NHS Structure and Function

Please note: If the NHS structure and ways of working change significantly, a revised version will be provided to candidates registered to take Unit 1.

Contents

Introduction
   Overview of the NHS
   Structure of the NHS in England

1.2.1 Organisations within the system
   1.2.1.1 Department of Health
   1.2.1.2 NHS England
   1.2.1.3 Clinical Commissioning Groups (CCGs)
   1.2.1.4 Provider organisations
   1.2.1.5 Public Health England and Health and Wellbeing Boards
   1.2.1.6 Monitoring and regulation: NHS Improvement, CQC and Healthwatch England
   1.2.1.7 Data and evidence: NICE and the Health and Social Care Information Centre (HSCIC)
   1.2.1.8 Training and development: Health Education England and LETBs
   1.2.1.9 Other networks within NHS England: Strategic Clinical Networks and Clinical Senates

1.2.2 Planning in the NHS and key documents
   1.2.2.1 The NHS Constitution
   1.2.2.2 The NHS Mandate
   1.2.2.3 Five Year Forward View
   1.2.2.4 Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

1.2.3 Funding allocations and financial flows

1.2.4 Incentives in the system
   1.2.4.1 NHS Outcomes Framework
   1.2.4.2 Quality and Outcomes Framework (QOF): Incentive for primary care practices
   1.2.4.3 Commissioning for Quality and Innovation (CQUINS): Incentive for providers
   1.2.4.4 Quality Premium (QP): Incentive for CCGs

1.2.5 Prescribing in the NHS
   1.2.5.1 Formularies
   1.2.5.2 Medicines optimisation

1.2.6 The pharmaceutical industry and NHS working together

1.2.7 NHS in the Devolved Nations
   1.2.7.1 Wales
   1.2.7.2 Scotland
   1.2.7.3 Northern Ireland
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 from those of the population of 1919, when the Ministry of Health was first created, or to those 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
  - Quality Premium
- Prescribing in the NHS
- Joint working – industry and the 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.

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.\textsuperscript{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).\textsuperscript{2} For 2015/16, the overall NHS budget was around £100.360 billion with an increase in 2016/17 to £105.836 billion.\textsuperscript{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.\textsuperscript{2}

Figure 1: UK Healthcare\textsuperscript{3, 4, 5, 6, 7, 8}

Most modern healthcare systems, within the UK and across the globe, are facing similar challenges which include:

- an ageing population
- a rise in long-term conditions
- advances in treatment/discovery of new drugs
- higher patient expectations.

All of these 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:

“\textit{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.}”\textsuperscript{9}
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 is 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.
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).

Figure 2: The process for the introduction of the Health and Social Care Act

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

*Monitor has now been absorbed to form NHS Improvement
Figure 3: Current structure of the NHS in England, showing key organisations

The structure looks complicated; however, it can be viewed as six interconnecting sections of the NHS:

Table 1: NHS structure – six sections

<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.
1.2.1 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 the NHS in England.

1.2.1.1 The 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 DH 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

1.2.1.2 NHS England

NHS England is an independent organisation, which is at ‘arm’s length’ from 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 and specialised services etc) 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

1.2.1.3 Clinical Commissioning Groups (CCGs)

CCGs are clinically led 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, as shown in the following table.⁴

<table>
<thead>
<tr>
<th>Table 2: Secondary care services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned hospital care</td>
</tr>
<tr>
<td>Rehabilitative care</td>
</tr>
<tr>
<td>Mental health and learning disability services</td>
</tr>
</tbody>
</table>
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, CCGs 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 the following:

<table>
<thead>
<tr>
<th>Table 3: CCG governing body members</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Chair</td>
</tr>
<tr>
<td>Deputy Chair</td>
</tr>
<tr>
<td>CCG’s Accountable Officer</td>
</tr>
</tbody>
</table>

1.2.1.4 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 7,000 general practices in England providing primary care services.

