



## BRIEFING PAPER

Number CBP 07206, 2 June 2020

# The structure of the NHS in England

By Thomas Powell

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## Summary

**Please note the content of this briefing was produced before the Covid-19 pandemic, and focuses on information and data about the NHS before coronavirus response measures were introduced.**

**The current pandemic has radically reshaped the delivery of health services, and there will likely be long term impacts on the health and wellbeing of both the public and health and social care staff. What the implications will be for how the NHS is organised in the long term remain to be seen, but beyond lessons for future pandemic response, the NHS will need to carefully prioritise resources as it returns to normal activity. There are likely to be significant implications for recently introduced strategies to improve clinical outcomes and tackle workforce issues, as well as greater urgency to calls for social care reform. Other existing trends, such as closer working between local health and care providers, and the move to online working, have been accelerated by system-wide responses to Covid-19. Some changes to ways of working that have been introduced in the NHS over the first weeks of the pandemic response may become a 'new normal'.**

**The Commons Library has produced a range of briefings on the response to Covid-19, which are available on the [Commons Library website](#) (see for example [Coronavirus: health and social care key issues and sources](#)). For the latest information on the UK's pandemic response you should refer to the coronavirus pages on the [Gov.uk](#) and [NHS websites](#).**

This Commons Library briefing provides an overview of the funding and accountability relationships in the English NHS, and an introduction to the roles of key organisations, including:

- NHS England and NHS Improvement, which since April 2019 have provided joint leadership through shared national and regional teams; and
- Clinical Commissioning Groups (CCGs), which are responsible for most local NHS services.

It also covers:

- The Care Quality Commission (CQC) and patient safety
- Health Education England (HEE) and workforce planning, education and training
- Public Health England (PHE) and local authorities' public health duties
- Health and Wellbeing Boards and local authority health scrutiny
- The NHS Constitution, the National Institute for Health and Care Excellence (NICE), and access to treatment

This briefing highlights key issues in health policy, including the performance, funding and workforce pressures facing the NHS. It also looks at proposals for the redesign and integration of services, reform competition rules, and develop the use of technology and data.

In terms of structural changes, this briefing provides an overview of the extensive changes introduced by the *Health and Social Care Act 2012*. A number of important non-statutory changes have taken place, and since 2016 these have included:

- The formation of 42 Sustainability and Transformation Partnerships (STPs) across England, with local health and care organisations coming together to create regional plans. STPs are intended to improve services, promote population health, and enable the NHS to become more financially sustainable.
- The development of STPs into Integrated Care Systems (ICSs) in 14 areas of England. ICSs are a step towards even closer collaboration between NHS organisations, in

partnership with local councils and others. ICSs take collective responsibility for managing resources, and improving population health.

- The two organisations responsible for setting the direction of the NHS, NHS Improvement and NHS England, have operated as single organisation since April 2019.
- The announcement of a 5-year funding settlement for the NHS in 2018, and the introduction of an [NHS Funding Bill](#) in January 2020.
- The publication of a 10-year strategic plan, the [NHS Long Term Plan](#), in January 2019.
- The September 2019 [Health Infrastructure Plan](#) set out commitments for additional capital funding to modernise the NHS estate.

Coinciding with the 70th anniversary of the creation of the NHS in 2018, the NHS in England was asked to produce a ten-year plan to improve access, care and outcomes for patients, in return for a five-year funding settlement. The resulting NHS Long Term Plan set out how the NHS should maximise the impact of extra funding. The Plan set objectives for improving public health and clinical outcomes, in areas such as preventing infant mortality, improving cancer survival rates, and better mental health services. To enable these changes, the Plan set out actions on workforce, technology, innovation and efficiency. It also proposed changes to the 'system architecture' of the NHS, to increase the coordination of services, with the creation of Integrated Care Systems. This has been seen as a move away from some of the market-based reforms of the *Health and Social Care Act 2012*, and also a shift from the commissioner/provider split introduced in the early 1990s.

Health policy is a largely devolved matter and this briefing paper is primarily concerned with the structure of the NHS in England, however, a brief summary on the health systems in the other parts of the UK (with links to further information) is also included in section 11 of this briefing.

While this briefing refers to policies to promote joint working between health and social care services in England (see section 10), the following House of Commons Library briefings provide further background on adult social care policy and proposals for reform:

- [Adult social care: the Government's ongoing policy review and anticipated Green Paper \(England\)](#)
- [Social care: Government review and policy proposals for paying for care since 1997 \(England\)](#)

See also the [Commons Library briefing paper on health and social care integration](#).

# 1. Background to NHS reform

## 1.1 The Health and Social Care Act 2012

The *Health and Social Care Act 2012* introduced the most wide-ranging and controversial reform to the structure of the NHS since the service was established in 1948. The 2012 Act implemented the major reforms to the health service that were outlined in the July 2010 White Paper [Equity and excellence: Liberating the NHS](#). This set out the 2010 Government's aims to reduce central control of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice.

