



NHS
England

UNDERSTANDING THE NEW NHS

A guide for everyone working and training within the NHS



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The NHS belongs to us all

This guide is for everyone working and training within the NHS*. Together we are the guardians of the NHS and it is us who will help to steer the NHS through the clinical and economic challenges of the next generation. These challenges are unprecedented in the history of the NHS: rising costs unmatched by funding, an ageing population with multiple chronic conditions, and a system that is not currently structured to meet modern standards of quality of care that surpass patients' expectations.

For most healthcare professionals, training is focused solely on the provision of clinical care. Yet, for every interaction with a patient (and NHS staff have contact with more than 1.5 million patients and their families every day) there is a vital system of purchasing and planning, financing, and regulatory activity required to support it.

To truly effect change and improve the quality of care for our patients, we need to go beyond our clinical training, and learn to understand and engage with the organisations, systems and processes that define, sustain and regulate the NHS. This is no easy task; the NHS is an increasingly complex system, and finding your way through the maze can be confusing.

In reading this guide, we hope that the structures of the NHS, and your place within it, become a little clearer. With understanding comes the confidence to engage with and challenge the system, helping to improve our NHS for patients and staff, now and in future generations

*** This guide mainly refers to the NHS in England, but we hope it will be of use to colleagues in other countries.**

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NHS England National Medical Director's Clinical Fellows 2013/14



Clinical professionals in training are fundamental to the success of the NHS; whether a nurse, scientist, doctor, or allied health

professional, it is you who will provide the insight and solutions to the many challenges that the NHS faces. As a medical student and a junior doctor I personally gave little thought to how the NHS worked – I was busy learning or looking after patients, and I felt that 'management' was someone else's responsibility. Over the years I began to appreciate that this perception was misguided. If I really cared about how well patients were treated then I had a moral and professional responsibility to understand the system in which I practised.

I know that many trainees feel undervalued and disenfranchised by the organisations in which they work. This feeling discourages them from engaging enthusiastically with others to change the way NHS organisations deliver services. This is a huge loss, given that our trainees in all professions not only have a unique insight into how things really work, but also have the most innovative ideas for how the NHS could be improved for the benefit of staff and patients alike. I want our trainees to play a central role in improving the NHS. Throughout my career I wanted to improve things. I could see some of the problems, but I didn't know how to go about making changes within the system. Over time I realised that making real improvement

was a collaborative process; it was not the role of one person alone. Change only happens when clinicians, managers, policy makers, and all sorts of people who are expert in the different aspects of healthcare have the will to work together to achieve the same goal or vision.

Young, enthusiastic clinicians can add significant insight into our biggest healthcare challenges, but unless you know how to channel this enthusiasm and how the system works, nothing will happen. I had to learn by experience, but if I had understood the system properly from the beginning, I would have avoided a great deal of trial and error, as well as frustration. This is why I want you to have this guide.

I know that clinical trainees have sometimes felt at the mercy of 'management' or 'policy'. Let's change that. Instead I invite you to be part of it. By all means use this guide for general interest, to answer interview questions, to understand policies, buzzwords and 'management speak'. Use it to immerse yourself in the system in which you work. But more importantly, I hope that you will also use it to empower yourself and your colleagues to get to know how the NHS works and to really make it your own. You are an integral part of the NHS system and you are tomorrow's clinical leaders.

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director



NHS values and the Constitution

The **NHS values** describe what we aspire to in providing NHS services, to facilitate co-operative working at all levels of the NHS. The NHS values were derived from extensive discussions with staff, patients and the public, and provide a framework to guide everything that we do within the NHS. **The NHS Constitution** was published by the Department of Health in 2011. It is the first document in the history of the

NHS to explicitly set out what patients, the public and staff can expect from the NHS and what the NHS expects from them in return. The Constitution cannot be altered by government without the full involvement of staff, patients and the public, and so gives protection to the NHS against political change.

➔ For details on the NHS Constitution or to download a copy, go to: www.nhs.uk/nhsconstitution

An overview of the Health and Social Care Act 2012

The Health and Social Care Act 2012 introduced radical changes to the way that the NHS in England is organised. The legislative changes from the Act came into being on 1 April 2013 and include:

A. A move to clinically led commissioning. Planning and purchasing healthcare services for local populations had previously been performed by England's 152 primary care trusts (PCTs). The Act replaced the PCTs with 211 clinical commissioning groups (CCGs), led by clinicians. CCGs now control the majority of the NHS budget, with highly specialist services and primary care being commissioned by NHS England.

