS budget and improve efficiency and productivity</td>
<td>Balancing the NHS budget</td>
</tr>
<tr>
<td>4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives</td>
<td>Obesity and Diabetes Dementia</td>
</tr>
<tr>
<td>5. To maintain and improve performance against core standards.</td>
<td>A&amp;E, Ambulances and Referral to Treatment (RTT)</td>
</tr>
<tr>
<td>6. To improve out-of-hospital care</td>
<td>New models of care and General Practice Health and social care integration Mental health, learning disabilities and autism</td>
</tr>
<tr>
<td>7. To support research, innovation and growth</td>
<td>Research and growth Technology Health and work</td>
</tr>
</tbody>
</table>

Within the Government’s Mandate Jeremy Hunt, Secretary of State for Health, pledged “to continue to back and fund the NHS’s own plan for the future, the Five Year Forward View. This blueprint for the transformation of out of hospital services achieved an extraordinary level of consensus across the NHS, and next year we will see those plans coming to fruition through the vanguards and new models of care programmes. We anticipate real progress in patient outcomes across these transformation areas, including a reduction in emergency admissions, and improvement in accident and emergency performance to ensure that standards are met.”\textsuperscript{9}

\textsection{1.2.3.3 Five Year Forward View}

The ‘Five Year Forward View’ was published on 23 October 2014 and sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care to create “a collective view of how the health service needs to change over the next five years if it is
to close the widening gaps in the health of the population, quality of care and the funding of services”. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.\(^\text{18}\)

Proposals include:\(^\text{19}\)

- Increased focus on prevention of disease and on public health
- Patients having greater control of their own care
- Better integration of primary and secondary care, physical and mental health, and health and social care

The theme receiving most attention is the new models of care. The models aim to break down the artificial divides between different parts of the health service, as well as between the NHS and social care. In January 2015, the NHS invited individual organisations and partnerships to apply to become ‘vanguard’ sites for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services.\(^\text{20}\)

### Vanguard Sites:

<table>
<thead>
<tr>
<th>Wave</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1st Wave: March 2015</td>
<td>29 sites were chosen - PACs*, MCPs* &amp; Enhanced Health in Care Homes</td>
</tr>
<tr>
<td>2nd Wave: July 2015</td>
<td>8 Emergency Care Vanguards</td>
</tr>
<tr>
<td>3rd Wave: September 2015</td>
<td>13 Acute Care Collaborations</td>
</tr>
</tbody>
</table>

*PACs – Primary and Acute Care Systems  
*MCPs – Multispecialty community providers

Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.\(^\text{19}\)
Efficiency and productive investment

It has previously been calculated that a combination of growing demand, no further annual efficiencies and flat real terms funding could produce a mismatch between resources and patient needs of nearly £30 billion per year, by 2020/21.

To sustain a high-quality comprehensive NHS, action will be required on three fronts:

1. Demand
   - A more activist prevention and public health agenda and new models of care

2. Efficiency
   - Efficiency gains have been estimated at around 0.8 per cent net annually. This will not be adequate and the NHS needs to accelerate some of its current efficiency programmes

3. Funding
   - Staged funding increases taking account of population growth, combined with investment to facilitate the move to new care models and ways of working

1.2.3.4 Delivering the Forward View: NHS planning 2016/17 – 2020/21

The leading national health and care bodies in England have come together to publish ‘Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21’, setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

It is published by NHS England, NHS Improvement (the new body which will bring together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England and NICE – the bodies which developed the Five Year Forward View in October 2014.

The planning guidance is backed up by £560 billion of NHS funding, including a new Sustainability and Transformation Fund which will support financial balance, the delivery of the Five Year Forward View, and enable new investment in key priorities.