Acute trusts (NHS Trusts and 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.
Table 4: 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, free to make strategic decisions</td>
<td>Directed by Government</td>
</tr>
<tr>
<td>Regulation: Financial Quality</td>
<td>NHS Improvement CQC</td>
<td>NHS Improvement 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 any surplus</td>
<td>Financially accountable to NHS England</td>
</tr>
</tbody>
</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.11

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.11

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.11

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.11

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 and that are best delivered at scale; 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.11

Non NHS providers: a range of other non-NHS providers provide health services, including social enterprises, local authorities, charities and community interest companies and private sector companies.
Within the core of the NHS there are commissioning organisations and provider organisations:

**Commissioners**

- **NHS England: Four Regional Offices**
  - Responsible for commissioning:
    - Primary Care and Directly Commissioned Services (specialised services, offender healthcare and military healthcare)

- **Clinical Commissioning Groups:** 209
  - Responsible for commissioning:
    - Planned hospital care
    - Rehabilitative care
    - Urgent and emergency care
    - Most community health services

**Providers**

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

- **Healthcare providers:**
  - **Primary Care:** GPs, Community Pharmacy, Dentistry and Ophthalmology
  - **Secondary Care:** NHS Trusts, Foundation Trusts, Specialist Tertiary Care, Mental Health Trusts
  - **Community Health Services**
  - **Ambulance Trusts**
  - **Commissioning Support Units**

---

### 1.2.1.5 Public Health England (PHE) and 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:**
- 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 local 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.\(^\text{11}\)

Table 5: Members of a Health and Wellbeing Board

<table>
<thead>
<tr>
<th>Who sits on a Health and Wellbeing Board? (^\text{11})</th>
<th>Director of Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locally elected representatives</td>
<td></td>
</tr>
<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></td>
</tr>
</tbody>
</table>

1.2.1.6 Monitoring and regulation

Table 6: Monitoring and regulation bodies

<table>
<thead>
<tr>
<th>Monitoring and regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Improvement</td>
<td>NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. They offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, they help the NHS to meet its short-term challenges and secure its future.</td>
</tr>
<tr>
<td>Care Quality Commission (CQC)</td>
<td>The CQC is the independent regulator for health and social care in England. 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 a fixed penalty notice, suspend or cancel registration, or prosecute the provider.(^\text{11})</td>
</tr>
<tr>
<td>Healthwatch England</td>
<td>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.(^\text{11}) 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 the local area, identifying gaps in services and feeding into health commissioning plans.(^\text{11})</td>
</tr>
</tbody>
</table>
1.2.1.7 Data and evidence

Table 7: Data and evidence bodies

<table>
<thead>
<tr>
<th>Data and evidence</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>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.</td>
</tr>
</tbody>
</table>

NICE’s role is to improve outcomes for people using the NHS and other public health and social care services.

NICE does 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 assesses the clinical and cost effectiveness of health technologies, such as new pharmaceutical and biopharmaceutical products, but also includes procedures, devices and diagnostic agents.
  - **Medical technologies and diagnostics guidance** helps 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 that the NHS has with General Practitioners.
  - **Clinical Commissioning Group Improvement Assessment Framework**. An on line framework (launched by NHS England)
which will include ratings published online to show patients how their local health service is performing in six important areas: cancer, dementia, diabetes, mental health, learning disabilities and maternity care.\(^{43}\)

- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.\(^{12}\)
  - **NICE Evidence**: an online search engine that identifies relevant clinical, public health and social care guidance.\(^{12}\)
  - **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.\(^{12}\)
  - **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.\(^{12}\)

**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.\(^{12}\)

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.\(^{12}\)

Patient access schemes are special ways which pharmaceutical companies can propose to enable patients to gain access to high-cost drugs.\(^{12}\)

| Health and Social Care Information Centre (HSCIC) | HSCIC is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.\(^{13}\) HSCIC is an executive non-departmental public body, sponsored by the Department of Health.\(^{13}\) |
1.2.1.8 Training and development