B. An increase in patient involvement in the NHS. The Act established independent consumer champion organisations locally (Healthwatch) and nationally (Healthwatch England) to drive patient and public involvement across health and social care in England. The Healthwatch network has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

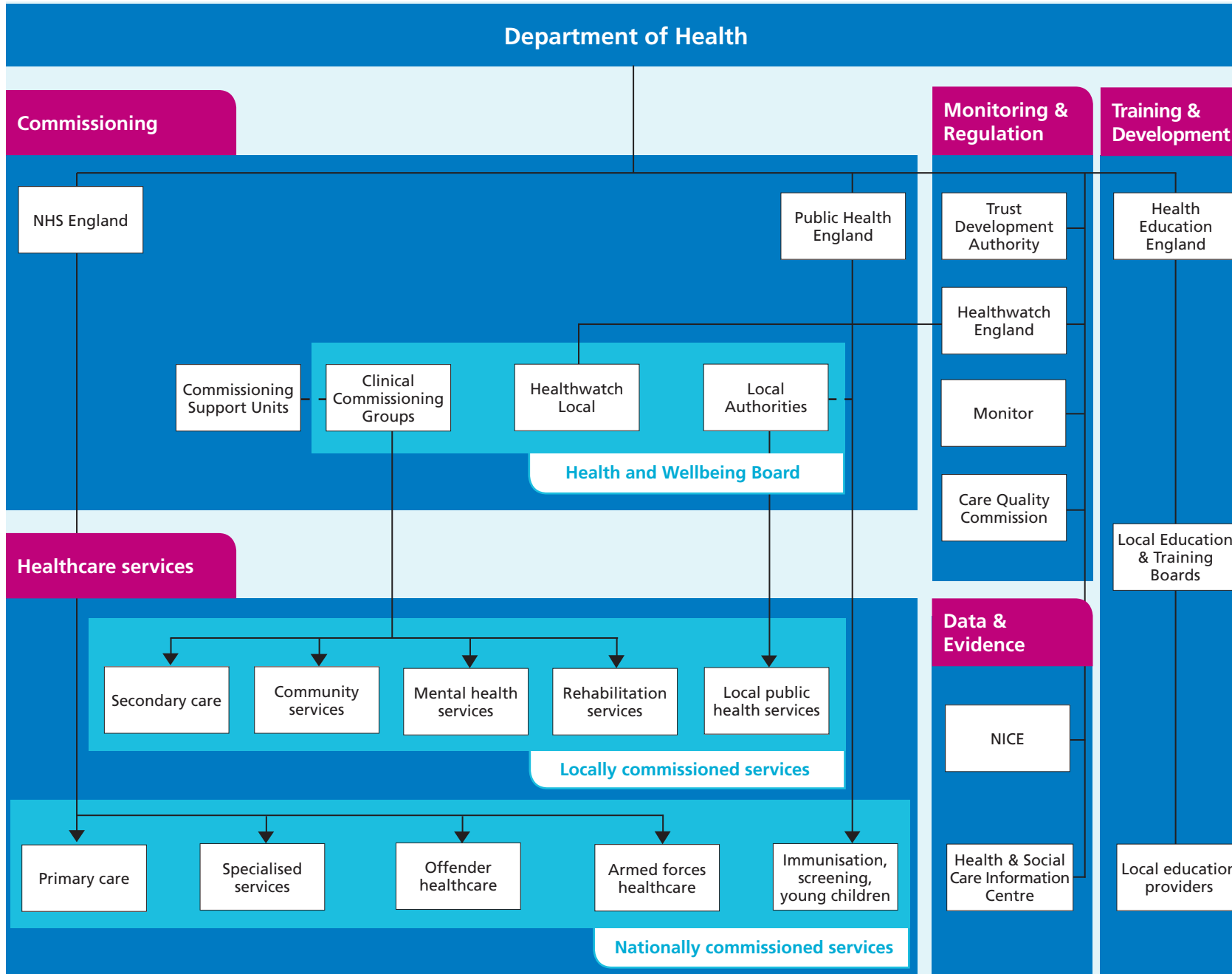
C. A renewed focus on the importance of public health. The Act provided the legislation to create Public Health England (PHE), an executive agency of the Department of Health. PHE's aim is to protect and improve the

nation's health and to address health inequalities.

D. A streamlining of 'arms-length' bodies. The Act conferred additional responsibility on the National Institute for Health and Care Excellence (NICE – formerly the National Institute for Clinical Excellence) to develop guidance and set quality standards for social care. The Health and Social Care Information Centre (HSCIC) was also tasked with responsibility for collecting, analysing and presenting national health and social care data.

E. Allowing healthcare market competition in the best interest of patients. The Act aimed to allow fair competition for NHS funding to independent, charity and third-sector healthcare providers, in order to give greater choice and control to patients in choosing their care. To protect the interests of patients under these new arrangements, Monitor was established as the sector regulator for health services in England. Monitor issues licences to NHS-funded providers, has responsibility for national pricing and tariff (in conjunction with NHS England) and helps commissioners ensure that local services continue if a provider is unable to continue providing services.