Many of the provisions under the 2012 Act came into force on 1 April 2013. This is when:

- NHS England and Clinical Commissioning Groups (CCGs) took on statutory responsibility for commissioning health services;
- local authorities took on new public health responsibilities;
- local Healthwatch organisations came into being; and
- Strategic Health Authorities and Primary Care Trusts were formally abolished.

While mainly concerned with social care, the *Care Act 2014* also established Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental bodies (NDPBs). This was intended to strengthen the independence of the two recently created bodies, which lead national systems for the education and training of health care professionals, and regulate health and social care research respectively.<sup>1</sup>

Several organisations have produced their own guides and diagrams explaining the structure of the NHS in England, post-2013, including the [Department of Health \(2013\)](#), the [All Party Parliamentary Health Group \(2013\)](#), the [BBC \(2013\)](#), [NHS England \(2014\)](#), the [Nuffield Trust \(2017\)](#), and the [King's Fund \(2017\)](#).

## 1.2 From the Five Year Forward View (2014) to the Long Term Plan (2019)

The NHS [Five Year Forward View](#) (FYFV), published in October 2014, identified three key drivers for change across the NHS: health and wellbeing, care and quality, and funding and efficiency. It called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. Some early adopters of this approach – so called 'vanguard' areas – have seen slower growth in emergency hospitalisations and less

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<sup>1</sup> Further information about these can be found in the Library briefings on the [Care Bill \[HL\] Commons Library Research Paper](#) (December 2013), prepared for the Commons Second reading stage, and the [Care Bill \[HL\] Committee Stage Report](#) (March 2014).

time spent in hospital compared to the rest of the country, particularly for over-75s.<sup>2</sup>

[Next Steps on the NHS Five Year Forward View](#) (March 2017) outlined a number of national service improvement priorities, including:

- Improving A&E performance and upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services.
- Strengthening access to high quality GP services and primary care.
- Improvements in cancer services (including performance against waiting times standards) and mental health.

The Next Steps report also set out plans to:

- tackle areas of waste or low value care;
- accelerate service redesign and integration through Sustainability and Transformation Partnerships and what were then referred to as Accountable Care Systems (now known as Integrated Care Systems); and
- focus on the workforce and technology and innovation within health services in order to deliver better care and support people in managing their own health.

Following the 5YFV, plans for specific service areas like general practice and mental health were also published.

In 2015 NHS England asked NHS organisations to come together to create local blueprints to improve health and care, delivering the objectives of the 5YFV.

## Sustainability and Transformation Plans

Sustainability and Transformation Plans were published for 44 footprint areas across England in 2016. They proposed wide-ranging changes, covering hospital, community, mental health and primary care services. They set out plans to improve efficiency, prevent ill-health and address other pressures facing the health and care system, such as workforce shortages (e.g. shared arrangements for using bank and agency staff). Responding to concerns about possible cuts to services, and a perceived lack of transparency, NHS England has said that plans were “a starting-point for local conversations.” Plans also attracted significant attention from Parliament and political parties.<sup>3</sup> Local plans later developed into 42 Sustainability and Transformation Partnerships (STPs) across England.

## The NHS Long Term Plan

Coinciding with the 70th anniversary of the creation of the NHS in 2018, Prime Minister Theresa May asked the NHS in England to produce a ten-year plan to improve access, care and outcomes for patients, in return for a five-year funding settlement. The resulting [NHS Long Term Plan](#), published in January 2019, set out how the NHS should maximise

<sup>2</sup> NHS England, [Next Steps on the NHS Five Year Forward View](#), March 2017

<sup>3</sup> The House of Lords Committee on the Long-term Sustainability of the NHS commented on the STP planning process ([The Long-term Sustainability of the NHS and Adult Social Care](#), 31 March 2017).

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the impact of extra funding. The Plan set objectives for improving public health and clinical outcomes, in areas such as preventing infant mortality, improving cancer survival rates, and better mental health services. To enable these changes, the Long Term Plan set out actions on workforce, technology, innovation and efficiency.

In June 2019, NHS England and NHS Improvement published an [Implementation Framework](#), providing further detail on how the plan would be delivered.

Local areas submitted have been asked to submit their draft five-year strategic plans to implement the Long-Term Plan to NHS England and NHS Improvement. Once these local plans are published, NHS England and NHS Improvement intend to publish a national implementation plan.<sup>4</sup> [The Government's 2019-20 Accountability Framework with NHS England and NHS Improvement](#) requires these plans to have “detailed, costed annual milestones and trajectories for key commitments and reforms to deliver the Long Term Plan, both at a national and local level”. The NHS England and NHS Improvement Boards must also “...fully assure themselves that the national implementation programme is affordable, realistic and deliverable as well as within the agreed financial settlement”.<sup>5</sup>

Further background can be found in the Lords Library briefing [NHS Long Term Plan: Recent Developments](#) (January 2020).

