

# A Junior Doctor's Guide to the NHS



## Contents

Chapter	Page
Foreword	3
Introduction	4
NHS structure	5
Parliament	6
Department of Health (DH)	7
Doctors holding senior roles in the DH	8
Arm's Length Bodies	8
Strategic Health Authorities (SHAs)	9
Primary Care Trusts (PCTs)	10
Trusts and Foundation Trusts	11
New providers	12
Regulating the health service	12
Complaints and litigation	13
Commissioning	14
World Class Commissioning	15
NHS finance	16
NHS strategy: policy into practice	18
NHS Next Stage Review: High Quality Care for All ("The Darzi Review")	19
Quality in the NHS	20
National Institute for Health and Clinical Excellence (NICE)	22
Clinical governance	23
IT in the NHS	24
The health system in Scotland	25
The health system in Wales	26
The health system in Northern Ireland	27

## Foreword

Postgraduate doctors in training are fundamental to the success of the NHS. They are the backbone of medical services and, more importantly, they hold the key to the future of our NHS.

As a medical student and a junior doctor I gave little thought to how the NHS worked – it was not on my radar; that 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.



Junior doctors who work closely with patients and alongside other members of staff on the shop floor 24 hours a day have penetrating insight into how things really work – where the frustrations and inefficiencies lie, where the safety threats lurk and how quality of clinical care can be improved.

But junior doctors often feel undervalued by their organisation. They are often seen as birds of passage and this can make them feel disenfranchised from the NHS as a whole. This feeling discourages them from engaging enthusiastically with others to change the way NHS organisations work and deliver services. This saddens me, as they are often the most informed and enthusiastic and have the most innovative ideas about how the NHS could be improved for the benefit of staff and patients alike.

I want junior doctors to play a bigger role in improving the NHS. Throughout my career I wanted my patients to have the best possible quality of care. 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 doctors can add significant insight, but unless you know how to channel it 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.

Junior doctors 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**  
NHS Medical Director

## Introduction

Beyond the hospital or clinic, apart from occasional interactions with management, many junior doctors are not really sure what happens in the upper echelons of the NHS. How the NHS, the Department of Health and the government interact can be hazy, and as for the various bodies in between, it can seem a little unclear. Even when you think you know, reforms often mean that the structure has changed. If you are going for an interview, have a particular reason for needing to understand, want an update/refresher, or just think it might be useful to know how your organisation actually works (or are embarrassed that you don't), you have several options. You could comb the internet. You could look at some of the dense tomes that are published. You could talk to people. Or you could let us do it all for you and summarise it into what you need to know.

We hope you find A Junior Doctor's Guide to the NHS helpful.

### Dr Layla McCay

ST3 doctor working on secondment with Professor Sir Bruce Keogh in the Medical Directorate, Department of Health.

### Dr Sarah Jonas

ST5 doctor working on secondment with Professor Sir Bruce Keogh in the Medical Directorate, Department of Health.

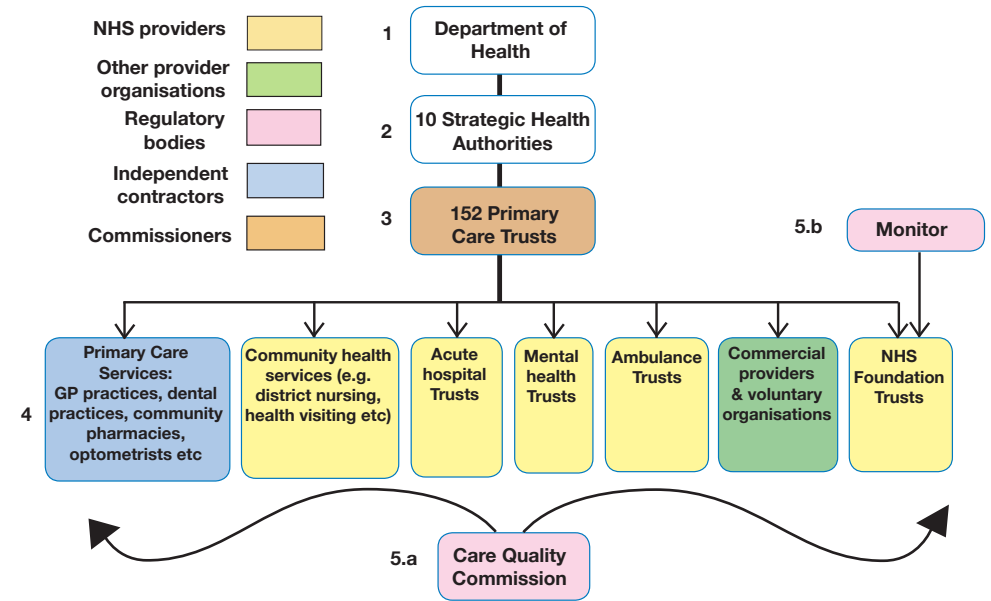
June 2009



**P.S.** This information is correct at the time of publication (June 2009), but, as is the nature of the NHS, we can't promise that some of it won't change.

## NHS structure

This is a simplified diagram giving an overview of the NHS structure in England.

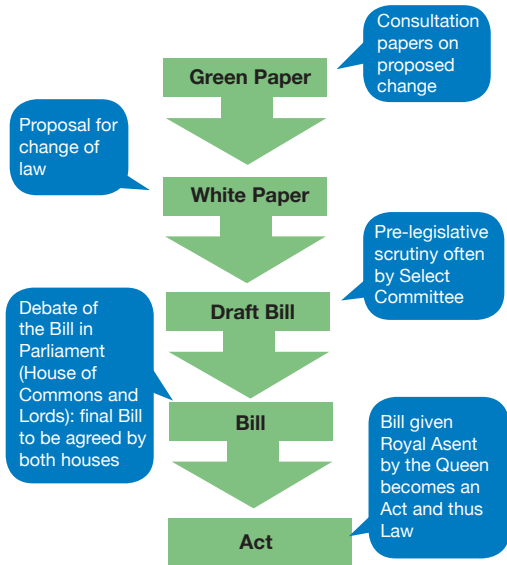


1. The Department of Health enacts the will of Parliament through policy development
2. Strategic Health Authorities (SHAs) manage the NHS locally. They occupy the middle tier between Primary Care Trusts and the Department of Health. They do not manage NHS Foundation Trusts.
3. Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services.
4. NHS providers, independent contractors and other provider organisations are responsible for actually providing these services.
5. Regulatory bodies ensure they run appropriately, are well managed (including financially), and that they provide a safe, quality service.
  - a. The Care Quality Commission (CQC) regulates and inspects providers of health and adult social care in both the public and independent sectors.
  - b. Monitor regulates the finances and governance of NHS Foundation Trusts.

# Parliament

Parliament is responsible for approving legislation and forming the framework in which the health service operates. Parliament also holds the Department of Health to account for their spending of taxpayers' money and operation of the National Health Service. This accountability is supported by the National Audit Office, which audits the accounts of all government departments and reports to Parliament on the economy, efficiency and effectiveness on their use of public funds.