The table below outlines the core content of the shared planning guidance:

| 3 Gaps | 1: Health and well being  
| 2: Care and quality  
| 3: Funding and efficiency |
| 3 Tasks | 1: Implementation of the Five Year Forward View  
| 2: Restore and maintain financial balance  
| 3: Deliver core quality and access standards |
| 2 Documents | 1: A five year Sustainability and Transformation Plan (STP) – place based and driving the Five Year Forward View  
| 2: A one year Operational Plan for 2016/17 – organisation based but consistent with the emerging STP |
The guidance also sets out nine ‘must do’s’ that organisations must address:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop a high quality and agreed Sustainability and Transformation Plan (STP)</td>
</tr>
<tr>
<td>2</td>
<td>Achieve aggregate financial balance</td>
</tr>
<tr>
<td>3</td>
<td>Develop and implement a local plan to address the sustainability and quality of practice</td>
</tr>
<tr>
<td>4</td>
<td>Get back on track with access standards for A&amp;E and ambulance waits</td>
</tr>
<tr>
<td>5</td>
<td>18 weeks wait from referral to treatment</td>
</tr>
<tr>
<td>6</td>
<td>Achieve and maintain the two new mental health access standards</td>
</tr>
<tr>
<td>7</td>
<td>Continue to meet dementia diagnosis rates</td>
</tr>
<tr>
<td>8</td>
<td>Transform care for people with learning disabilities</td>
</tr>
<tr>
<td>9</td>
<td>Develop and implement an affordable plan to make improvements</td>
</tr>
</tbody>
</table>

**Sustainability and Transformation Plans:**

The NHS shared planning guidance 2016/17 – 2020/21, outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions. As in previous years, NHS organisations are required to produce individual operational plans for 2016/17. In addition, every health and care system will work together to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision. To do this, local health and care systems will come together in STP ‘footprints’. The health and care organisations within these geographic footprints will work together to narrow the gaps in the quality of care, their population’s health and wellbeing, and in NHS finances.

A system wide approach to planning:

All plans should be aligned to and consistent with the STP which will also reflect both national and local priorities for the population that they serve. CCGs will be responsible for the development of the in-year operational plans along with their commissioning intentions and QIPP (Quality, Innovation, Productivity and Prevention) plans. Providers will publish both their strategic annual business plans alongside their Cost Improvement Plans (CIP).
1.2.4 Funding Allocations and Financial Flows

The NHS is mainly funded from general taxation and National Insurance contributions. Small amounts each year come from patient charges for services like optical care, prescriptions and dental care. The decision about how much money parliament will give to the Department of Health to spend on the NHS in England is made as part of the Spending Round process.  

How is the budget for the NHS calculated?
The Treasury holds a Spending Review every two to three years, through which the budgets for all major public services are agreed. Health is a major national issue: it receives around £107 billion a year, compared with £53 billion for education and £25 billion for defence.  

How does the money flow from the Treasury to patient services?
The Treasury allocates money to the Department of Health, which in turn allocates money to NHS England. The Department of Health retains a proportion of the budget for its running costs and the funding of bodies such as Public Health England.  

In November 2015 the government announced a five year funding settlement for the NHS. Annual funding will rise in real terms by £3.8bn in 2016/17 and £8.4bn by 2020/21. Total allocations for NHS England for 2016/17 is £106.8bn rising to £110.2bn in 2017/18.
What is the money spent on?
Nearly half (47%) of the NHS budget is spent on acute and emergency care. General practice, community care, mental health and prescribing each account for around 10% of the total spend. ¹¹

How is money paid to service providers?
Payment by Results (PbR) is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs. ²⁵

The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency. ²⁵

PbR currently covers the majority of acute healthcare in hospitals, with national tariffs for admitted patient care, outpatient attendances, accident and emergency (A&E), and some outpatient procedures. For example, £180 for a first respiratory medicine outpatient attendance ²⁶ or £5,941²⁶ for a major non trauma hip operation. The Government is committed to expanding PbR by introducing currencies and tariffs for mental health, community and other services. ²⁵

Services that are not covered by PbR are paid for through block payments or cost and volume payments. With block payments commissioners pay healthcare providers a fixed amount of money for a defined range and volume of service – often based on historical patterns of care and local costs.
of providing that care. Block payments are often used for community healthcare services. Fixed sums may be paid for a defined range and volume of services; mechanisms are available for variation in activity levels. Procedures that are uncommon or may have significant cost variations may be paid for on a ‘cost per case’ basis.