### Integrated care

The [NHS Long Term Plan](#) proposed changes to the ‘system architecture’ of the NHS, to increase the coordination of services, with the development of STPs into [Integrated Care Systems](#) (ICSs) by 2021 (14 STP areas have already become ICSs). ICSs are advanced local partnerships taking shared responsibility to improve the health and care system for their local population, bringing together NHS and local government bodies. The Long Term Plan proposed further changes that have been seen as a move away from some of the market-based reforms of the *Health and Social Care Act 2012*, and also a shift from the commissioner/provider split introduced in the early 1990s.<sup>6</sup>

In June 2019 [Primary Care Networks \(PCNs\)](#) were established as groups of GP practices, working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. There are around 1,300 PCNs, covering populations of around 30-50,000. The Long Term Plan also proposed [Integrated Care Provider \(ICP\) contracts](#). These have not yet been introduced but would see a number of local providers coming together to take responsibility for the health services of a defined population.

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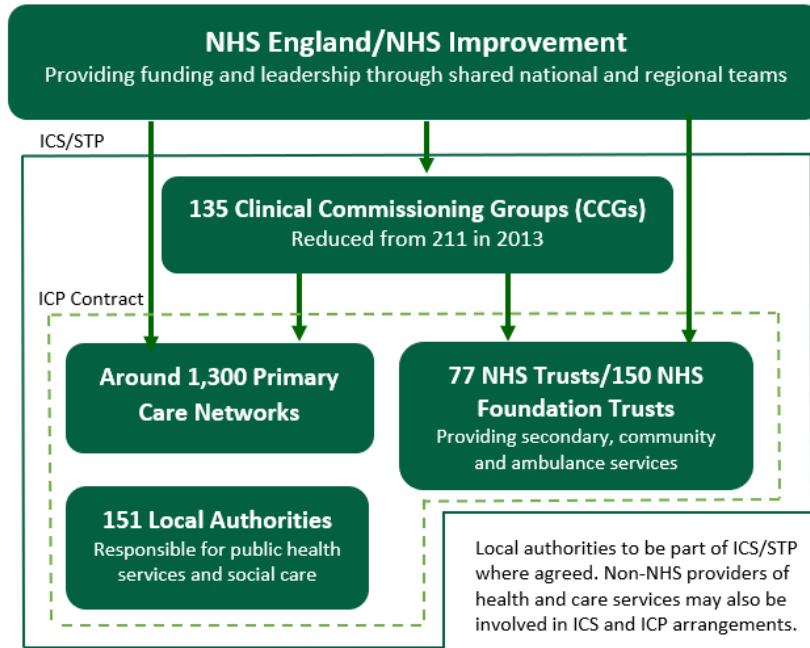
<sup>4</sup> These were expected in November 2019, but their publication was postponed as a result of the pre-election ‘purdah’ period.

<sup>5</sup> [The Government's 2019-20 Accountability Framework with NHS England and NHS Improvement](#) (May 2019)

<sup>6</sup> King's Fund, [The NHS Long-term Plan Explained](#), 23 January 2019

A diagram showing how Integrated Care Systems (ICSs) (and any future Integrated Care Provider (ICP) contracts) span the NHS and local government can be found below:

**Figure showing how Integrated Care Systems (ICSs) (and any future Integrated Care Provider (ICP) contracts) span the NHS and local government**



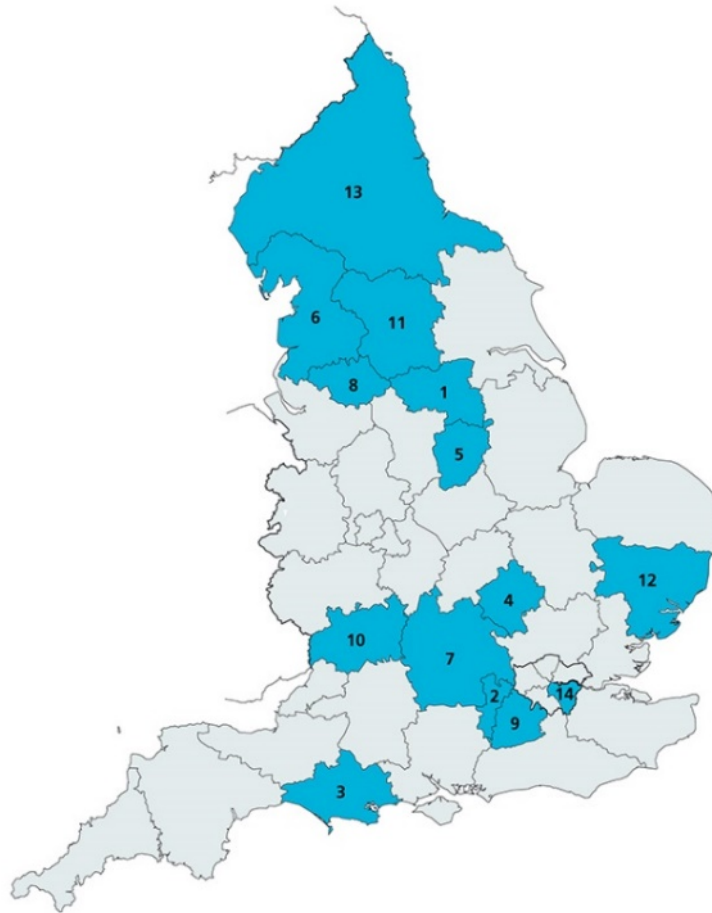
Arrows indicate funding and accountability relationships. To simplify this diagram we have not included a range of other statutory and non-statutory bodies. A more detailed structure of health and care organisations in England can be found in the [National Audit Office \(NAO\) Departmental Overview for Health and Social Care 2018-19](#).