➔ Find out more about the changes resulting from the Act at: www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets



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

Chief Medical Officer
 The Chief Medical Officer is the UK government's principal medical and scientific adviser, the professional lead for doctors in England, and the professional lead of all directors of public health in local government.

National Medical Director
 The Medical Director of NHS England is responsible for clinical policy and strategy, promoting a focus on clinical outcomes, enhancing clinical leadership and promoting innovation.

Chief Nursing Officer
 The Chief Nursing Officer is the professional lead for nurses and midwives in England and oversees quality improvements in patient safety and patient experience.

Chief Professional Officers
 The Chief Professional Officers (including the Chief Scientific Officer, Chief Dental Officer, Chief Pharmaceutical Officer and Chief Health Professions Officer) are the heads of their respective professions and provide expert clinical advice across the health system.

Finance in the NHS: your questions answered

Where does the money come from?

The money for the NHS comes from the Treasury. Most of the money is raised through taxation.

How does NHS England decide how much each CCG gets?

CCG budgets are allocated on a 'weighted capitation' basis. This means that budgets are set based on the size of the population, and adjusted for other factors: the age profile of the population; the health of the population; and the location of the population.

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 is money paid to service providers?

Historically, service providers were paid an annual lump sum to provide a service locally. These were known as 'block contracts', and were not linked to the number of patients seen, the work actually carried out, or the quality of care provided. In 2003/04 the government introduced 'Payment by Results' (PbR), an activity-based system that reimburses providers for the work that they carry out, at an agreed national price. Currently, PbR represents almost 30% of NHS expenditure. Most of the remainder is covered by old-style block contracts and local variations on these. NHS England and local commissioners are working towards a payment system based on quality of care and health outcomes achieved.

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. The NHS Mandate, issued annually from the government to NHS England, sets out what must be achieved in return for the taxpayer investment in the NHS.

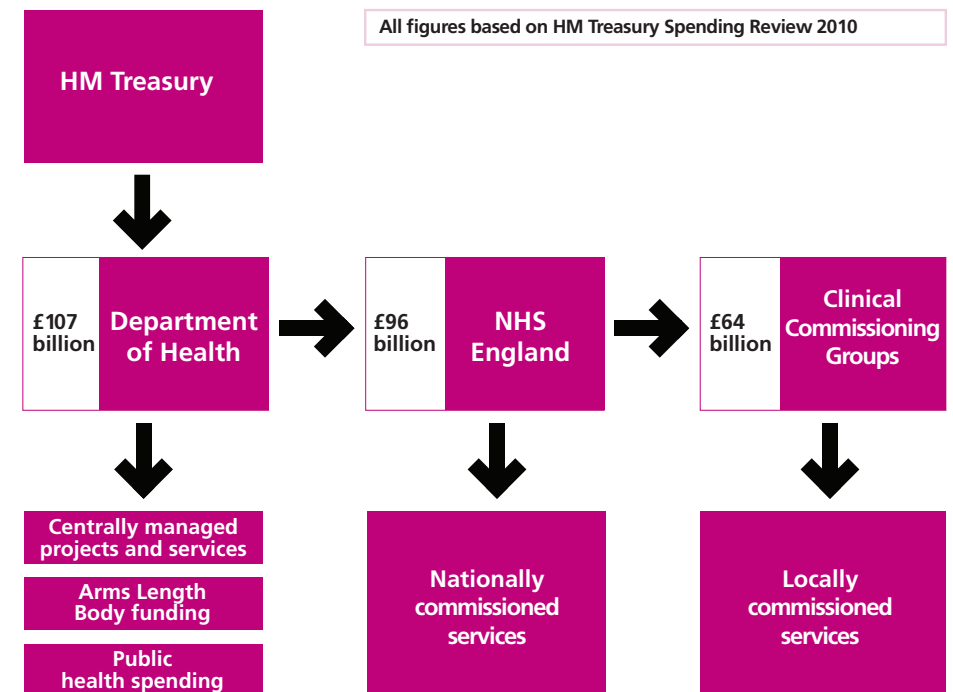
How does the money flow from the Treasury to patient services?

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.

NHS England currently receives around £96 billion a year from the Department of Health (2012/13). Approximately £30 billion is retained by NHS England to pay for its running costs and the services it commissions directly: primary care (including GP services), specialised services, offender and military healthcare. The remainder is passed on to clinical commissioning groups (CCGs) to enable them to commission services for their populations.