1.2.5 Incentives in the System

As with most organisations, in order to drive specific activities and increase quality there needs to be targets set and rewards allocated. The NHS is no different and there are a number of reward based programmes across the system, all of which are underpinned by the NHS Outcomes Framework.

1.2.5.1 NHS Outcomes Framework

The NHS Outcomes Framework provides national level accountability for the outcomes the NHS delivers; it drives transparency, quality improvement and outcome measurement throughout the NHS. It also sets out the national outcome goals that the Secretary of State uses to monitor the progress of NHS England. It does not set out how these outcomes should be delivered, it is for NHS England to determine how best to deliver improvements by working with Clinical Commissioning Groups to make use of the tools at their disposal.

Indicators in the NHS Outcomes Framework are grouped into five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each domain, there are a small number of overarching indicators followed by a number of improvement areas.
1.2.5.2 Quality and Outcomes Framework (QOF): Incentive for Primary Care Practices

The Quality and Outcomes Framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004.\(^{29}\)

The QOF rewards practices for the provision of ‘quality care’ and helps to fund further improvements in the delivery of clinical care. Practice participation in QOF is voluntary but most practices with GMS contracts, as well as many with Personal Medical Services (PMS) contracts, take part in QOF.\(^{29}\)

When QOF was first introduced, the following principles were agreed on where QOF standards should apply:\(^{29}\)

- where responsibility for ongoing management of the patient rests primarily with the GP and the primary care team
- where there is evidence of health benefits resulting from improved primary care
- where the disease is a priority in a number of the four nations

*For 2015/16 there are 559 points in QOF across two domains for clinical and public health indicators. The value of a QOF point for 2015/16 is £160.15.\(^{30}\)
1.2.5.3 Commissioning for Quality and Innovations (CQUINs): Incentive for providers

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed.\(^{31}\)

National and local goals are available to providers allowing them to earn up to 2.5% of the actual contract value as defined in the 2016/17 NHS Standard Contract\(^ {32}\) and agreed with their commissioners. The percentage value will be dependent on the performance of the provider.\(^ {32}\)

<table>
<thead>
<tr>
<th>National Goals</th>
<th>Local Pick List</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Staff health and well being</td>
<td>Integration</td>
</tr>
<tr>
<td>Identification and early treatment of sepsis</td>
<td>Learning disabilities</td>
</tr>
<tr>
<td>Improving the physical health for patients with severe mental illness (PSMI)</td>
<td>Mental health</td>
</tr>
<tr>
<td>Cancer 62 day waits</td>
<td>Person centred care</td>
</tr>
<tr>
<td>Antimicrobial resistance</td>
<td>Physical health</td>
</tr>
<tr>
<td></td>
<td>Productivity</td>
</tr>
<tr>
<td></td>
<td>Urgent and emergency care</td>
</tr>
</tbody>
</table>

1.2.5.4 Premium Quality (QP): Incentive for CCGs

The Quality Premium (QP) scheme is about rewarding clinical commissioning groups (CCGs) for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.\(^ {33}\)

NHS England has sought to design the QP taking into account the regulations, and promoting the objectives in the Five Year Forward View and the NHS Mandate through:\(^ {33}\)

- Rewarding CCGs for improved outcomes in the services they commission in line with the CCG Improvement and Assessment Framework
- Supporting local priority-setting by identifying the opportunities via the Commissioning For Value (CFV) packs so they can be aligned with the joint health and wellbeing strategies
- Promoting reductions in health inequalities and recognising the different starting points of CCGs
- Reinforcing the importance of patients’ rights and pledges under the NHS Constitution

The maximum QP payment for a CCG is expressed as £5 per head of population.\(^ {33}\)
There are four national measures equating to 70% of the total value: 33

- Cancer (20% of quality premium)
- GP Patient Survey (20% of quality premium)
- E-Referrals (20% of quality premium)
- Improved antibiotic prescribing in primary care (10% of quality premium).