Table 8: Training and development bodies

| Health Education England (HEE) | HEE exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right number of staff, skills, values and behaviours, at the right time and in the right place. There are 13 Local Education and Training Boards (LETBs) that are responsible for the training and education of NHS staff, both clinical and non-clinical, within their area. The LETBs, which will be committees of HEE, are made up of representatives from local providers of NHS services and cover the whole of England. |

1.2.1.9 Other networks within the NHS

Table 9: NHS networks

| Other networks within the NHS | Strategic Clinical Networks (10) | Strategic clinical networks focus on priority service areas to improve equity and quality of care and health outcomes for their population. They bring together those who use, provide and commission services (including local government) to support more effective delivery of services. Current focus areas are: cardiovascular (including cardiac, stroke, renal and diabetes), maternity, children and young people, mental health, dementia and neurological conditions, cancer. |

| Clinical Senates (12) | Clinical senates are multi-professional advisory groups of experts from across health and social care, including patients, volunteers and other groups. There are 12 clinical senates, covering the whole of England. Their purpose is to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them in making the best decisions about healthcare for the populations they represent. This is so that they can make informed decisions and ensure that organisations are in alignment with each other to improve the quality of healthcare. |

Key learnings:

- Public Health England and local Health and Wellbeing Boards have the remit to protect and improve the nation’s health and to address health inequalities.
- NHS Improvement 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.
1.2.2 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.

Figure 4: Key documents 2016/17 – 2020/21

1.2.2.1 The NHS Constitution

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.\(^\text{17}\)

This 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 which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.\(^\text{17}\)

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution, to be renewed at least every 3 years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution.\(^\text{17}\)
Table 10: NHS core values

The diagram below outlines how the core values underpin all that NHS England aims to achieve:

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 this Constitution in their decisions and actions. References in this document to the NHS and NHS services include local authority public health services, but references to NHS bodies do not include local authorities.17

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.17
- 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.17
- 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.17
1.2.2.2 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.9

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 2015.9

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.9

The Mandate clearly sets out seven overarching objectives for NHS England and has 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.9

The table below details the objectives and goals for 2016/17:9

<table>
<thead>
<tr>
<th>Objective</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Through better commissioning, to improve local and national health outcomes, particularly by addressing poor outcomes and inequalities</td>
</tr>
<tr>
<td>2</td>
<td>To help create the safest, highest quality health and care service</td>
</tr>
<tr>
<td>3</td>
<td>To balance the NHS budget and improve efficiency and productivity</td>
</tr>
<tr>
<td>4</td>
<td>To lead a step change in the NHS in preventing ill-health and supporting people to live healthier lives</td>
</tr>
<tr>
<td>5</td>
<td>To maintain and improve performance against core standards</td>
</tr>
<tr>
<td>6</td>
<td>To improve out-of-hospital care</td>
</tr>
<tr>
<td>7</td>
<td>To support research, innovation and growth</td>
</tr>
</tbody>
</table>
January 2017 version

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.”

1.2.2.3 The 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.

Proposals include:

- 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.
Each vanguard site will take the 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.\textsuperscript{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.\textsuperscript{19} To sustain a high-quality, comprehensive NHS, Government has backed the plan pledging £8 billion with the remainder being achieved through action on three fronts:\textsuperscript{19}

Table 12: Action required by 2020/21

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demand</td>
<td>A more active prevention and public health agenda and new models of care</td>
</tr>
<tr>
<td>2. Efficiency</td>
<td>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</td>
</tr>
<tr>
<td>3. Funding</td>
<td>Staged funding increases taking account of population growth, combined with investment to facilitate the move to new care models and ways of working</td>
</tr>
</tbody>
</table>
1.2.2.4 Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

The leading national health and care bodies in England have come together to publish Delivering the Forward View: NHS 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.\(^2\)