Service providers are paid in a number of different ways (see opposite for further details). The diagram below illustrates the flow of money from the Treasury to CCGs.

How the money flows



Commissioning

The day-to-day operations of the NHS can be split into two major functions: commissioning services for patients and providing them.

Commissioning organisations: NHS England

NHS England was formally established as the NHS Commissioning Board in October 2012. It 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:

- Providing national leadership for improving outcomes and driving up the quality of care;
- Overseeing the operation of clinical commissioning groups (CCGs);
- Allocating resources to clinical commissioning groups;
- 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 just over £95 billion. Within this 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 and to operational costs. NHS England's responsibilities are discharged through four regional teams (North, Midlands & East, London and South) and 27 Local Area Teams (LATs). Out of the 27 area teams, ten have responsibility for specialised

Direct commissioning

NHS England has responsibility for commissioning:

- Primary care
- Specialised healthcare services (provided in relatively few hospitals and accessed by comparatively small numbers of patients; accounts for around 10% of the total NHS budget)
- Health services for serving personnel and families in the armed forces
- Health services for people who are in prison or other secure accommodation, and for victims of sexual assault (adults and children)

The mandate

To ensure that the taxpayer (to whom the government is accountable) has a say in how NHS money is spent, a Mandate is published yearly to provide ambitions and directions for NHS England. NHS England has a duty to achieve the ambitions that are set out in the Mandate and will be held to account by the Secretary of State for Health to do so. However, the day-to-day running of the NHS is determined by NHS England, independent of political control.

Who are the CCGs?

Clinical Commissioning Groups 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 members set out in their constitution the way in which they will run their CCG. Constitutions are agreed with NHS England and published. 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 a chair and a deputy chair:

The CCG's Accountable Officer
The Chief Finance Officer
A registered nurse
A secondary care specialist
Two lay members

Many CCGs have appointed additional members to bring added perspectives to their governing body. Details must be set out in their constitution. Although the members of CCGs are GP practices, CCGs are required to obtain expert advice from a broad range of health professionals.

services and some have responsibility for offender or armed forces commissioning. The oversight function for area teams and regional teams is vital. These teams also provide an important link with the national NHS England team and it is hoped these relationships will improve communication between national strategy and local delivery of healthcare.

➔ You can find out more about the work of NHS England at: www.england.nhs.uk/about

Commissioning organisations: clinical commissioning groups

The Health and Social Care Act 2012 replaced the previous system of primary care trusts with 211 clinical commissioning groups (CCGs), each serving a median population size of around 250,000 people (range 61,000 to 860,000). The advantage of the new

system is that CCGs are clinically led local organisations that know the area in which they are working, and so are able to commission services that are specifically required by the population that they serve. CCGs are responsible for commissioning the following services in their 'patch':

- Urgent and emergency care (for example, A&E);
- Elective hospital care (for example, outpatient services and elective surgery);
- Community health services (services that go beyond GP);
- Maternity and newborn;
- Mental health and learning disabilities.

Clinical commissioning groups can commission services from a range of providers, including from the voluntary and private sectors. Any body that provides these services must be registered with a regulating body (for further information see the section on Monitoring the NHS).

Support for commissioning organisations: Commissioning Support Units, Strategic Clinical Networks and Clinical Senates

CCGs are supported in their work by a number of organisations at national, regional and local level. This support

helps to ensure that the CCGs' output is focused on improving the health and wellbeing of their local population.

Commissioning Support Units

Commissioning support units (CSUs) assist CCGs in the more practical aspects of their roles. CSUs are hosted by NHS England and provide support in a number of areas, including:

- **Transactional commissioning** – for example, market management, contract negotiation, information and data analysis.

- **Transformational commissioning** – for example, service redesign.

There are 9 groups of CSUs across England. They do not have defined boundaries and can serve any CCG. CCGs can use CSUs as they wish, from a very minimal amount to a much broader partnership – there is no obligation to use them and accountability for delivery of services will always remain with CCGs.

Strategic Clinical Networks

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

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. Clinical senates are comprised of a core Clinical Senate Council and wider Clinical Senate Assembly or Forum.

Delivering NHS services

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

organisations are predominantly known as trusts, which can be classified as NHS foundation trusts or NHS trusts:

Differences between NHS foundation and NHS trusts		
	NHS foundation trust	NHS trust
Government involvement	Not directed by government, therefore more freedom to make strategic decisions	Directed by government
Regulation: Financial	Monitor	Trust Development Authority
Quality	CQC	CQC
Finance	Free to make their own financial decisions according to an agreed framework set out in law and by regulators. Can retain and reinvest surpluses	Financially accountable to government

Delivery of NHS services involves:

- **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** 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.

- **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.