This year’s local element of the QP focuses on the Right Care* programme and is worth 30% of the QP. CCGs are expected to identify three measures and each will be worth 10%. CCGs will need to work with NHS England regional teams to agree the local proposal, and the levels of improvement needed to trigger the reward. 33

Quality Premium measures are monitored through the CCG Outcomes Indicator Set (CCGOIS).

All of the CCG outcomes indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework. 35

* The primary objective for Right Care is to maximise value: 34

- the value that the patient derives from their own care and treatment
- the value the whole population derives from the investment in their healthcare

To build on the success and value of the Right Care programme, NHS England and Public Health England are taking forward the Right Care approach through new programmes to ensure that it becomes embedded in the new commissioning and public health agendas for the NHS.

Key Learnings:
1.2.6 Prescribing in the NHS

Prescribing is the most common patient-level intervention in the NHS, and covers all sectors of care: primary, hospital, public and community health.

Guidance from the Medicines and Healthcare products Regulatory Agency (MHRA), an executive agency of the Department of Health, states that only "appropriate practitioners" can prescribe medicine in the UK.36

A prescriber is a healthcare professional who can write a prescription. This applies to both NHS prescriptions and private prescriptions.

Appropriate practitioners can be independent prescribers or supplementary prescribers36

<table>
<thead>
<tr>
<th>Independent Prescribers</th>
<th>Supplementary Prescribers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess health</td>
<td>Responsible for continuing care after an independent prescriber has made an assessment</td>
</tr>
<tr>
<td>Make clinical decision about how to manage a condition, including prescribing medication</td>
<td>They work with the independent prescriber to fulfil a clinical management plan</td>
</tr>
<tr>
<td></td>
<td>A supplementary prescriber can prescribe any medicine, including controlled medicines, for any condition within their competence under the agreed clinical management plan</td>
</tr>
</tbody>
</table>

Who are the prescribers?

<table>
<thead>
<tr>
<th>Independent Prescribers</th>
<th>Supplementary Prescribers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors, GP or a hospital doctor</td>
<td>Nurses/midwives</td>
</tr>
<tr>
<td>Dentists</td>
<td>Pharmacists</td>
</tr>
<tr>
<td>Nurse independent prescribers, who can prescribe any medicine for any medical condition within their competence</td>
<td>Optometrists</td>
</tr>
<tr>
<td>Pharmacist independent prescribers, who can prescribe any medicine for any medical condition within their competence</td>
<td>Podiatrists</td>
</tr>
<tr>
<td>Optometrist independent prescribers, who can prescribe any medicine for conditions that affect the eye</td>
<td>Physiotherapists</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and therapeutic radiographers</td>
</tr>
</tbody>
</table>
Pharmaceutical Pricing

In the UK, the Pharmaceutical Price Regulation Scheme (PPRS) is a voluntary agreement negotiated by the ABPI on behalf of industry. Different schemes have been in place for over 40 years, each new scheme is re-negotiated, on average every four to five years.

The current 2014 PPRS is a unique deal in which industry agreed to under-write the growth in the branded medicines bill, and does so through a set of payments made quarterly throughout the scheme. The 2014 PPRS is intended to run for five years. Alongside the payment mechanism, the PPRS also sets out a range of commitments from government and the NHS on NICE, and uptake and access to innovative branded medicines.

If a company chooses not to join the PPRS, they are subject to a statutory scheme, the latest of which required companies to cut their list prices by 15% (Jan 2013).

1.2.6.1 Formularies

The purpose of a prescribing formulary is to ensure evidence-based and cost-effective prescribing and to provide information relating to drug use. Local formularies across England vary in the number of NHS organisations covered by the formulary, the range of medicines the formulary includes, and the processes for developing and updating the formulary.