## How health laws are made (not all laws go through every stage):



## How Parliament holds the Department of Health to account:

### Questions to the Secretary of State for Health

These questions can be both written and oral in both Houses of Parliament

### Parliamentary select committees, such as:

- Health Select Committee
- Public Accounts Committee
- Public Administration Committee

These committees scrutinise aspects of the work at the Department of Health via a series of enquiries questioning witnesses on specific topics of interest, e.g. patient safety, alcohol, top-up fees etc.

These sessions are open to the public so you can go along to see them in action, or submit evidence: [http://www.parliament.uk/parliamentary\\_committees/health\\_committee.cfm](http://www.parliament.uk/parliamentary_committees/health_committee.cfm)

## Health ministers provide political leadership to the Department of Health

The prime minister appoints them and agrees their portfolios

- Secretary of State** – overall strategic responsibility for the work of the Department.
- Minister of State for Health Services** – responsibilities include NHS policy and strategy, finance, system management and regulation, commissioning and departmental management.
- Minister of State for Public Health** – responsibilities include public health, health protection, emergency preparedness, health inequalities, health improvement programmes, medicines and pharmaceuticals, research and development.
- Minister of State for Care Services** – responsibilities include social care, mental health, prison/offender health, third sector, carers, equality and human rights.
- Parliamentary Under-Secretary of State for Health Services** – responsibilities include healthcare quality, patient safety, workforce, dentistry, chronic disease, child health.
- Parliamentary Under-Secretary of State (Lords)** – commissioned to review health services.

# Department of Health (DH)

The Department of Health (DH) is a government department, headed by the Secretary of State for Health. It is based in London and Leeds, with 9 regional Public Health teams, and is accountable to the public through Parliament. The DH does not directly deliver health or social care services to the public; it works with delivery partners, including the NHS, local government and Arm's Length Bodies.

The DH's goals are twofold:

- Attainment of better health, wellbeing, care and value for the country
- Provision of leadership for the NHS, social care, and public health

The DH does this in the following ways:

- Setting direction for the NHS, adult social care, and public health** – policy, strategy, legislation, resource allocation, and NHS operating framework.
- Supporting delivery of care** – performance monitoring, managerial leadership, building capacity and capability, and ensuring value for money.

**Leading health and wellbeing on behalf of the government** – working with other government departments, third and private sectors, and international partners.

**Accounting to parliament and the public** – answering parliamentary questions and communicating to the public via the media, letters, visits and speeches.

Three people are responsible for managing the DH:

## Chief Medical Officer

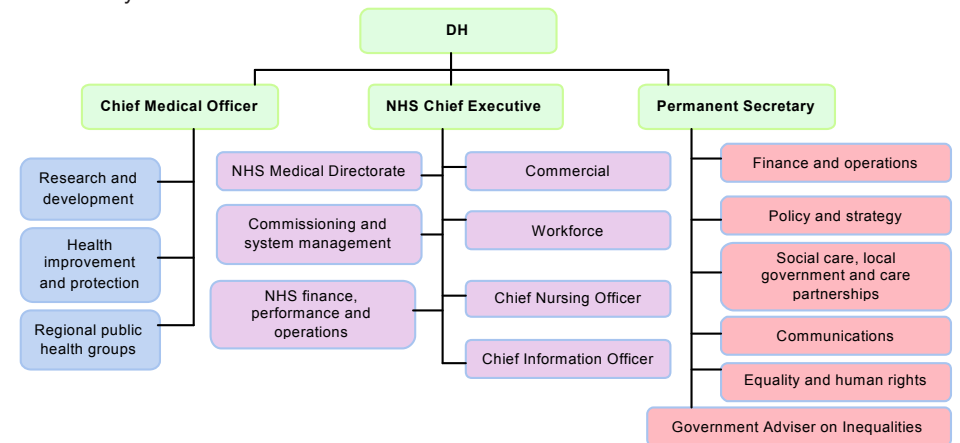
Government's chief adviser on medical issues and public health.

## NHS Chief Executive

Government's chief adviser on NHS issues, and leader of the NHS.

## Permanent Secretary

Senior civil servant responsible for leadership and management of the DH, ensuring that it operates efficiently and coherently as a department of state in support of ministers.



Email DH: [dhmail@dh.gsi.gov.uk](mailto:dhmail@dh.gsi.gov.uk)  
 Email the CMO: [CMOweb@dh.gsi.gov.uk](mailto:CMOweb@dh.gsi.gov.uk)

Write to the Secretary of State for Health,  
 Department of Health, Richmond House, 79  
 Whitehall, London, SW1A 2NS

## Doctors holding senior roles in the DH

A number of doctors provide advice to the DH and to Ministers. Like civil servants, their roles are not political and they do not change with Governments.

### Chief Medical Officer (CMO)

The role of the UK Government's principal medical adviser dates back to Victorian times. The CMO provides independent advice to the Secretary of State for Health, other Health Ministers, Ministers of other Government departments and the Prime Minister. Responsibilities include developing policies and programmes to reduce health inequalities and to protect and improve the health of the public and reviewing policy in new, changing and contentious areas of health. Over the years the CMO has shown a particular interest in improving safety and quality of care in the NHS.

### NHS Medical Director

This new position commenced in November 2007. This is an operational role with responsibility for clinical quality, safety and strategy; this includes the medicines supply chain into the UK, including policy relating to drugs, pharmacy and the pharmaceutical industry. The role has oversight of funding and work programmes of NICE, the NPSA (National Patient Safety Agency), and Medical Education England. The occupant is also Deputy CMO.

### Associate NHS Medical Director

Supports the Medical Director in his roles.

### Director General of Research and Development

Responsible for establishing the NHS as an international centre for research excellence and commissioning research to underpin policy and practice in health and healthcare, by running the National Institute for Health Research and the Policy Research Programme.

### Director of Medical Education

Responsible for the full range of medical education, including Modernising Medical Careers (MMC), and reports directly to the NHS Medical Director.

### Health Improvement and Protection

The Directors of Immunisation, Emergency Preparedness and Pandemic Influenza Pre specific clinical areas such as cancer, heart disease, stroke, diabetes, renal disease, trauma, transplantation, mental health, and maternal and child health.

### Regional Directors of Public Health

Responsible for providing regional leadership, vision, advice, advocacy and implementation.