Health and wellbeing in the NHS

Health is not simply an absence of disease. A key aim of the Health and Social Care Act 2012 was to renew the importance of improving the health of

the public. Public Health England and Health and Wellbeing Boards have the remit to protect and improve the nation's health and to address health inequalities.

Public Health England

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

The main functions of PHE are:			
Health protection	Health improvement	Knowledge and information	Operations
For example, notifiable disease outbreak prevention, recording and management and major incident response	Responsible for developing a 21 st century health and wellbeing service addressing health inequalities – for example, health promotion and screening services	For example, disease registration, research and development	Ensuring delivery of consistently high-quality services – for example, the national microbiology unit

Health and Wellbeing Boards

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.

Who sits on the HWBs?

- Locally elected representatives
- Healthwatch representative
- Representative from each local CCG
- Director of Adult Social Services (LGA)
- Director of Children's Services (LGA)
- Director of Public Health (LGA)
- Other invited persons to provide specific expertise

Lessons learned and taking responsibility

The NHS Values describe how everyone using or working within the NHS should be treated. Following the failings at Mid Staffordshire NHS Foundation

Trust, it is vital that everyone involved in the NHS learns from the findings of the subsequent Francis inquiry and Keogh and Berwick reviews.

FRANCIS INQUIRY
February 2013

Robert Francis QC led a public inquiry into the failings at Mid Staffordshire NHS Foundation Trust. The inquiry, which cost £13m, identified many reasons for why things went so wrong and the report made 290 recommendations. At the heart of these was a need to develop: a culture of openness and transparency; a system of accountability for all; a system promoting clinical leadership and an emphasis on always putting patients first.

➔ www.midstaffpublicinquiry.com

KEOGH REVIEW
July 2013

Sir Bruce Keogh was asked to lead a review of 14 hospital trusts which had a persistently high mortality rate. The inspections used a new methodology involving teams of clinicians of differing grades and specialties. Eleven of the 14 trusts inspected were put into special measures and scheduled for re-inspection, and the review report set out eight key ambitions for improving care. The Care Quality Commission has built on the Keogh review in developing its process of inspecting all trusts throughout England.

➔ www.nhs.uk/NHSEngland/bruce-keogh-review

BERWICK REVIEW
August 2013

In response to the Francis inquiry report, Professor Don Berwick was asked to look at how 'zero harm' could be made a reality in the NHS. In total ten recommendations were made with core themes around transparency, continual learning, leadership, regulation and seeking patient and carer opinions.

➔ www.gov.uk/government/publications/berwick-review-into-patient-safety

Regulation and monitoring

Revalidation is the process by which clinicians have to demonstrate to their regulatory bodies (for example, GMC and NMC) that they are up to date and fit to practise. It is a way of regulating the professions and contributing to the ongoing improvement in the quality of care delivered to patients.

How does it work? Revalidation is based on local evaluation of the clinician's performance through appraisal. All doctors already participate in an annual appraisal and maintain a portfolio of supporting information. Revalidation for nurses and midwives is expected to start in 2015.

Monitor is the financial regulator of foundation trusts. Monitor works to make sure that:

- NHS foundation trusts are well-led and well-run, so they provide quality care;
- Essential NHS services are maintained if a provider gets into difficulty;
- The NHS payment system promotes quality and efficiency;
- Procurement, choice and competition operate in the best interests of patients.

The **National Quality Board (NQB)** is a multi-stakeholder board established to champion quality and ensure alignment of quality goals throughout the NHS. It aims to bring together multiple organisations with an interest in improving quality to agree the NHS quality goals, while respecting the independent status of participants.

The **Trust Development Authority (TDA)** is responsible for ensuring that non-foundation trusts develop the capability to achieve independent foundation trust status. Key functions of TDA include:

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

The **Care Quality Commission (CQC)** is the independent regulator for quality in health and social care in England (including private providers). 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 powers to issue warnings, restrict the service, issue a fixed penalty notice, suspend or cancel registration, or prosecute the provider.

The **General Medical Council (GMC)** is the independent regulator of nearly 260,000 doctors in the UK and was established in the Medical Act 1958. The GMC:

- Sets the standards that are required of doctors practising in the UK;
- Decides which doctors are qualified to work in the UK and oversees their education and training;
- Ensures that doctors continue to meet these standards throughout their careers through a five-yearly cycle of revalidation;
- Can take action when a doctor may be putting the safety of patients at risk.

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 healthcare by gathering views 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 areas, identifying gaps in services and feeding into local health commissioning plans.

The **Nursing and Midwifery Council (NMC)** regulates more than 670,000 nurses and midwives in the UK. Key responsibilities include:

- Setting professional standards of education, training, performance and conduct, and ensuring that these standards are upheld;
- Investigating nurses and midwives who are thought to fall short of its standards.