Benefits of local formularies may include:

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<thead>
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<tbody>
<tr>
<td>1</td>
<td>Improving patient outcomes by optimising the use of medicines</td>
</tr>
<tr>
<td>2</td>
<td>Supporting the inclusion of patient factors in decisions about medicines</td>
</tr>
<tr>
<td>3</td>
<td>Improving local care pathways</td>
</tr>
<tr>
<td>4</td>
<td>Improving collaboration between health professionals and commissioners</td>
</tr>
<tr>
<td>5</td>
<td>Improving quality by reducing inappropriate variations in clinical care</td>
</tr>
<tr>
<td>6</td>
<td>Improving quality through access to cost effective medicines</td>
</tr>
<tr>
<td>7</td>
<td>Supporting the supply of medicines across a local health economy</td>
</tr>
<tr>
<td>8</td>
<td>Supporting financial management and expenditure on medicines across health communities</td>
</tr>
<tr>
<td>9</td>
<td>Supporting prescribers to follow guidance published by professional regulatory bodies in relation to medicines and prescribing</td>
</tr>
</tbody>
</table>
1.2.6.2 Medicines optimisation

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. In an era of significant economic, demographic and technological challenge it is crucial that patients get the best quality outcomes from medicines. However, there is a growing body of evidence that shows us that there is an urgent need to get the fundamentals of medicines use right. 38

Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time. By focusing on patients and their experiences, the goal is to help patients to: improve their outcomes; take their medicines correctly; avoid taking unnecessary medicines; reduce wastage of medicines; and improve medicines safety. Ultimately medicines optimisation can help encourage patients to take ownership of their treatment. 38

The pharmaceutical industry also has a key role to play in medicines optimisation through transparent and value for money partnerships with the NHS that help secure better outcomes for patients. 38

Key Learnings:

- Prescribing is the most common patient-level intervention in the NHS
- Prescribers can be independent prescribers or supplementary prescribers
- PPRS is a voluntary agreement negotiated by the ABPI on behalf of industry
- The purpose of a prescribing formulary is to ensure evidence-based and cost-effective prescribing and to provide information relating to drug use
- Medicines optimisation is about ensuring that the right patients get the right choice of medicine, at the right time

1.2.7 The pharmaceutical industry and NHS working together

Working in partnership represents a fundamental shift in the relationship between the pharmaceutical industry and the NHS, moving away from the traditional sponsorship model, and towards Joint Working in a way which is both fair and mutually beneficial, with the shared aim of achieving pre-determined improvements for patients.

The pharmaceutical industry, apart from supplying medicines that improve patients’ lives, can contribute expertise arising from its extensive knowledge of the therapy areas relevant to its medicines. It can also share its experience in business and financial management. 39

Working collaboratively can take many forms including promotion, Joint Working and Medical Education grants and services (MEGS) and sponsorship.

Joint Working describes situations where the NHS and pharmaceutical companies pool skills, experience and/or resources for the benefit of patients and share a commitment to successful
delivery. Many such projects have been successfully implemented, across a range of health economies and disease areas.\textsuperscript{39}

Many such projects have been successfully implemented, benefiting patients across the UK. Examples have been included in a guide to joint working with the pharmaceutical industry.\textsuperscript{39} Joint Working must comply with the ABPI Code of Practice and it is recommended that all parties refer to the Department of Health Best Practice Guidance on Joint Working.\textsuperscript{40} ABPI has also produced a ‘quick start’ reference guide for NHS and pharmaceutical industry partners with the aim of simplifying the initiation of Joint Working projects.\textsuperscript{41}

Pharmaceutical representatives must also comply with all internal company procedures before setting up any collaboration with the NHS.

**Assessing a collaborative activity:**

<table>
<thead>
<tr>
<th></th>
<th>Promotion</th>
<th>Joint Working</th>
<th>Medical Education and Services (MEGS)</th>
<th>Sponsorship</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patient benefit?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS/pharmaceutical company pool resources?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical company investment?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS involvement?</td>
<td>Yes</td>
<td></td>
<td>Optional</td>
<td></td>
</tr>
<tr>
<td>Detailed agreement in place?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared commitment to successful delivery?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Details of the agreement are made public?</td>
<td>Yes</td>
<td></td>
<td>Optional</td>
<td></td>
</tr>
<tr>
<td>Prospective return on investment?</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes must be measured?</td>
<td>Yes</td>
<td></td>
<td>Optional</td>
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</table>
1.2.8 NHS in the Devolved Nations

The devolved nations are Wales, Scotland and Northern Ireland.