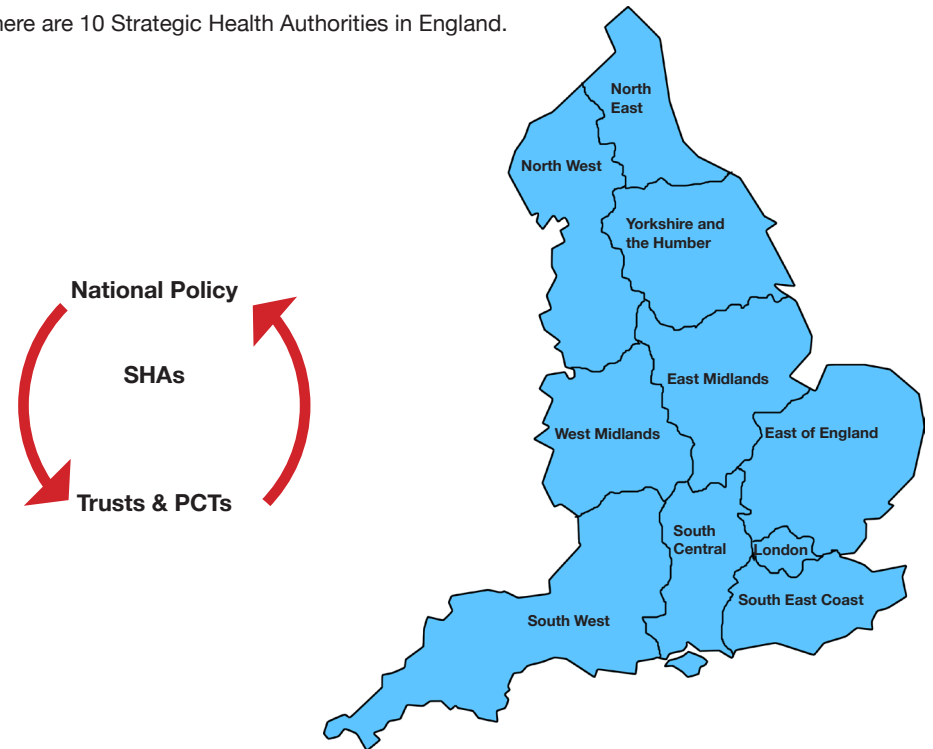
## Arm's Length Bodies

These have a role in the process of national government, but are not part of government departments. They operate at arm's length from ministers. They are sponsored by government departments and derive all or part of their funding from their sponsor departments.

## Strategic Health Authorities (SHAs)

Strategic Health Authorities (SHAs) manage the NHS locally. They occupy the middle tier between the Department of Health and local Trusts and PCTs.

There are 10 Strategic Health Authorities in England.



### Strategic Health Authorities are responsible for:

- Developing strategic plans for improving health services in their region
- Ensuring local health services are accessible, of a high quality and performing well
- Increasing the capacity and capability of local health services so they can provide more and higher quality services
- Ensuring national priorities and policies — for example, programmes for improving cancer services — are explained and integrated into local health service plans
- Offering services to Trusts where pooling of regional resources is helpful
- Managing corporate affairs for the region, including strategic direction and communication
- Holding all NHS organisations (except NHS Foundation Trusts) to account for performance

Find out more about each SHA here:

<http://www.nhs.uk/ServiceDirectories/Pages/StrategicHealthAuthorityListing.aspx>

## Primary Care Trusts (PCTs)

Primary Care Trusts (PCTs) are the key organisations responsible for ensuring there is a comprehensive range of health services for the local population.

Functions of the PCT:

### Public health care

PCTs work to improve the health and well-being of their local population by assessing needs and working directly with other local partners (e.g. local authorities, children's services and housing services) to provide services to meet these needs.

### Commissioning and contracting services

PCTs control the vast majority of the NHS budget and are responsible for commissioning the healthcare services for their area. They commission services (including acute care, primary care and mental health care) for the whole of their population, with a view to improving their population's health. All services are NHS-funded but may be provided by voluntary or independent sector organisations as well as by NHS organisations. (The process of commissioning is described on pages 14 and 15.)

### Direct provision of services

PCTs can directly provide services to patients, for instance community services.

### Governance

PCTs hold service providers to account via contracts. They can ask regulators to intervene if the providers are not meeting expected standards.

PCTs are held to account by the relevant SHA. The PCT board is accountable to the relevant SHA board.

PCTs deliver services to the population via:

- Acute Trusts
- Mental Health Trusts
- Ambulance Trusts
- GP practices
- Dental practices
- Community pharmacies
- Optical practices
- Community hospitals
- And more

Find out more about your PCT here: <http://www.nhs.uk/ServiceDirectories/Pages/PrimaryCareTrustListing.aspx>

## Trusts and Foundation Trusts

NHS Trusts provide healthcare services that have been commissioned by PCTs and practice-based commissioners. Trusts generally concentrate on one work area: acute care, mental health, learning disability, community or ambulance. All Trusts have a legal duty to break even, financially earn a specific return on capital and meet minimum quality standards.

Since 2004, Trusts have been able to apply to change their status in the NHS to NHS Foundation Trusts. As of 1st May 2009 there were 120 NHS Foundation Trusts in the UK. The Department of Health wants as many trusts as possible to become NHS Foundation Trusts in the next few years.

### How do NHS Foundation Trusts differ from NHS Trusts?

- Must meet financial requirements to become one
- Independent from SHA/DH control
- Regulated by Monitor who reports directly to Parliament
- Increased financial obligations to maintain surplus

### Freedoms include:

- Keep receipts from capital sales
- Decide how to meet national targets rather than being performance-managed
- Borrow money under strict conditions
- Set terms and conditions for staff locally

### Special kinds of Trusts

Care Trusts exist as partnerships between health and social care, delivering both services in tandem.

Children's Trusts were introduced by the Children's Act of 2004; they are not necessarily one organisation in the same way, as other trusts but exist to help co-ordinate children's services in an area through a partnership between health, social care and education.

### Trust Board

#### Functions:

- Sets strategic direction, define objectives and agree plans
- Monitors performance and ensure corrective action
- Ensures effective financial stewardship
- Ensures high standards of corporate governance and personal behaviour
- Appoints, appraises and remunerates senior executives
- Ensures dialogue between the Trust and the local community

#### Boards are typically composed of 11 members:

**Chairperson** provides leadership to the board.

**Chief Executive Officer (CEO)** ensures that board decisions are implemented, the organisation works properly and financial stewardship is maintained, as accountable officer.

**Non-Executive Directors** are lay members who provide independent judgement and critical detachment; they perform special functions relating to areas of interest.

**Executive Directors** hold operational responsibility for different areas in the organisation, e.g. Directors of Medicine, Nursing, Finance, Strategy, Communications, Governance, Corporate Affairs, Operations, Workforce etc.

Trust board meetings should be open to the public. Find details on the relevant trust's website: <http://www.nhs.uk/ServiceDirectories/Pages/AcuteTrustListing.aspx>

## New providers

In the UK, there have always been healthcare providers other than the NHS; however, historically these providers have mainly provided care to those who either had private insurance or paid directly and there was very little provision of NHS care.

Since 1997 many other providers have entered the NHS market.

The new providers can be divided into three groups:

### 1. Private sector

This sector is managed and owned by private companies. It has been established in the secondary care market as a provider to insurance companies, but increasingly provides NHS services, either through free choice (e.g. elective care) or through winning contracts to provide specific services via commissioning.