The **General Dental Council (GDC)** regulates all dental professionals including dentists, nurses, technicians and hygienists.

The **General Pharmaceutical Council (GPhC)** is the independent regulator for more than 70,000 pharmacists, technicians and pharmacy premises in the UK.

The **General Optical Council (GOC)** regulates around 26,000 optometrists, dispensing opticians, student opticians and optical businesses.

The **Health and Care Professions Council (HCPC)** regulates a wide range of professions including art therapists, biomedical scientists, chiropractors and podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, social workers in England and speech and language therapists.

Better training, better care

The biggest asset of the NHS is its staff. Ensuring that the NHS workforce has the right skills, values and training, and is available in the right numbers, to support the delivery of excellent healthcare is the responsibility of Health Education England (HEE). HEE is an independent organisation at arm's length of the Department of Health.

The key functions of Health Education England include:

- Providing national leadership for planning and developing the whole healthcare and public health workforce.
- Appointing and supporting development of Local Education and Training Boards (LETBs) and holding them to account.
- Promoting high-quality education and training which is responsive to the changing needs of patients and communities and delivered to standards set by regulators.
- Allocating and accounting for NHS education and training resources – ensuring transparency, fairness and efficiency in investments made across England.
- Ensuring security of supply of the professionally qualified clinical workforce.
- Assisting the spread of innovation across the NHS in order to improve quality of care.

HEE holds a budget of £4.9 billion for multi-professional education and training, which it distributes to Local Education and Training Boards (LETBs).

Local Education and Training Boards

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. LETBs, which are committees of HEE, are made up of representatives from local providers of NHS services and cover the whole of England. LETBs have the flexibility to invest in education and training to support innovation and development of the wider health system. They are also able to ensure that money follows students and trainees on the basis of quality in education and training outcomes.

➔ *Find out more about the work of HEE, along with links to your local LETB, at: www.hee.nhs.uk*

Leading healthcare excellence

Leadership development for all healthcare staff has become increasingly important in recent times. High-calibre leadership has a direct, positive impact on staff and patients, and this leadership is needed at all levels and across all health professions. A number of organisations have a remit to drive excellence in healthcare leadership:

The NHS Leadership Academy

The NHS Leadership Academy is part of the NHS and aims to ensure that all sectors and all levels of healthcare staff are engaged in leadership development. They offer a range of leadership development programmes accessible to all healthcare staff, including the Edward Jenner Programme, an online open-access programme aimed at everyone working in healthcare.

➔ *To find out more about the NHS Leadership Academy, including self-assessment leadership tools and the leadership development programmes, go to: www.leadershipacademy.nhs.uk/discover/*

The Faculty of Medical Leadership and Management

The Faculty of Medical Leadership and Management (FMLM) is a membership organisation established to promote the advancement of medical leadership, management and quality improvement for all doctors and dentists. It is responsible for

developing the standards for medical leadership and its vision is to inspire excellence in medical leadership and drive continuous healthcare improvement across the UK, for the benefit of patients. FMLM offers development opportunities to medical staff through:

- An online bank of leadership, management and quality improvement resources;
- An annual conference providing education and access to some of the UK's top leadership experts;
- A large national and regional community of medical leaders, supported through networking, peer learning and regional events.

FMLM supports and manages the National Medical Director's Clinical Fellow Scheme, a scheme that places doctors in training in apprenticeships to some of the most senior healthcare leaders across England, offering an unparalleled opportunity to develop a range of skills including: leadership, policy development, project management, research and analysis, writing and publishing.

➔ *To find out more about FMLM, including the National Medical Director's Clinical Fellow Programme, go to: www.fmlm.ac.uk*