Since political devolution in 1999, there has been increasing policy divergence between the health systems of the four countries of the United Kingdom (UK).¹ The divergence affects structures, management approaches and how social care relates to health.

1.2.8.1 Wales

Overview of the NHS in Wales

Wales does not have the “purchaser-provider split” – the internal market where parts of the English NHS buy services from other parts. Instead the Welsh NHS operates through integrated health boards. Unlike England, it makes very little use if any of the private sector.²

The Welsh population is older, sicker and has more deprivation than the population of England. All of these factors affect people’s health, and therefore mean greater demands on the Welsh health service. The devolved government in Wales has used its powers to set different priorities and has emphasised prevention and public health more than England. Health spending has been cut in real terms by 4.3 per cent between 2009/10 and 2012/13, although there have now been further cash injections in 2014/15 and 2015/16 to reverse this trend.² The total expenditure in 2013-14 for all programme budget categories was £5.5 billion or £1,803.82 per head of population.³

The reorganisation of NHS Wales, which came into effect on October 1st 2009 created single local health organisations that are responsible for delivering all healthcare services within a geographical area, rather than the Trust and Local Health Board system that existed previously.⁴
The NHS now delivers services through seven Local Health Boards (LHB) and three NHS Trusts in Wales. There are currently 3 NHS Trusts in Wales with an all-Wales focus.

These are the Welsh Ambulance Services Trust for emergency services, Velindre NHS Trust offering specialist services in cancer care and a range of national support services and the new Public Health Wales.

**NHS Wales Structure**

**Health and Social Care Strategy for Wales**

The five year vision for the NHS in Wales was published in 2011 as ‘Together for Health’. This, together with ‘Achieving excellence – the quality delivery plan for the NHS in Wales 2012-2016’ sets out the aims and how they are going to be achieved.
Local Government Wales Act 2015 became law in Wales on 25 November 2015. The act is the first of 2 proposed bills which aim to deliver local government reform in Wales and facilitate a programme of mergers of local authorities. The draft Local Government Wales Bill was out to consultation until the middle of February 2016 and proposed the number of councils in Wales reduce from 22 to eight or nine which would potentially cut the cost of local government outcomes awaited.

The Social Services and Well-being (Wales) Act is in force from April 2016. It is the new legal framework that brings together and modernises social services law and requires local authorities and health boards to come together in new statutory partnerships to drive integration, innovation and service change.

In 2016, there will be an election for the National Assembly for Wales and the Welsh Government which is elected will develop new policies.

**Medicines**

Prescriptions are free in Wales

The All Wales Medicine Strategy Group (AWMSG) provide advice on medicines management and prescribing to the Welsh Government’s Minister for Health and Social Services.

- There is mandatory funding for all positive NICE and AWMSG guidance three months after a decision has been made, making all NICE and AWMSG-approved routinely available.
- Welsh Patient Access Scheme (WPAS) may be proposed by a pharmaceutical company and agreed by the Welsh Government, following advice from the Patient Access Scheme Wales Group before inclusion in the AWMSG Health Technology Appraisal (HTA) process.
- Individual Patient Funding Requests (IPFR) are requests for individual patients who require a service or treatment that would not normally be provided.

**1.2.8.2 Scotland**

**Overview of the NHS in Scotland**

Responsibility for the National Health Services in Scotland is a devolved matter and therefore rests with the Scottish Government. Legislation about the NHS is made by the Scottish Parliament. The Cabinet Secretary for Health and Wellbeing has ministerial responsibility in the Scottish Cabinet for the NHS in Scotland. The Scottish Government decides what resources are to be devoted to the NHS, in the context of devolved public expenditure. Of approximately £34.7 billion controlled by the Scottish Government, around £11.9 billion is spent on health. These figures quoted are from the Budget Act 2013-14 and relate to total managed expenditure.