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The following map shows the 14 areas of England where STPs have developed into ICSs:

### Map: Integrated Care Systems in England



1. [South Yorkshire and Bassetlaw](#)
2. [Frimley Health and Care](#)
3. [Dorset](#)
4. [Bedfordshire, Luton and Milton Keynes](#)
5. [Nottinghamshire](#)
6. [Lancashire and South Cumbria](#)
7. [Buckinghamshire, Oxfordshire and Berkshire West](#) ([Buckinghamshire](#) and [Berkshire West](#) were already ICSs prior to June 2019).
8. [Greater Manchester \(devolution deal\)](#)
9. [Surrey Heartlands \(devolution deal\)](#)
10. [Gloucestershire](#)
11. [West Yorkshire and Harrogate](#)
12. [Suffolk and North East Essex](#)
13. [The North East and North Cumbria](#)
14. [South East London](#)

Further information on Integrated Care Systems, including the devolution of health and social care to Greater Manchester, can be found in the Library briefing on [Health and Social Care Integration](#) (January 2020).

## 1.3 Funding and performance

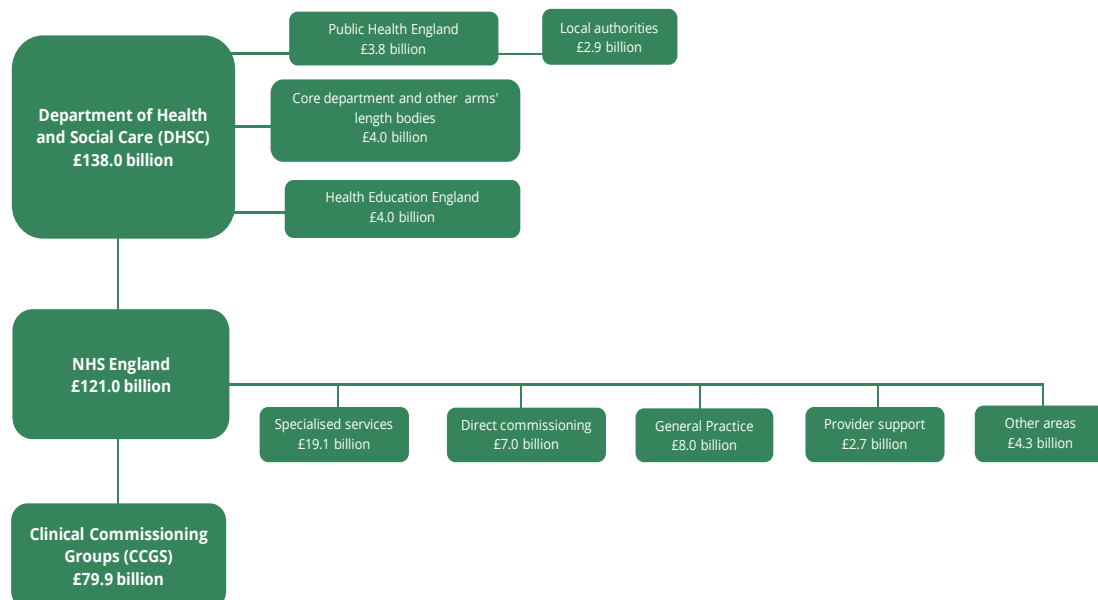
### Funding flows

Funding for health services comes from the total budget for the Department of Health and Social Care (DHSC). In 2019/20 the total allocated DHSC budget was £138 billion for England. The majority of this budget (£121 billion) was transferred to NHS England with the remainder divided between DHSC's other agencies and programmes, including funding for Arm's Length Bodies like the Care Quality Commission, NHS Improvement and NICE.

NHS England's budget is used to deliver its mandate from the DHSC. NHS England is responsible for allocating resources to local commissioners of health services: Clinical Commissioning Groups (CCGs) and local authorities. Most of the commissioning resource allocations go to CCGs (£79.9 billion in 2019/20).