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 over the five year period, including the creation of 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.\(^2\)

The table below outlines the core content of the shared planning guidance:\(^2\)

### Table 13: Planning guidance: core content

| Three gaps                  | 1: Health and wellbeing  
|                            | 2: Care and quality  
|                            | 3: Funding and efficiency |
| Three tasks                | 1: Implement the Five Year Forward View  
|                            | 2: Restore and maintain financial balance  
|                            | 3: Deliver core quality and access standards |
| Two 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:\(^2\)

### Table 14: Nine ‘must-do’s’ for 2016/17

|   | Develop a high-quality and agreed Sustainability and Transformation Plan (STP)  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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 have come together in 44 STP ‘footprints’ or ‘places’. 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.\textsuperscript{21}

\textbf{Figure 6: 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 (CIPs).

\textbf{Key learnings:}

- New models of care are seen as the vehicles for change with 50 vanguard sites identified
- Place-based planning (STPs) is essential for the sustainability and transformation of the NHS
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 DH to spend on the NHS in England is made as part of the Spending Round process.23

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: NHS England receives around £107 billion a year, compared with £53 billion for education and £25 billion for defence.11

How does the money flow from the Treasury to patient services?
The Treasury allocates money to the DH, which in turn allocates money to NHS England. The DH retains a proportion of the budget for its running costs and the funding of bodies such as Public Health England.11

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 2017/18.24

Figure 7: Funding allocations and flows 2016/17

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.

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.

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 or £5,941 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.

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.

Key learnings:

- Approximately 98% of NHS funding comes from taxation and National Insurance payments.
- The budget is allocated by the Treasury and given to NHS England via the Department of Health.
- NHS England receives the NHS budget and allocates funding to the CCGs for commissioning of healthcare services accordingly.
- Providers of healthcare services receive payment, the majority of which is through payment by results, from commissioners for activity delivered.
- Approximately 50% of the CCG budgets are spent on acute and emergency care, with around 10% being spent on prescribing.
1.2.4 Incentives in the system

As with most organisations, in order to drive specific activities and increase quality targets need to be 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.

1.2.4.1 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 CCGs 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.

- Domain 1 – Preventing people from dying prematurely
- Domain 2 – Enhancing quality of life for people with long-term conditions
- Domain 3 – Helping people recover from episodes of ill health or following injury
- Domain 4 – Ensuring that people have a positive experience of care
- Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Figure 8: The five domains

1.2.4.2 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.

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.

When QOF was first introduced, the following principles were agreed: that QOF standards should apply:

- 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.

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 £165.18.

1.2.4.3 Commissioning for Quality and Innovation payments (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.

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 and agreed with their commissioners. The percentage value will be dependent on the performance of the provider.

<table>
<thead>
<tr>
<th>National goals</th>
<th>Local pick list</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS staff health and wellbeing</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>

1.2.4.4 Quality Premium (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, reduce inequalities in health outcomes and improve access to services.

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:
• 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

QP 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.
1.2.5 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.\textsuperscript{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 prescribers.\textsuperscript{36}

Table 16: Independent and supplementary prescribers

<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</td>
<td>Work with the independent prescriber to fulfil a clinical management plan</td>
</tr>
<tr>
<td>condition, including prescribing medication</td>
<td></td>
</tr>
<tr>
<td>Can prescribe any medicine, including controlled medicines, for any condition within their competence under the agreed clinical management plan</td>
<td></td>
</tr>
</tbody>
</table>
Table 17: Who are the prescribers?

<table>
<thead>
<tr>
<th>Independent prescribers</th>
<th>Supplementary prescribers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Doctors: GPs or hospital doctors</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, and 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 underwrite 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 the 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% (January 2013).

**1.2.5.1 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.37

Benefits of local formularies may include those shown in the table following:
Table 18: Benefits of local formularies

<table>
<thead>
<tr>
<th>No.</th>
<th>Benefit</th>
</tr>
</thead>
<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>

1.2.5.2 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.
1.2.6 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.