Scotland, like Wales, focuses on integration and collaboration, rather than, as in England, competition and choice. Therefore there is no tariff for hospital services (except for cross boundary flow activity) and they are building towards integrated health and social care.
NHS Scotland Structure

There are 14 NHS Boards covering the whole of Scotland. In addition, seven national or ‘special’ NHS Boards provide national services and the healthcare improvement body – Healthcare Improvement Scotland – provides scrutiny and public assurance of health services.\(^ {14}\)

NHS Boards in Scotland are all-purpose organisations: they plan, commission and deliver NHS services and take overall responsibility for the health of their populations. They therefore plan and commission hospital and community health services including services provided by GPs, dentists, community pharmacists and opticians, who are independent contractors.\(^ {14}\)

NHS Scotland Structure

Health and Social Care Strategy for Scotland

The Healthcare Quality Strategy for Scotland was launched by the Cabinet Secretary for Health, Wellbeing and Cities Strategy in May 2010. This vision and the focus on quality healthcare is the context for all strategic and operational decision-making across NHS Scotland and is about three deliverables: \(^ {15}\)

| Putting people at the heart of the NHS | Building on the values of the people working in and with NHSScotland | Making measurable improvement in the aspects of quality of care that patients, families and carers feel important |
In 2011 following on from the launch of the Quality Strategy, the Scottish Government announced its ambitious plan for integrated health and social care and set out the 2020 Vision and Strategic Narrative for achieving sustainable quality in the delivery of health and social care across Scotland.16

The Scottish Government’s 2020 Vision is for everyone to live longer healthier lives at home, or in a homely setting, and that Scotland has a healthcare system where:17

- they have integrated health and social care
- there is a focus on prevention, anticipation and supported self-management
- hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm
- whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

To deliver integrated health and social care The Public Bodies (Joint Working) (Scotland) Act was granted royal assent on April 1, 2014. There are nationally agreed outcomes, which apply across health and social care, and for which NHS Boards and Local Authorities will be held jointly accountable.18

The nine National Health and Wellbeing Outcomes are:19

**Outcome 1:** People are able to look after and improve their own health and wellbeing and live in good health for longer

**Outcome 2:** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

**Outcome 3:** People who use health and social care services have positive experiences of those services, and have their dignity respected

**Outcome 4:** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

**Outcome 5:** Health and social care services contribute to reducing health inequalities

**Outcome 6:** People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

**Outcome 7:** People using health and social care services are safe from harm

**Outcome 8:** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

**Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services
There is now a requirement on NHS Boards and Local Authorities to integrate health and social care budgets.  

**Health and Social Care Integration Partnerships**

As of December 2015, 25 of the 31 Health and Social Care Partnerships have had their integration schemes formally approved and have been legally established, with five areas fully operational. (East Ayrshire, North Ayrshire, South Ayrshire, West Dunbartonshire and Highland).

**Medicines**

People receive free prescriptions in Scotland.

The Scottish Medicines Consortium (SMC) provides advice to NHSScotland about the value for patients of every newly licensed medicine. Before a medicine can be prescribed routinely in Scotland, it has to be accepted for use by the SMC:

- As part of their submission, pharmaceutical companies may propose a Patient Access Scheme (PAS) to improve the cost effectiveness of a medicine which may otherwise not be cost effective for NHSScotland.

- When SMC accepts a new medicine, NHS boards are expected to make it, or an equivalent SMC-accepted medicine, available. NHS boards are expected to publish updated lists of SMC accepted medicines included and excluded from their formularies together with the reasons for such decisions.

- Where a medicine is not recommended by SMC, all NHS boards have procedures in place to consider individual requests when a doctor feels the medicine would be right for a particular patient.

1.2.8.3 **Northern Ireland**

**Overview of the NHS in Northern Ireland**

Northern Ireland has an integrated system of health and social care and separate commissioning and provider organisations.

The current structure of the Health and Social Care (HSC) system in Northern Ireland came from the Health and Social Care (Reform) Act (Northern Ireland) 2009 which provides the legislative framework within which the Health and Social Care structures operate and establishes the high level functions of the various HSC bodies.