The first phase of Independent Sector Treatment Centres was created to increase the capacity to

treat patients within the NHS. The second phase of Treatment Centres has been more integrated within the current NHS facilities, and has increased contractual obligations to quality. Any future procurement of this kind of service is likely to be taken forward locally.

### 2. Third sector

This includes voluntary groups and charitable organisations, co-operatives, Trusts, community interest groups and foundations, working for instance in the mental health and substance misuse sectors. These groups are often able to bridge the gap between care sectors.

### 3. Social enterprise

Social enterprises are organisations that are run along business lines, but where any profits are reinvested into the community or into service developments. Encouraging social enterprise in health and social care is a key part of the patient-led reforms.

## Regulating the health service

The NHS has a number of different regulators for different purposes. The main ones are listed below.

### Regulators of NHS organisations

#### Care Quality Commission

The Care Quality Commission replaced the Healthcare Commission, Mental Health Act Commission, and the Commission for Social Care Inspection in April 2009. Its role is to regulate the quality of both health and adult social care in England as an independent regulator. Visit <http://www.cqc.org.uk>

#### Monitor

This body assesses Trusts applying for Foundation Trust status to ensure they are legally constituted, financially sound and well-governed. The regulator ensures that, once authorised, NHS Foundation Trusts continue to meet the terms of their licence. Monitor reports directly to Parliament. Visit <http://www.monitor-nhsft.gov.uk>

#### Audit Commission

The Commission audits NHS Trusts, PCTs and SHAs to review the quality of their financial systems. It also publishes independent reports which highlight risks and good practice to improve the quality of financial management in the health service and, working with CQC, undertakes national value for money studies. Visit <http://www.audit-commission.gov.uk>

### Regulators of treatment

#### Medicines and Healthcare Regulatory Agency

This Agency monitors the safety of new medications and products and licences new medicinal products.

Visit <http://www.mhra.gov.uk>

### Regulation of professionals

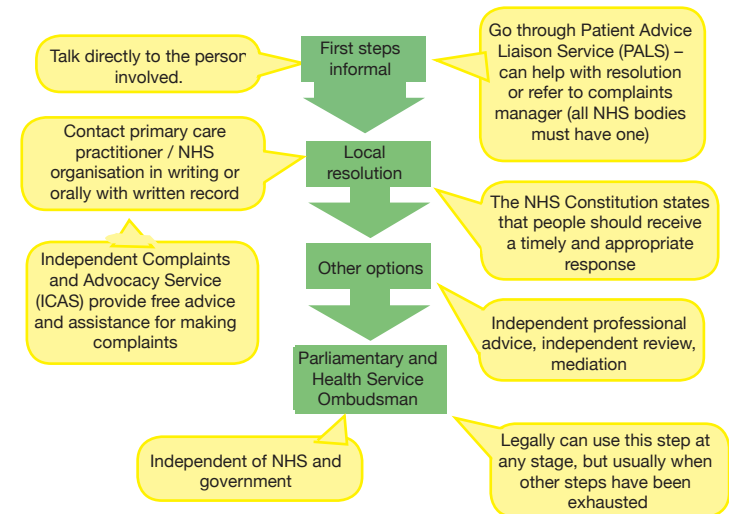
Individual professionals within the NHS are also regulated, through the professional regulatory bodies, such as the General Medical Council, the Nursing and Midwifery Council, the Health Professions Council, the General Dental Council, the General Optical Council, and the General Osteopathic Council.

## Complaints and litigation

### Top 10 NHS complaints

- Safety/effectiveness of clinical practice
- Poor communication/lack of information
- Poor response to a complaint
- Patient's experience of care
- Clinical treatment
- Delay or cancellation of appointment
- Attitude of staff
- Lack of access to personal records
- Access to services and waiting times
- Lack of carer/relative involvement

### NHS complaints



### NHS Litigation Authority (NHSLA)

A Special Health Authority within the NHS, responsible for handling negligence claims (including employee negligence) made against member NHS bodies in England through the following schemes (membership is voluntary):

### Clinical Negligence Scheme for Trusts (CNST)

Covers clinical negligence claims relating to incidents occurring after April 1995. If a claim is made, the NHS body remains the legal defendant but the NHSLA takes responsibility for handling the claim and meeting the costs.

### Existing Liabilities Scheme (ELS)

Covers clinical negligence claims relating to an incident that occurred before April 1995. Funded centrally by the Department

of Health. If the NHS body no longer exists, the relevant SHA occasionally becomes the legal defendant.

### Risk Pooling Scheme for Trusts (RPST)

has 2 schemes, the Liabilities to Third Parties Scheme (LTPS), which covers falls, bullying, stress, defamation, injury, and the Property Expenses Scheme (PES), which covers theft and damages.

The NHSLA has risk management programmes to raise standards and minimise negligence claims. Adherence to the programme results in reduction in cost of contributions; 96% of negligence claims are settled out of court by the NHSLA.

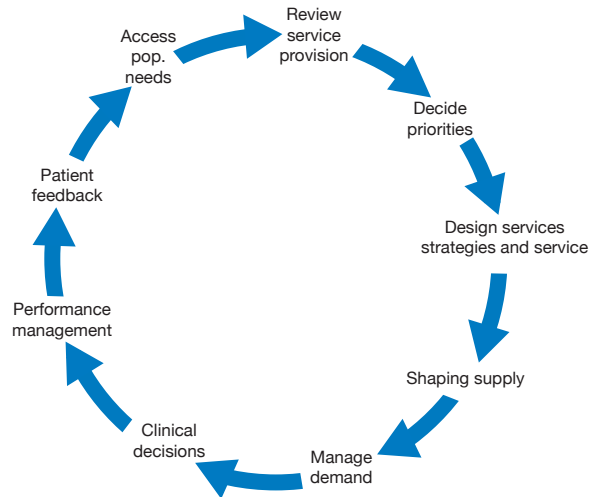
# Commissioning

## Commissioning is the process of determining:

- the health needs of the population
- the resources available
- how to organise service provision

## Commissioning occurs:

- mainly at PCT level
- at PCT group, SHA, or national level to provide for very rare conditions



PCTs are responsible for buying services from local providers. The first step in this process is a Joint Strategic Needs Assessment to determine the healthcare needs of the local population.

### What is... a Joint Strategic Needs Assessment (JSNA)?

This is a process conducted in partnership by local government, PCTs and the local community to identify areas for priority action to improve local health and wellbeing through Local Area Agreements. The JSNA has been a statutory requirement since 1st April 2008 and helps commissioners to specify outcomes that help providers shape services to address local needs.

### What is... practice-based commissioning?

This reform gives individual GPs and practice nurses more say in how the NHS provides

services to their patients, so that services better represent patients' preferences. Practices can group together but the PCT retains the legal responsibility. Practices can use 70% of the savings made for reinvestment for new services or more equipment for existing ones.

### What about... SHA and national commissioning?

For services serving populations of greater than a million people, there is a small amount of commissioning for specialist services at the SHA level (through regional specialist commissioning groups) and at the national level (the National Commissioning Group). This grouping of commissioning allows PCTs to pool the risk of unlikely but expensive treatments.