Working collaboratively can take many forms including promotion, joint working, 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, benefiting patients across the UK, and across a range of health economies and disease areas.

Examples have been included in a guide to joint working with the pharmaceutical industry. Joint working must comply with the ABPI Code of Practice and it is recommended that all parties refer to the Department of Health’s *Best Practice Guidance on Joint Working*. 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.

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

From June 2016 the pharmaceutical industry will publish details of all transfers of value – payments and benefits in kind – made to UK healthcare professionals and organisations as part of our working together. This includes Joint Working and other collaborative working and meets the requirement of Clause 24 of the Code of Practice.
Table 19: Assessing a collaborative activity

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

Key learnings

- Working collaboratively with the NHS takes many forms: promotion, joint working, MEGS and sponsorship.
- Company representatives must comply with the ABPI Code of Practice and all internal company procedures.
- Company representatives are recommended to refer to the ABPI Quick Start guide: http://www.abpi.org.uk/our-work/library/guidelines/Documents/joint_working_handbook.pdf
1.2.7 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). The divergence affects structures, management approaches and how social care relates to health.

1.2.7.1 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.

Data from the Nuffield Trust indicates that 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 been further cash injections in 2014/15 and 2015/16 to reverse this trend. The total expenditure in 2013/14 for all programme budget categories was £5.5 billion or £1,803.82 per head of population.

The reorganisation of NHS Wales, which came into effect on 1 October 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.

The NHS now delivers services through seven Local Health Boards (LHBs) 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.
Figure 10: 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.

The Local Government Wales Act 2015 became law in Wales on 25 November 2015. The Act is the first of two 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 went out to consultation until the middle of February 2016 and proposed that the number of councils in Wales be reduced from 22 to eight or nine, which would potentially cut the cost of local government – outcomes are 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 – new policies may be developed after this.
Medicines

Prescriptions are free in Wales.

The All Wales Medicine Strategy Group (AWMSG) provides advice on medicines management and prescribing to the Welsh Government’s Minister for Health and Social Services.53

- 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 medicines routinely available.54

- Wales Patient Access Schemes (WPAS) are proposed by a pharmaceutical company and agreed with the Welsh Government, with input from the Patient Access Scheme Wales Group (PASWG) within the AWMSG Health Technology Assessment (HTA) process.55

  o If it is considered feasible, the company will then be invited to include the WPAS alongside its submission for medicines appraisal by the All Wales Medicines Strategy Group (AWMSG).

- Individual Patient Funding Requests (IPFR) are requests from individual patients who require a service or treatment that would not normally be provided.56

1.2.7.2 Scotland

Overview of the NHS in Scotland

Responsibility for the National Health Service 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.57

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 Scotland is 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.57

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.57
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 as shown below:\textsuperscript{58}

Table 20: Three deliverables for NHS Scotland

| Putting people at the heart of the NHS | Building on the values of the people working in and with NHS Scotland | 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.\textsuperscript{59}

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:\textsuperscript{60}

- there is integrated health and social care
January 2017 version

- there is a focus on prevention, anticipation and supported self-management
- if hospital treatment is required, and cannot be provided in a community setting, day care 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 1 April 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.61

The nine National Health and Wellbeing outcomes are shown in the table below: 62

**Table 21: National Health and Wellbeing outcomes in Scotland**

<table>
<thead>
<tr>
<th>Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer</th>
<th>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</th>
<th>Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of the people who use those services</td>
<td>Outcome 5. Health and social care services contribute to reducing health inequalities</td>
<td>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</td>
</tr>
<tr>
<td>Outcome 7. People using health and social care services are safe from harm</td>
<td>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</td>
<td>Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services</td>
</tr>
</tbody>
</table>

There is now a requirement on NHS Boards and Local Authorities to integrate health and social care budgets.18

**Health and Social Care Integration Partnerships**63

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).64
January 2017 version

Medicines

People receive free prescriptions in Scotland.