Of the remaining resources (£41.1 billion in 2019/20) NHS England directly commissions certain services on a national level, covering specialised services (£19.1 billion), general practice (£8.8 billion) and other directly commissioned services (£7.0 billion) such as care, military and offender services. The remainder of NHS England's budget is spent on centrally administered projects and services, including its public health responsibilities on behalf of Public Health England, which broadly comprise immunisation and screening programmes. The diagram below outlines the main funding flows in the NHS in England.

#### Main funding flows in the NHS in England

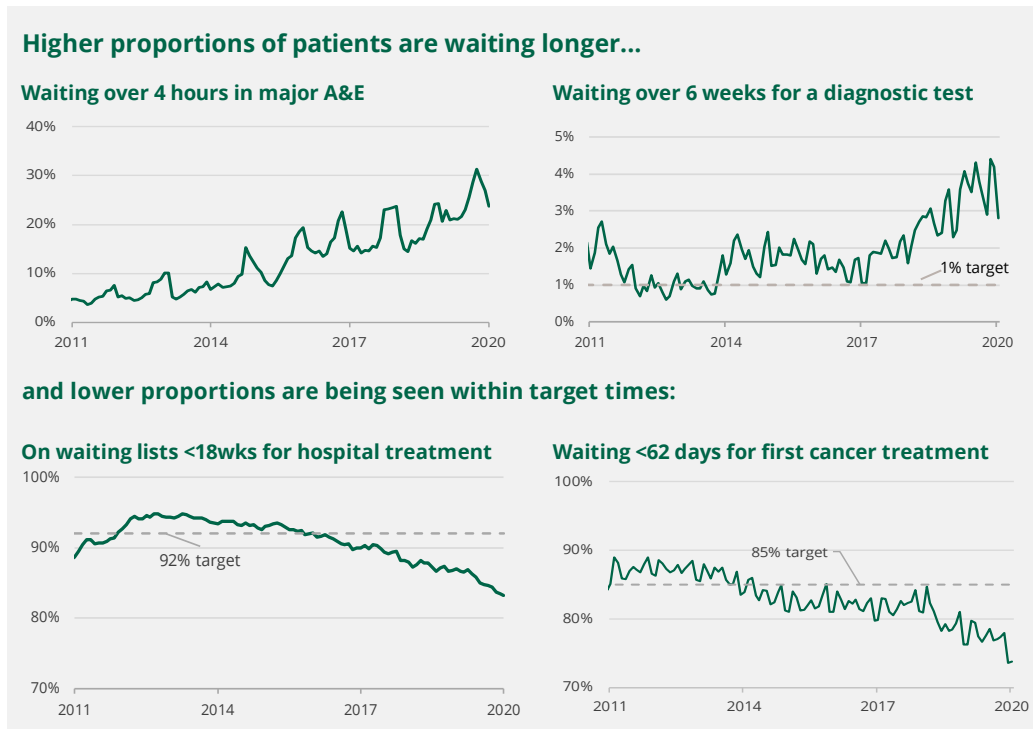


Sources: HM Treasury [Public Expenditure Statistical Analyses 2019](#), NHS England and NHS Improvement [NHSE and NHSI Funding and resources 2019/20](#), Health Education England [Business Plan 2019/20](#), Public Health England [Financial report to September 2019](#)

Further information can be found in the Commons Briefing Paper [NHS Funding and Expenditure](#).

## Performance

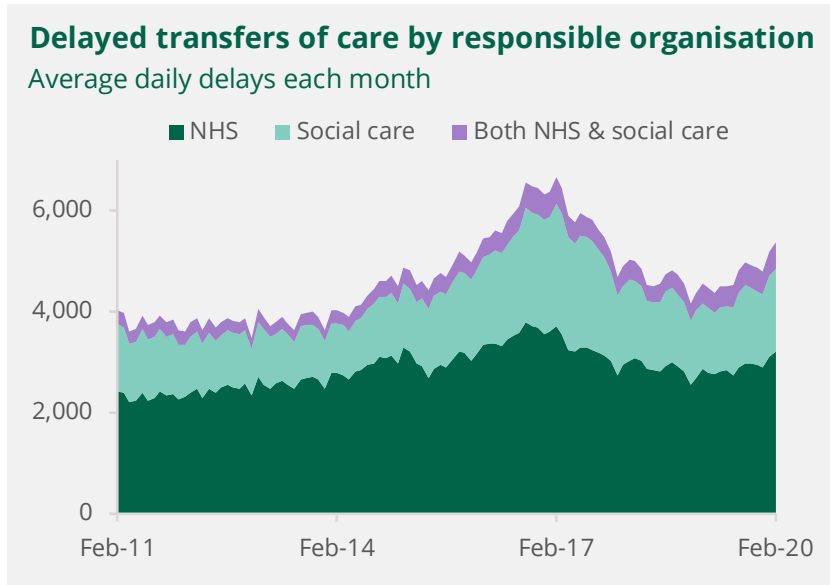
The NHS has experienced significant financial and demand challenges as a consequence of the ageing and growing population, the rising cost of new drugs and treatments and the need to maintain safe staffing and access to care. Such pressures have resulted in declining performance in a number of areas such as those shown below.