# World Class Commissioning

Improving commissioning is key to improving quality of care. World Class Commissioning (WCC) is a statement of intent for how the NHS will secure (from locally available resources) maximum improvement in locally prioritised health and wellbeing outcomes.

PCTs will become World Class Commissioners by developing 11 organisational competencies. They will be assessed against these competencies by an annual commissioning-assurance process.

## WCC aims to deliver:

### Better health and wellbeing for all

- People will live longer, healthier lives
- Health inequalities will be dramatically reduced

### Better care for all

- Evidence-based, high-quality services
- People will have choice and control over services

### Better value for all

- Investment decisions will be made in an informed and considered way
- PCTs will work with others to optimise care

## Competencies

### 1. Locally lead the NHS

Actively steer the local health agenda as leaders of the local NHS.

### 2. Work with community partners

Identify the wider determinants of health, and develop solutions together with key partners.

### 3. Engage with the public and with patients

Build local trust, actively seeking the views of patients, carers, and the public.

### 4. Collaborate with clinicians

Strengthen clinical leadership and engagement throughout all stages of commissioning.

### 5. Manage knowledge and assess needs

Base commissioning decisions on sound evidence of specific present and future local needs.

### 6. Prioritise investment

Develop outcome-focused strategic priorities and investment plans.

### 7. Stimulate the market

Improve the patient's experience of NHS services and outcomes of care by using investment choices to influence service design and increase choice.

### 8. Promote improvement and innovation

Specify required quality and outcomes, and base commissioning on results.

### 9. Secure procurement skills

Facilitate good working relationships with providers, with clear agreements.

### 10. Manage the local health system

Ensure delivery of the highest possible quality of service and value for money.

### 11. Make sound financial investments

Ensure commissioning decisions are sustainable and improve outcomes.



# NHS finance

## Where does the money for the NHS come from?

The budget for the NHS in 2008/9 was £96 billion and will rise to about £110 billion in 2010/11.

Most money comes from general taxation and National Insurance (NHS portion) receipts. A small proportion comes from other sources, such as:

- Treatment charges (including prescriptions)
- Dental charges
- Charges for road traffic and personal injury victims (money claimed from insurers)
- Overseas visitors
- Capital receipts

## How does the Government decide how much to spend?

Spending limits for Government Departments for the three years from 2008/09 to 2010/11 were the outcome of the Comprehensive Spending Review (CSR) announced by Treasury in October 2007. Spending Reviews are usually run every two years.

As part of the CSR the DH enters into a set of agreements with the Treasury regarding what

### 2007 PSA Targets

- Increase life expectancy to 78.6 years for men and 82.5 years for women
- Reduce gap in life expectancy by at least 10% by 2010
- Reduce smoking rates to 21% by 2010
- Maximum wait of 18 weeks from GP referral to the start of hospital treatment by Dec 2008
- Sustain progress on reducing the number of MRSA blood stream infections achieved
- Reduce the number of *C.difficile* infections by 30% by March 2011

they will deliver for the money; these agreements are called Public Service Agreements (PSAs). They set out specific targets and aims towards which the DH will work.

## Future spending predictions

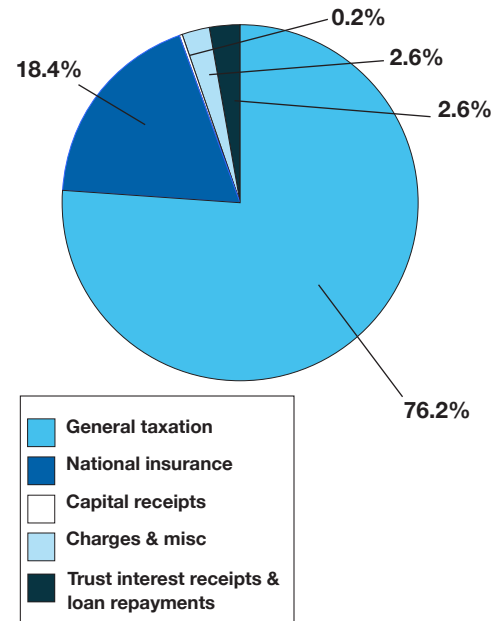
Given the size and importance of health spending, the Treasury commissioned a report by Derek Wanless to look at future trends for healthcare and how spending would change.

The Wanless report (2002)\* concluded that costs would be driven up; the main cause would not be an aging population but patients demanding more choice and higher quality services.

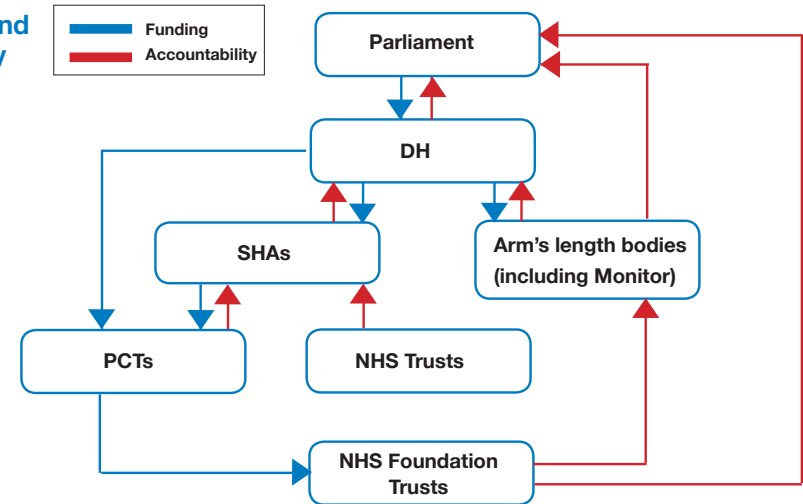
He recommended that improving spending on IT and communication would be key, as would changes in skill-mix and ways of working, and that the role of primary care needed enhancing.

*\*Securing our future: taking a long-term view. Final Report. April 2002*

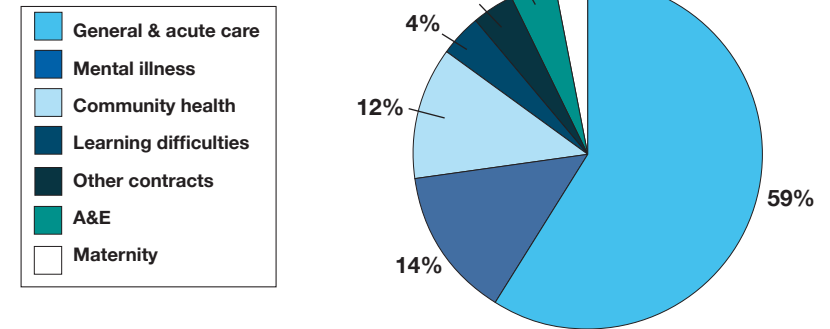
## NHS finance sources



## Money flow and accountability



## On what areas of health do we currently spend money?



## NHS strategy: policy into practice

The DH creates, maintains, adapts and integrates policy on public health, social care and the NHS to provide a clear national framework within which service development can take place locally.