The Scottish Medicines Consortium (SMC) provides advice to NHS Scotland 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:65

- 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 NHS Scotland.

- 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.

1.2.7.3 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.66

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.66

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 overly-committed health and social care service.67

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.67

On 4 November 2015 the Health Minister announced that he was proposing radical changes to the way health and social care in Northern Ireland is delivered.68
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{66}

a) \textit{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

b) \textit{to performance-manage} Health and Social Care Trusts

c) \textit{to effectively deploy and manage} its annual funding from the Northern Ireland Executive, currently around £4 billion.

**Figure 14: The five local commissioning groups (LCGs)**

LCGs are responsible for the commissioning of health and social care, and the Trusts for the delivery of services commissioned.\textsuperscript{69}

A consultation document produced by the Minister for Health on health and social care reform and transformation has proposed the three following changes:\textsuperscript{66}
January 2017 version

- 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 down the Health and Social Care Board.

The consultation closed in the middle of February 2016 and the outcome is awaited.

**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 covers the majority of prescribing choices in Northern Ireland.\(^70\)

It is the responsibility of HSC organisations to put in place the necessary systems for implementing NICE guidance.\(^71\)

---

**Key learnings:**

- There is marked divergence of policy and structure between England and the devolved nations.
- Collaboration and integration between health and social care are key drivers.
- There is no separation between commissioning and provider functions in Scotland and Wales; Northern Ireland is aiming to follow suit.
- Prescriptions are free in all three devolved nations.
References

1. Helping people live better for longer: A guide to the Department of Health’s role and purpose post-April 2013

2. NHS Choices website http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx

3. Allocations of resources to NHS England and the commissioning sector for 2016/17 to 2020/21

4. NHS Choices website: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx

5. Office for National Statistics


9. NHS Mandate 2016/17


12. NICE website https://www.nice.org.uk/about/who-we-are


15. Considerations for determining local health and social care economies


January 2017 version

21 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/


25 A simple guide to Payment by Results

26 https://www.england.nhs.uk/wp.../2015/03/2015-16-eto-spreadsheet.xlsx

27 http://www.hscic.gov.uk/nhsosf

28 NHS Outcomes Framework


31 http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html


34 http://www.rightcare.nhs.uk/index.php/programme/#more-11

35 https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/


37 http://publications.nice.org.uk/developing-and-updating-local-formularies-gpg1


39 Joint working with the pharmaceutical industry – guide and case studies, ABPI 2013
http://www.abpi.org.uk/our-work/library/Pages/default.aspx


NHS Improvement website https://improvement.nhs.uk/about-us/who-we-are/

NHS England website https://www.england.nhs.uk/2016/03/framework-launched/


Knowledge and analytical services Welsh Government, NHS expenditure programme budgets: 2013-14, 23 June 2015


Welsh Government, Together for Health: A Five Year Vision for the NHS in Wales, 2011


Welsh Government, Social Services and Well-being (Wales) Act 2014


All Wales Medicines Strategy Group, AWMSG Recommendation Wording, January 2015


All Wales Policy, Making Decisions on Individual Patient Funding Requests (IPFR), September 2011


The Scottish Government, A Route Map to the 2020 Vision for Health and Social Care, 2011


The Scottish Government, National Health and Wellbeing Outcomes, February 2015


Health Improvement Scotland, A Guide to the Scottish Medicines Consortium

Department of Health, Social Services and Public Safety, Health and Social Care, Reform and Transformation, December 2015

BMA Northern Ireland, Response to Health and social care; reform and transformation, getting the structures right, 12 February 2016


70 http://niformulary.hscni.net/Formulary/Pages/default.aspx: last accessed 9 March 2016

71 Department of Health, Social Services and Public Safety, NICE Clinical Guidelines – Process for Endorsement, Implementation, Monitoring and Assurance in Northern Ireland, 11 December 2013