Source: [NHS England performance statistics](#)

More detailed analysis of NHS demand and performance indicators for England can be found in the Commons Library's quarterly publication [NHS Key Statistics: England](#)

In addition, the wellbeing of older people and the pressures on the NHS are also linked to how well social care is functioning. Issues around delayed hospital discharges are likely to have placed additional pressure on NHS Services. As the chart below shows, a substantial number of NHS bed days are lost to delays in transfer of care (commonly known as delayed discharges). Despite some improvements since the peak of around 6,600 daily delays in February 2017, the figure has shown an increasing trend since August 2019. In February 2020 average daily delays were 18% higher than in February 2019 and 34% higher than in February 2011.



Source: [NHS England: Delayed transfer of care data](#)

## Response to pressures

The demands placed on the NHS in recent years have associated financial pressures. For a number of years, NHS Trusts and Clinical Commissioning Groups (CCGs) have ended the financial year with an overall deficit.

In 2018/19, NHS Trusts overspent by £571 million and CCGs by £264 million. However, underspends in NHS England's own budget and commissioning spending were sufficient to offset deficits and achieve overall financial balance.<sup>7</sup>

Achieving such financial balance was dependent upon a mixture of short-term cost savings and emergency funds like the Provider Sustainability Fund (PSF)<sup>8</sup>. Many commentators have argued that this is not an adequate basis on which to plan a stable financial recovery.<sup>9</sup> Indeed, the underlying trust sector deficit, which discounts non-recurrent income and savings, was £5 billion in 2018/19.<sup>10</sup>

On 2 April 2020 the Government announced that £13.4 billion of historic NHS debt would be written off<sup>11</sup>. The decision to write off this debt was taken in response to the Coronavirus epidemic and in acknowledgement of the need to support the NHS to become more financially sustainable.

The [NHS Long Term Plan](#) recognises that the NHS in England needs to progress towards a more co-ordinated, integrated, and collaborative approach to the planning and delivery of services. Such an approach involved the NHS working closely with local government and other key partners in the delivery of health and social care.

<sup>7</sup> [NHS England Board Papers June 2019 Financial Performance Update](#)

<sup>8</sup> The Provider Sustainability Fund replaced the Sustainability and Transformation Fund in 2018/19.

<sup>9</sup> See for example: [Having your fudge and eating it, Nuffield Trust \(2019\)](#)

<sup>10</sup> [NHS Improvement: Performance of the NHS provider sector Quarter 4 2018/19](#)

<sup>11</sup> [DHCS: NHS to benefit from £13.4 billion debt write off.](#)

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The Plan notes that additional funding is needed to achieve desired health and care service objectives and ensure financial sustainability.

In January 2019, the [Secretary of State's Oral Statement on The NHS Long Term Plan](#) confirmed details of the annual allocations to NHS England. These are shown in the table below in cash and real terms. The cash amounts for the years 2019/20 to 2023/25 were confirmed as minimum levels in the [NHS Funding Act 2020](#).

| <b>NHS England budget</b> |           |                 |                |                 |
|---------------------------|-----------|-----------------|----------------|-----------------|
| £billions                 |           |                 |                |                 |
|                           | Cash      |                 | 2019/20 prices |                 |
|                           | £billions | Annual % change | £billions      | Annual % change |
| 2018/19                   | 114.8     |                 | 117.0          |                 |
| 2019/20                   | 121.0     | 5.4%            | 121.0          | 3.4%            |
| 2020/21                   | 127.2     | 5.1%            | 124.8          | 3.1%            |
| 2021/22                   | 133.4     | 4.9%            | 128.3          | 2.8%            |
| 2022/23                   | 140.2     | 5.0%            | 132.1          | 3.0%            |
| 2023/24                   | 148.6     | 6.0%            | 137.5          | 4.1%            |

Sources:

[Secretary of State's statement on the NHS Long Term Plan, January 2019](#)

[HMT: GDP deflators March 2020](#)

Further information on the current funding settlement for the NHS in England, the financial and operational performance of the health service, and measures being taken to ensure its future sustainability, can be found in the National Audit Office (NAO) report, [NHS financial management and sustainability](#) (5 February 2020). The NAO's [Review of capital expenditure in the NHS](#) (5 February 2020) expands on issues in the NHS financial sustainability report to set out the facts on NHS capital investment. The House of Lords' Inquiry on the Long-Term Sustainability of the NHS also reported on these issues in 2017.<sup>12</sup>

### Box 1: proposals to increase efficiency

A number of Government backed reviews have looked at potential ways to improve NHS efficiency, including:

- The [Carter review](#) (February 2016) considered unwarranted variation in productivity and concluded that the NHS hospitals could save £5 billion each year by 2020/21 through measures such as better procurement and shared back office support.
- The potential of digital technology to improve efficiency, and the challenges of implementing new IT systems in healthcare, were addressed in the [Wachter review](#) (September 2016).
- The [Naylor review](#) (March 2017) highlighted how better management of the NHS estate could generate up to £5 billion (and land for 26,000 new homes) but also estimated that £10 billion of capital investment is needed to address the backlog of maintenance in the NHS, and to deliver STPs.