### Why is policy needed?

Policy is the translation of government's political priorities and principles into programmes and courses of action to deliver desired change (Modern policy-making, National Audit Office, November 2001). Policy develops in response to rising expectations, changes in population, developments in medicine and the need to tackle quality (including safety, effectiveness, patient experience, access and value for money).

### How is policy need identified?

There is a wide variety of methods of identifying policy need, including evidence-based analysis of current problems, response to things going wrong, public inquiries, alerts raised by pressure groups and media campaigns, financial restraints, and reaction to political pressure.

### Where does policy come from?

Policy is developed by civil servants in consultation with stakeholders (the individuals and groups affected by the strategy and policy proposals, including healthcare staff), pressure groups, experts, academics, lobbyists and politicians. Ministers make final policy decisions.

### How is policy implemented at national level?

#### Public Service Agreement (PSA)

Every 2 years the Department of Health draws up a PSA with the Treasury, describing what it aims to provide with its allocated resources; thus the Government ensures that increased resources lead to reform.

#### DH Strategic Framework

This is the translation of the PSA into a framework for implementation to allow organisations to plan change. It shows how the high-level objectives of DH mesh with the wider Government performance framework.

#### NHS Operating Framework

The Operating Framework is published annually by the NHS Chief Executive and sets out the priorities for the NHS over the next year and the strategies for addressing them.

### How is policy implemented at local level?

Local Delivery Plans (LDPs) – LDPs are local translations of the DH Strategic Framework. They cover SHA areas and form the basis of the relationship between DH and SHAs. NHS planning takes place locally, within the national framework.

PCTs develop strategic commissioning plans to deliver the improvements in outcomes that they have identified their population needs.

## NHS Next Stage Review: High Quality Care for All (“The Darzi Review”)

**What:** A report on the way forward for the NHS on its 60th Anniversary

**Why:** To carry out a wide-ranging review of the NHS to achieve a properly resourced NHS that is clinically-led, patient-centred and locally accountable, and to consider the case for a new NHS constitution ([www.dh.gov.uk/nhsconstitution](http://www.dh.gov.uk/nhsconstitution)).

**Commissioned by:** the Prime Minister, Chancellor of the Exchequer and Secretary of State for Health.

**Commissioned:** Lord Ara Darzi, a practicing colorectal surgeon, and Minister (Parliamentary Under-Secretary of State).

**How:** A year-long review of the NHS was carried out, led by nearly 2,000 clinicians and engaging 65,000 healthcare staff, social-care staff, patients and members of the public.

The 2,000 clinicians were part of 8 clinical pathway groups (maternity and newborn care, children's health, planned care, mental health, staying healthy, long-term conditions, acute care and end-of-life care) in each of the 10 SHAs. They looked at the evidence available and engaged widely to produce a vision for the future. The groups also considered the barriers to delivering these visions. These barriers were addressed in High Quality Care for All, an enabling report designed to support local delivery of the regional clinical visions.

**When:** The regional visions were published in May and June 2008 (July 2007 in London). High Quality Care for All was published in June 2008.

**Where:** High Quality Care for All is available on the Department of Health website [http://www.dh.gov.uk/en/publication-sandstatistics/publications/publication-spolicyandguidance/DH\\_085825](http://www.dh.gov.uk/en/publication-sandstatistics/publications/publication-spolicyandguidance/DH_085825)

The regional visions are available on SHA websites and on the Department of Health website

[http://www.dh.gov.uk/en/Publication-sandstatistics/Publications/Publication-sPolicyAndGuidance/DH\\_085400](http://www.dh.gov.uk/en/Publication-sandstatistics/Publications/Publication-sPolicyAndGuidance/DH_085400)

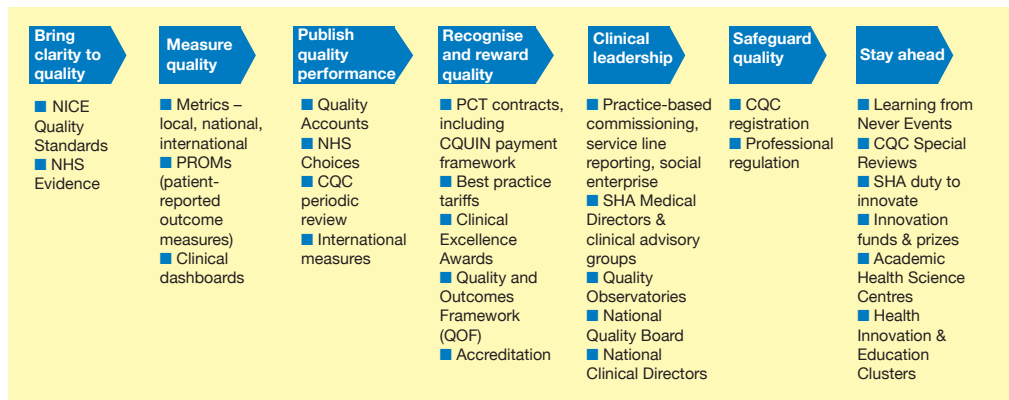
Aims of the report:

- To ensure that improving quality is the organising principle of the NHS
- To improve patient care, including providing high-quality, joined-up services for those suffering long-term or life-threatening conditions
- To ensure that primary and secondary providers integrate more accessible and convenient care
- To establish for the next decade of the NHS a vision based less on central direction and more on patient control, choice and local accountability.



# Quality in the NHS

High quality care means that care is safe, effective, and provides the best possible patient experience. The quality of care is determined by each individual interaction you and your colleagues have with patients. Lord Darzi's NHS Next Stage Review report described a framework for enabling local quality improvement in the NHS.



## Bringing clarity to quality

Clinicians reported that there was too much guidance – that it was too difficult to find the most up-to-date guidance and to know what was required and what was good practice. In response, the role of NICE was expanded to set **quality standards**, which will distil the range of guidance available into a short set of key markers of high-quality care in a particular clinical area. NICE will also manage **NHS Evidence**, a new online portal to access quality-assured evidence and practice at <http://www.evidence.nhs.uk>. NICE will continue to evaluate drugs (more quickly on key drugs) and other health interventions for clinical- and cost-effectiveness.

## Measuring quality

High-performing teams not only have good clinical leadership, but are also defined by their willingness to measure their own performance and use this information to continuously improve. To support front-line teams to select indicators and benchmark themselves against others, a **Menu of Assured Quality Measures** will be published, pulling together indicators from existing sources. Existing commonly used indicators do not give full coverage of all pathways and all aspects of quality (safety,

effectiveness, and patient experience) and further work over the next few years is needed to develop new indicators. These will include PROMs (patient-reported outcome measures).

## Publishing quality performance

All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish **Quality Accounts** for the public. These will be reports on the quality of services they provide (safety, experience and outcomes).