Northern Ireland, like the rest of the UK, is experiencing demographic shifts in terms of ageing, life expectancy and a growing population. Unhealthy lifestyle behaviours, such as poor nutrition, smoking and alcohol consumption have a significant impact on quality of life and life expectancy and place a huge burden on an already over-committed health and social care service.
A number of other challenges will further intensify the pressure on the financial stability of health and social care in Northern Ireland. Issues such as patterns of disease and disability, medical advances, information technology and the workforce will need to be factored in.\textsuperscript{24}

On the 4\textsuperscript{th} November 2015 Health Minister announced he proposes radical changes to the way health and social care in Northern Ireland is delivered.\textsuperscript{25}

**NHS Northern Ireland Structure**

The Health and Social Care Board (HSCB) is a non-profit making statutory body responsible for the commissioning of health and social care services for the population of Northern Ireland. The role of the Health and Social Care Board is broadly contained in the following functions: \textsuperscript{23}

\begin{itemize}
\item[a)] To arrange or ‘commission’ a comprehensive range of modern and effective health and social services for the 1.8 million people who live in Northern Ireland
\item[b)] To performance manage Health and Social Care Trusts
\item[c)] To effectively deploy and manage its annual funding from the Northern Ireland Executive, currently around £4 billion
\end{itemize}
LCGs are responsible for the commissioning of health and social care and the Trusts for the delivery of services commissioned.\(^\text{26}\)

A consultation document produced by the Minister for Health on health and social care reform and transformation has proposed the three following changes\(^\text{23}\):

- It is proposed that at a regional level Northern Ireland should move away from a structure with a separate performance management and commissioning function.
- It is proposed that Trusts should take on responsibility for planning the bulk of health and social care services delivered in Northern Ireland.
- It is proposed to close the Health and Social Care Board down.

The consultation closed in the middle of February 2016 and we await the outcomes.

**Medicines**

Prescriptions are free in Northern Ireland.

The Northern Ireland Formulary was launched in 2014. The aim of the Northern Ireland Formulary is to promote safe, clinically effective and cost-effective prescribing of medicines. The Formulary provides guidance on first and second line drug choices and will cover the majority of prescribing choices in Northern Ireland.\(^\text{27}\)

It is the responsibility of HSC organisations to put in place the necessary systems for implementing NICE guidance.\(^2\)

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**Key Learnings:**
- Marked divergence of policy and structure between England and the devolved nations.
- Collaboration and integration between health and social care a key driver.
- No separation between commissioning and provider functions in Scotland and Wales, Northern Ireland aiming to follow suit.
- Free prescriptions for all devolved nations.
References: NHS England

Ref 1: Helping People Live Better for Longer, A guide to the Department of Health’s role and purpose post-April 2013

Ref 2: NHS Choices Website http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx
Ref 3: Allocations of resources to NHS England and the commissioning sector for 2016/17 to 2020/21

Ref 4: NHS Choices Website: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.asp
Ref 5: Office for National Statistics
Ref 7: Northern Ireland Government

Ref 9: NHS Mandate 2016/17

Ref 10: NHS England Website: https://www.england.nhs.uk/about/our-vision-and-purpose/
Ref 12: NICE Website https://www.nice.org.uk/about/who-we-are

Ref 13: Health and Social Care Information Centre
Ref 14: Health Education England https://www.hee.nhs.uk/hee-your-area/wessex
Ref 15: Considerations for determining local health and social care economies

Ref 16: https://www.england.nhs.uk/ourwork/part-rel/ahsn/
Ref 17: NHS Constitution Handbook


Ref 21: https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
Ref 25: PBR A simple Guide
References: Devolved Nations

Ref 3: Knowledge and analytical services Welsh Government, NHS expenditure programme budgets:2013-14, 23 June 2015
Ref 5: Welsh Government, Together for Health: A Five Year Vision for the NHS in Wales, 2011
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Ref 11: All Wales Medicines Strategy Group, AWMSG Recommendation Wording, January 2015
Ref 13: All Wales Policy, Making Decisions on Individual Patient Funding Requests (IPFR), September 2011
Ref 17: The Scottish Government, A Route Map to the 2020 Vision for Health and Social Care, 2011
Ref 22: Health Improvement Scotland, A Guide to the Scottish Medicines Consortium