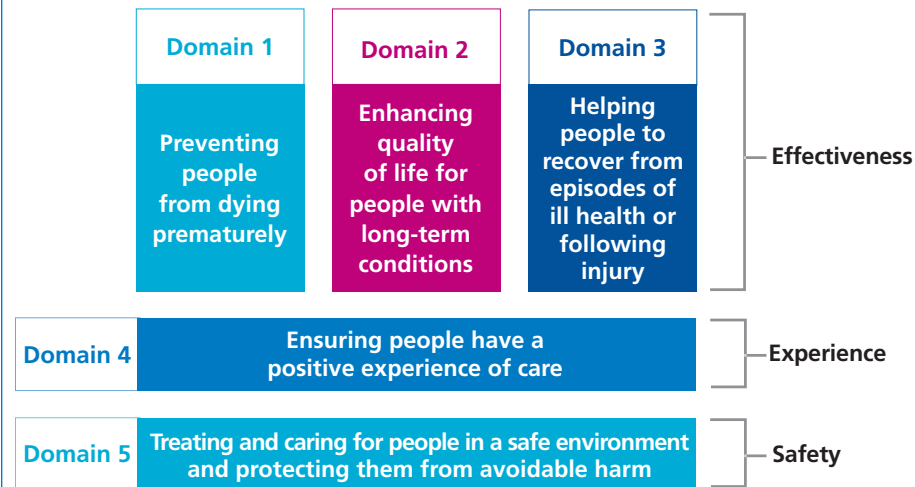
High-quality care for all

Defining quality

Quality has become the organising principle of the NHS. Quality is defined as excellence in patient safety, clinical effectiveness and patient experience. No individual or organisation is offering high-quality care unless they satisfy all three of these principles. An effective healthcare system should prevent people from dying prematurely, improve the quality of life for people living with long-term

health conditions and aid recovery for those with ill health, or following injury. All care should be delivered in a safe environment and in a way that is positive for patients and their families. These five principles have been defined in the NHS Outcomes Framework, which provides a process by which performance is measured, and acts as a catalyst to drive quality improvement.

The NHS Outcomes Framework



Domains one, two and three relate to the effectiveness of care; domains four and five relate to patient experience and safety.

The Health and Social Care Act 2012 promoted the healthcare quality agenda by establishing new organisations or widening the remit of existing organisations to focus on healthcare excellence:

NHS IQ

NHS Improving Quality was established in April 2013 to help promote and drive improvement across the NHS by building capability and capacity, and improving knowledge and skills. NHS IQ has been built upon many existing organisations, such as the NHS Institute for Innovation and Improvement and NHS Diabetes and Kidney Care.

➔ www.nhsiq.nhs.uk

NICE

The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care. It achieves this by:

- Producing evidence-based guidance and advice for health, public health and social care practitioners;
- Developing legally binding quality standards for those providing and commissioning health, public health and social care services;
- Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.

➔ www.nice.org.uk

Commissioning for quality and innovation

A number of tools have been developed to encourage and incentivise quality and innovation in all areas of NHS care.

CQUIN

CQUIN stands for Commissioning for Quality and Innovation. This is a system that was introduced in 2009 to make a proportion of a healthcare provider's income conditional on demonstrating improvements in quality or innovation in specified areas of care. Its value varies but is in the region of 2.5% of the total contract value for that organisation. When implemented effectively, it can lead to dramatic improvements in care for patients. Examples of CQUIN goals include the Friends and Family Test and assessing for patients at risk of developing a blood clot in hospital and dementia screening.

Quality Premium

NHS England is able to reward CCGs to reflect the quality of services they commission and associated health outcomes. The quality premium is one of the methods in which NHS England does this. Guidance is released yearly on the areas in which CCGs will be rewarded with a quality premium payment if they achieve the required improvements in quality of services. These areas can change yearly depending on clinical need; examples include improving access to psychological therapies and reducing avoidable emergency admissions.

The NHS in Scotland, Wales and Northern Ireland

The healthcare service in **Northern Ireland** provides both health and social care and is administered by the Department of Health, Social Services and Public Safety.

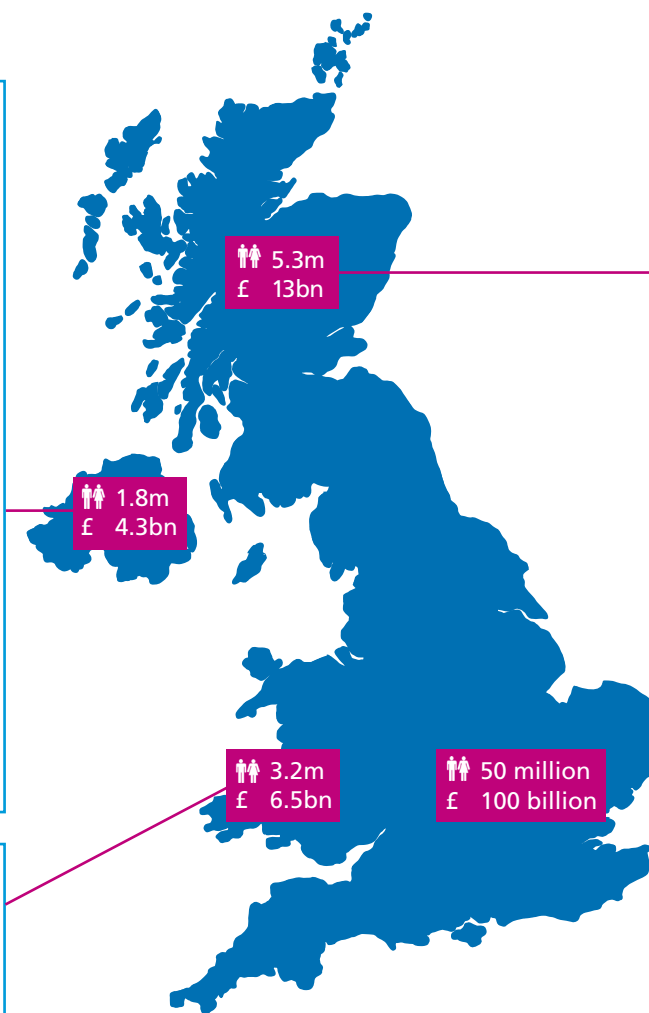
- The **Health and Social Care Board** holds overall responsibility for commissioning services through five Local Commissioning Groups.
- Five **Local Commissioning Groups** are responsible for commissioning health and social care by addressing the needs of their local population.
- Five **Health and Social Care Trusts** have responsibility for providing integrated health and social care in their regions. The Northern Ireland Ambulance Service is designated as a sixth trust.
- The **Patient and Client Council** exists to provide a powerful, independent voice for patients, carers and communities.
- The **Regulation and Quality Improvement Authority** is an independent organisation that encourages continuous improvement through a programme of inspections.
- The **Public Health Agency** is an organisation with the remit to improve health and wellbeing, provide health protection and directly input into commissioning via the Health and Social Care Board.