The **Care Quality Commission** will publish an independent assessment of provider and commissioner performance using nationally agreed indicators of quality. The CQC will also carry out general reviews and investigations of issues of interest to the public and will submit an annual report to Parliament.

## Recognising and rewarding quality

The **CQUIN (Commissioning for Quality and Innovation) Payment Framework** will make a small percentage of hospital funding conditional on quality of care. Schemes will be agreed locally between providers and commissioners. The Quality and Outcomes Framework (QOF) already rewards quality in primary care.

## Clinical leadership

There are clinical leaders throughout the NHS. High Quality Care for All built on this and introduced the following groups:

**National Quality Board:** This board will provide strategic oversight and leadership on quality in the NHS. It is chaired by the NHS Chief Executive and has members representing national and statutory bodies. It will:

- Advise the Secretary of State on priorities for quality standards (set by NICE) and oversee the development of quality indicators
- Submit an annual report on the state of quality in England (internationally comparable)

**SHA Medical Directors:** Responsible for overseeing implementation of local clinical visions and for providing medical leadership to NHS organisations in their area.

**Quality Observatories:** A “Quality Observatory” will be established in every SHA to help develop local indicators, enable local benchmarking, and support front-line staff to innovate and improve their services.

## Safeguarding quality

### Care Quality Commission (CQC)

The CQC is the new health and adult social care regulator. It will register providers of health and adult social care to provide assurance that they meet essential levels of safety and quality, and will use its enforcement powers to address failings.

## Staying ahead

Innovation is the successful implementation of new ideas. A number of policies support innovation.

**The Health Innovation Council** champions innovation for the NHS and helps develop innovation proposals.

**Best Practice Tariffs** enable the NHS to pay prices that reflect the cost of best practice rather than the average cost. SHAs have a new legal duty to promote innovation funds. SHA Regional Innovation Funds will identify, grow and diffuse innovation through funding and prizes.

**Health Innovation and Education Clusters** bring together the talents of different sectors for education and learning and run joint innovation programmes reflecting local needs.

**Academic Health Science Centres** bring together a small number of health and academic partners to focus on world class research, teaching and patient care. Their purpose is to promote the application of new discoveries in the NHS and around the world.



# National Institute for Health and Clinical Excellence (NICE)

NICE was established in 1999. It is an independent NHS organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. Its work focuses on three areas:

- **Public health** – Guidance for those working in the NHS, the local authorities and the wider public and voluntary sector on the promotion of good health and the prevention of ill health.
- **Health technologies** – Guidance on the use of new and existing medicines, treatments and procedures within the NHS.
- **Clinical practice** – Guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

## What is NICE and who develops the guidance?

NICE guidance is developed by independent advisory groups composed of health professionals, NHS staff, patients, carers, and the public. The NICE Board and senior management team set strategic direction and oversee delivery and oversee financial issues and ensure corporate governance.

## How will NICE develop following the Darzi review?

Following the Next Stage Review (2008) the role of NICE will be expanded to set and approve independent national quality standards. The National Quality Board will advise Ministers on the priorities for NICE's clinical standard setting. NICE will also provide guidance on significant new drugs within a few months of their launch.

NICE will be responsible for NHS Evidence, where anyone will be able to access clinical and non-clinical evidence and best practice, with clear descriptions of high quality care and how to deliver it. This will support commissioning the most clinically and cost-effective diagnostics, treatments and procedures.

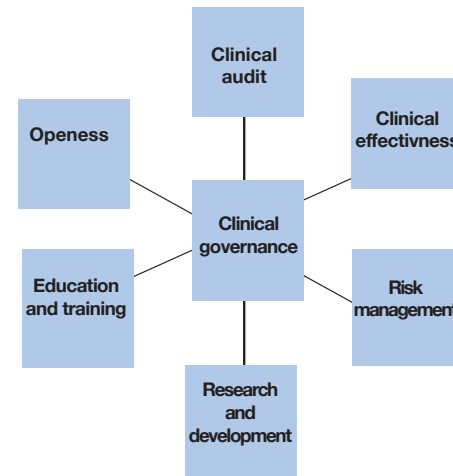
The new NHS Constitution will set out the right of all patients to receive interventions positively appraised by NICE when clinically appropriate, helping to minimise perceptions of a "postcode lottery" of access to care.

For more information about NICE, visit <http://www.nice.org.uk>

To explore NHS Evidence, visit <http://www.evidence.nhs.uk>



# Clinical governance



**“The system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services.”**

**Scally G and Donaldson LJ. Looking forward: Clinical governance and the drive for quality improvement in the new NHS in England. BMJ 1998; 317: 61-65**

## Clinical audit

The review of clinical practice against defined national standards is a cyclical process in which care is continuously measured, improved and re-measured, thereby enabling continuous improvement.

## Clinical effectiveness

The measure of how well a particular intervention works in practice. This is obviously important in clinical practice but can be further enhanced by measuring appropriateness and value for money. In the NHS NICE takes on the role of assessing the clinical and cost effectiveness of treatments in a systematic way for the whole NHS.

Aligning audit with the Trust's current priorities can help lead to changes in policy and practice

## Risk management

There are three areas of risk:  
 1) Risk to patients (patient safety)  
 2) Risk to staff (infection, radiation)  
 3) Risks to the organisation (financial, poor quality, legal, reputational, staff employment)

These are all managed by identifying possible risks and developing solutions before the event, and having a mechanism for learning where things went wrong.

## Research and development

Good practice is continuously evolving in response to research evidence; however, there is often a long delay between research findings being known and implementation in clinical settings. Tools (such as the critical appraisal of papers) have developed in this area, but there is still a need for improvement.

## IT in the NHS

NHS Connecting for Health (NHS CFH) supports information technology (IT) systems for the NHS in England. It works with both local NHS organisations and suppliers in introducing new IT systems and services to improve the way health information is stored and shared.

Specifically, NHS CFH is responsible for:

- New IT systems and services – together known as the National Programme for IT (NPfIT)
- Existing business-critical national NHS IT systems (originally delivered by the former NHS Information Authority), and
- Legislative and digital policy advice on information systems for the NHS.

The National Programme for IT in the NHS underpins the modernisation of the NHS. It helps the NHS to meet patients' growing expectations about choice, convenience, quality and responsiveness. It also supports complex modern care, where treatment is delivered by a team of healthcare staff based in different buildings or organisations across primary and secondary care, or out in the community. The complexity of this care requires information to be shared effectively – computer systems support this function.

Responsibility for implementing NPfIT systems and services at local level lies with SHAs.