<sup>12</sup> House of Lords Select Committee on Long-Term Sustainability of the NHS, [The Long-term Sustainability of the NHS and Adult Social Care](#), 31 March 2017

## 2. Commissioning and regulation of health services

### Box 2: What is NHS commissioning?

NHS commissioning is the process of planning, agreeing and monitoring health services to ensure that they are provided effectively meet the needs of a given population.<sup>13</sup> Commissioning is seen as a key means of helping achieve a wide range of policy objectives in the NHS, including improving the safety and quality of services; creating better value for money and wider patient choice; and reducing inequalities in health. The Commons Library briefing [NHS commissioning before 2013](#) contains background on the development of NHS commissioning from the introduction of the purchaser/provider split in the early 1990s. See also, the King's Fund, [What is commissioning and how is it changing?](#) (September 2019).

### 2.1 Clinical Commissioning Groups

[Clinical Commissioning Groups](#) (CCGs) were established in local areas across England in 2013 and are responsible for the majority of NHS services.<sup>14</sup> Under the *Health and Social Care Act 2012* they took on statutory responsibilities for commissioning services including:

- Urgent and emergency care (for example, A&E)
- Elective hospital care (for example, outpatient services and elective surgery)
- Community health services (for example community mental health services)<sup>15</sup>

Since 2013, CCGs have taken greater responsibility for commissioning other areas, including primary care and specialised services (see boxes 4 and 5 below).

The *Health and Social Care Act 2012* sets out the functions, duties, and governance structures for CCGs. The Act makes CCGs directly responsible for commissioning NHS services they consider appropriate to meet reasonable local needs.<sup>16</sup> In assessing local needs and developing commissioning plans to meet them, CCGs must work with local authority Health and Wellbeing Boards.

Under the 2012 Act all general practices must be a part of the CCG for their area. The Act also requires that CCGs have a published constitution and that CCG Boards must have at least six members (including a chair), with Boards including at least one of each of the following:

<sup>13</sup> DH, [commissioning](#) (webpage archived on 6 May 2010)

<sup>14</sup> CCGs replaced the previous local commissioning bodies, Primary Care Trusts (PCTs).

<sup>15</sup> NHS England has published a document, [The functions of clinical commissioning groups](#) (March 2013), which sets out the range of core CCG functions as set out in legislation. NHS England also produced a [factsheet](#) explaining the services that are commissioned by CCGs.

<sup>16</sup> Commissioning Support Units (CSUs) assist CCGs with external support, specialist skills and knowledge to support them in their role as commissioners, although responsibility for commissioning decisions remain with CCGs. Some background can be found in [Developing Commissioning Support: Towards Service Excellence](#), February 2012.

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- CCG Accountable Officer;
- CCG Finance Officer (who must have an accountancy qualification and experience);
- Registered nurse;
- Secondary care specialist;
- Lay person (experienced in financial management);
- Lay person (experienced in an area of a CCGs functions).

NHS England keeps CCG authorisation conditions under review to ensure they continue to fulfil the duties and governance arrangements required under the 2012 Act.<sup>17</sup>

### Box 3: From GP consortia to clinical commissioning

The Government's July 2010 Health White Paper set out proposals for changing the NHS commissioning system in England. This included giving groups of GPs responsibility for commissioning the majority of health services through what were termed "GP commissioning consortia" (and abolishing Primary Care Trusts (PCTs), the NHS bodies then responsible for commissioning services). Previous attempts at giving GPs control of NHS budgets—GP fundholding, between 1991 and 97, and Practice Based Commissioning from 2005—were voluntary schemes. The White Paper went further, proposing that all GPs should be involved in commissioning consortia.

Provisions establishing GP commissioning consortia were included in the *Health and Social Care Bill* introduced in January 2011. Following recommendations from the Government-established NHS Future Forum that there should be wider clinical involvement in commissioning the Government introduced amendments to the Bill to specify that commissioning consortia governing bodies must include at least one nurse and one specialist doctor. As a result of these changes it was announced that GP commissioning consortia would be known as Clinical Commissioning Groups (CCGs).<sup>18</sup>

## 2.2 NHS England

NHS England is an executive non-departmental public body which leads and oversees the funding, planning and delivery of healthcare in England. NHS England allocates most of the funding it receives from the Department of Health and Social Care to Clinical Commissioning Groups (CCGs), and supports them to commission services based on local need. NHS England also directly commissions some healthcare services including primary care services (dentists, opticians, pharmacists and parts of GP services), screening and immunisation programmes, and specialised services (including drugs and services for rare diseases) (see box 5).