➔ www.dhsspsni.gov.uk

The NHS in **Wales** is devolved, and is the responsibility of the Welsh Government.

- Seven **Local Health Boards** plan, secure and deliver healthcare services for their populations;
- There are three **National Trusts**: the Welsh Ambulance Service, Velindre NHS Trust (provides specialist services in cancer and other national support) and the new Public Health body for Wales.
- Seven **Community Health Councils** represent the health and wellbeing interests of the public in their district.

➔ www.wales.nhs.uk



The NHS in **Scotland** is completely devolved, meaning that responsibility for it rests fully with the Scottish Government. The Cabinet Secretary for Health and Wellbeing and Scottish Government set national objectives and priorities for the NHS that should be delivered and monitored via NHS Boards and Special NHS Boards.

- Fourteen **NHS Boards** – these replaced trusts in 2004 and cover the whole of Scotland. They are all-purpose organisations that are expected to plan, commission and deliver NHS services for their area. They take overall responsibility for the health of their populations and commission all services including GP, dental, community care and hospital care. These boards are expected to also work together regionally and nationally so that specialist healthcare – for example, neurosurgery – is correctly commissioned. At a local level the boards have representation or partnerships with community health and social care teams and there is close involvement of local authorities, patients and public.

- Seven **Special Boards** and a **Health Improvement Board** provide national services and scrutiny as well as public assurance of healthcare.

➔ www.show.scot.nhs.uk

Differences between the NHS in England and the other home countries

- Northern Ireland has a fully integrated health and social care service; Scotland has passed legislation to achieve this goal
- Scotland and Wales have integrated boards as opposed to trusts that commission services at a local level
- Scotland has SIGN (Scottish Intercollegiate Guidelines Network) and not NICE for their clinical guidance

👤 Population
 £ Healthcare budget

Arm's Length Body A non-departmental public body which carries out its work independent of ministers or government
CCGs (Clinical Commissioning Groups) Commission health services for their local population
Clinical Senates Source of independent strategic and clinical advice for commissioners
Commissioning Process by which services are planned and provided effectively to meet population's needs
CQC (Care Quality Commission) The independent regulator of health and social care in England
CQUIN (Commissioning for Quality and Innovation) A financial incentive to improve quality of services and achieve better outcomes
CSU (Commissioning Support Unit) Provide support to CCGs, NHS England, acute trusts and government
DH (Department of Health) Branch of UK government responsible for health and social care policy and legislation
Healthwatch Independent consumer champion; its role is to represent the views of patients
HEE (Health Education England) A special health authority providing leadership for new education and training systems for healthcare professionals
HWB (Health and Wellbeing Board) A forum which brings key leaders across the healthcare system together to improve health and inequalities in a local population
LETB (Local Education and Training Board) 13 Local Education and Training Boards are responsible for training and education of clinical and non-clinical NHS staff in their area
Monitor NHS regulator that supports organisations which purchase and provide healthcare to make decisions in the best interest of patients
NHS England A non-departmental public body of the Department of Health; oversees the budget, planning, delivery and day-to-day operations of the NHS in England
NICE (National Institute for Health and Care Excellence) Provides national guidance and advice to improve health and social care
PHE (Public Health England) An executive agency of the Department of Health with a mission to protect and improve the nation's health and address inequalities
TDA (Trust Development Authority) Responsible for providing leadership and support to non-foundation trust sector



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