### Core programmes within the NPfIT:

- N3 – the secure broadband National Network for the NHS
- NHS Care Records Service (NHS CRS) – a secure service linking patient information electronically, with detailed records shared locally between NHS organisations caring for the patient and Summary Care Records available across England to support emergency and out-of-hours care
- Picture Archiving Communications Systems (PACS) – digital x-rays and scans for faster diagnosis
- NHSmail – the only email and directory service endorsed by the BMA and RCN for the secure transfer of patient information
- Choose and Book – electronic booking service, enabling the patient to choose the time, date and place of their first outpatient appointment
- Electronic Prescription Service (EPS) – enabling prescription messages to be sent electronically from prescriber to dispenser
- Support for GP IT – including GP Systems of Choice (GPSoc), electronic patient record transfer between GP practices (GP2GP) and QMAS (GP payment system)

More information is available at <http://www.connectingforhealth.nhs.uk>

## The health system in Scotland

**Differences between the Scottish and English NHS (Scottish population: 5 million)**

### The devolved parliament is responsible for NHSScotland (since 1999)

Parliamentary Committees involved in NHSScotland:

- Health and Sport Committee: health policy, public health, and community care
- Finance Committee: public expenditure
- Public Audit Committee: considers reports produced by the Audit General for Scotland, including reports on NHS expenditure

### Scottish Executive Health and Wellbeing Directorates (SEHD) is responsible for NHSScotland policy

The head of SEHD is also the chief executive of NHSScotland and is accountable to the Scottish Parliament. SEHD develops strategies, implements policy, and holds the NHS to account for its performance. Scotland's CMO is the Scottish Government's medical adviser, with responsibility for clinical effectiveness, quality assurance, accreditation and research.

### NHS Boards, not Trusts (since 2004)

NHSScotland abolished Trusts in favour of integrated boards, responsible for protecting and improving health, delivering hospital and community services, developing a local health plan, allocating resources, and performance management.

There are 14 area Health Boards. In each area, an NHS Board oversees the NHS locally. Within each Board, Community Health Partnerships manage primary and community services.

There are 8 Special Health Boards: Scottish Ambulance Service, NHS 24, State Hospitals Board for Scotland, NHS Health Scotland, NHS Quality Improvement Scotland, NHS Education for Scotland, National Waiting Times Centre Board, and NHS National Services Scotland.

### Financed by the Scottish Executive (via UK Parliament); no internal market

NHSScotland is funded by general taxation and National Insurance through the UK Government, which allocates public money to the Scottish Government for distribution within its departments. NHSScotland has rejected market-based reforms and there is currently no role for internal market within Scottish healthcare.

### SIGN, not NICE

The Scottish Intercollegiate Guidelines Network (SIGN) improves quality by reducing variation in practice and outcome by publishing national clinical guidelines. The Scottish Medicines Consortium (SMC) develops advice on new drugs for the NHS in Scotland. Scotland adopts NICE guidelines for interventional procedures and some technology appraisals.

### Managed Clinical Networks to integrate health and social care

NHSScotland works through 'managed clinical networks' to integrate systems of care for specific conditions.

## The health system in Wales

**Differences between the Welsh and English NHS (Welsh population: 2.9 million)**

**The Welsh National Assembly is responsible for NHS Wales (since 1999)**

The Assembly can pass secondary legislation, but not primary legislation.

Assembly committees involved in NHS Wales:

- Health and Social Services Committee: develop policy, scrutinise legislation, and advise on budget allocation
- Audit Committee: public expenditure

**Health and Social Care Department sits within the Welsh Assembly Government**

Established in 2004, this department advises the Assembly on health and social care policy and strategy, contributes to legislation, manages health and social care delivery, and is responsible for funding NHS Wales. The head of department is Chief Executive of NHS Wales; three regional offices act as local agents.

**Local Health Boards (LHBs), not SHAs**

Wales has 22 LHBs which receive 75% of the NHS budget and work with local authorities, including housing and education, to deliver a public health strategy.

**Fewer Trusts than LHBs**

There are 14 NHS trusts, providing services mainly commissioned by LHBs.

**Health Commission Wales pays for national services**

This is an executive commissioning body for specialist and tertiary services throughout Wales.

**Community Health Councils (CHCs) hold NHS Wales to account by the public**

There are 19 of these statutory lay organisations, which work to improve the quality of local healthcare.

**Financed by the National Assembly for Wales (via UK Parliament)**

The Assembly Government allocates resources each year to LHBs and Health Commission Wales to pay for the costs of hospital treatments provided by NHS trusts and other independent healthcare providers.

**NICE and National Service Frameworks are used**

NICE provides clinical guidelines, technology appraisals and interventional procedure guidance for NHS Wales. The Welsh Assembly works with DH to deliver a common quality agenda.

## The health system in Northern Ireland

**Differences between the Northern Irish and English NHS (Northern Irish population: 1.7 million)**

**The Northern Ireland Assembly is responsible for healthcare in Northern Ireland**

Devolved powers were returned to the Northern Ireland Assembly in 2007. The Assembly can pass both primary and secondary legislation.

Assembly committees involved with Health, Social Services and Public Safety:

- Health and Social Services Committee: advise and assist the Minister for Health, Social Services and Public Safety. The committee undertakes a scrutiny, policy development and consultation role with respect to the Department of Health, Social Services and Public Safety and plays a key role in the consideration and development of legislation.
- Public Accounts Committee: consider and reports on accounts laid before the Assembly.

**The Department of Health, Social Services and Public Safety (DHSSPS) is responsible for health, social services and public safety**

The NHS in Northern Ireland is called Health and Social Care (HSC) and it provides integrated health and social care services. It has retained the commissioner-provider split.

DHSSPS was created as part of the Northern Ireland Executive and is responsible for health and social care, public health, and public safety. The Permanent Secretary of DHSSPS is also Chief Executive of the HSC system.

**Reforms are underway to restructure the HSC system**

In April 2007, 19 HSS Trusts were merged to create six Health and Social Care Trusts. They have responsibility for delivering the full range of health and social care.

By 1 April 2009 the following was due to be established:

- A single Regional Health and Social Care Board (RHSCB), responsible for commissioning, performance management/improvement and financial management.
- A Regional Agency for Public Health and Social Well-being (RAPHSW), responsible for health protection, health improvement and addressing existing health inequalities.
- A Regional Business Support Organisation (RBSO), responsible for supporting the health and social care sector.
- a Patient and Client Council (PCC), providing a strong voice for patients, clients and carers.





THE NEW  
**NATIONAL  
HEALTH  
SERVICE**

\*

**Your new National Health Service begins on  
5th July. What is it? How do you get it?**

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a “charity”. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

This is an Affinity publishing service provided by BMJ Group

**affinity**  
BMJ Group

BMA House, Tavistock Square, London WC1H 9JR. Tel. +44 (0)20 7383 6055. Fax. +44 (0)20 7383 6668  
©2009 BMJ Publishing Group and The Department of Health

All rights reserved. No part of this booklet may be transmitted or reproduced in any form or by any electronic or mechanical means, including information storage and retrieval systems, without prior permission in writing from the publisher.

Published by the BMJ Publishing Group Ltd. Printed by Precision Colour Printing Ltd.

For extra copies of A junior doctor's guide to the NHS please email [sronayne@bmjgroup.com](mailto:sronayne@bmjgroup.com)

[affinity.bmj.com](http://affinity.bmj.com)