NHS England is also responsible for:

- ensuring that there is an effective and comprehensive system of CCGs;
- providing commissioning support and guidance;
- administering the Cancer Drugs Fund.

<sup>17</sup> NHS England provide further information on the [Improvement and Assessment Framework/Oversight Framework](#) it uses to assess the performance of CCGs

<sup>18</sup> The Library note, [NHS Commissioning](#), contains information on how commissioning within the health service in England had been organised prior to the *Health and Social Care Act 2012* reforms.

While CCGs commission the majority of NHS services, including most hospital services, NHS England directly [commissions directly](#) certain services at a national or regional level.

NHS England commissions [primary care services](#), for example GPs, dentists and opticians. Although, for GPs (primary medical services) this is devolved to most CCGs through [primary care co-commissioning](#) (see box 4).

NHS England also directly commissions ‘[specialised](#)’ services (such as treatments for rare conditions and secure mental health care – see box 5), [military and veteran health services](#) and health services for [people in prisons \(including youth offender institutions\)](#). Some [public health services](#) are also directly commissioned by NHS England.

#### **Box 4: An increased role for CCGs in commissioning primary care**

In May 2014 CCGs were invited to take an increased role in the commissioning of primary care services and in November 2014 a CCG/NHS England co-commissioning programme group published [Next steps towards primary care co-commissioning](#). NHS England publish a [list of CCGs](#) that have some form of co-commissioning arrangement for primary care services.<sup>19</sup>

#### **Box 5: Specialised services**

Specialised services are those accessed by comparatively small numbers of patients, provided in relatively few hospitals (with catchment populations of usually more than one million). These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. Specialised services account for approximately 15% of the total NHS budget for England.

The commissioning of specialised services is a prescribed direct commissioning responsibility of NHS England. Four factors determine whether NHS England commissions a service as a prescribed specialised service. These are:

- The number of individuals who require the service;
- The cost of providing the service or facility;
- The number of people able to provide the service or facility and
- The financial implications for Clinical Commissioning Groups (CCGs) if they were required to arrange for provision of the service or facility themselves.

Any transfer of responsibilities between NHS England and CCGs requires an amendment to secondary legislation listing the prescribed specialised services to be commissioned by NHS England.

NHS England is also the body responsible for ensuring that there is an effective and comprehensive system of CCGs. It provides national leadership on commissioning and allocates CCG funding.<sup>20</sup> NHS England has a duty to publish commissioning guidance, to which CCGs must have regard, and CCGs are ultimately accountable to NHS England for their performance and under the *Health and Social Care Act 2012*. Where it is satisfied that a CCG has failed to discharge any of its functions, NHS England has powers to direct a CCG to discharge its functions in a particular way.

<sup>19</sup> <https://www.england.nhs.uk/commissioning/pc-co-comms/pc-comms/>

<sup>20</sup> NHS England allocates funding to NHS Trusts and NHS Foundation Trusts and providers of primary care and other services as well as CCGs.



## Statutory duties of CCGs and NHS England

In carrying out their responsibilities NHS England and CCGs are subject to a number of statutory duties under the 2012 Act, including:

- promoting the [NHS Constitution](#);
- securing continuous improvements in the quality of services commissioned;
- reducing inequalities;
- enabling choice and promoting patient involvement;
- securing integration; and
- promoting innovation and research.<sup>21</sup>

## 2.3 NHS Improvement

NHS Improvement is the operational name for several different bodies that support and oversee providers of NHS services. It was set up in 2016, bringing together Monitor (the statutory regulator of NHS Foundation Trusts) and the NHS Trust Development Authority. It also incorporated patient safety functions (including the National Reporting and Learning System) and responsibilities for service transformation and change.

NHS Improvement's role is to support providers, to ensure they provide patients with safe and compassionate care, and that local health systems are financially sustainable. Where there are concerns that existing foundation trust or NHS trust management cannot make the necessary improvements NHS Improvement can intervene. For example, it works alongside the Care Quality Commission (CQC) to take action when the CQC reports that a hospital trust is failing to provide good quality care.

NHS Improvement has inherited Monitor's statutory powers to act as a sector regulator for health services in England (for example, powers to set and enforce a framework of rules for providers and commissioners; implemented in part through licences issued to NHS-funded providers). It is also responsible for setting prices for NHS-funded services alongside NHS England, tackling anti-competitive practices, helping commissioners ensure that essential local services continue if providers get into financial difficulty, and enabling better integration of care.<sup>22</sup>

The [NHS Oversight Framework for 2019/20](#) (August 2019) outlines the joint approach NHS England and NHS Improvement take to oversee organisational performance and identify where commissioners and providers may need support. The framework assesses performance under five key themes:

- New service models
- Preventing ill health and reducing inequalities

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<sup>21</sup> A number of these duties are the result of amendments to the *Health and Social Care Act 2012* made in response to recommendations of the NHS Future Forum made in June 2011.

<sup>22</sup> NHS Improvement also brought together a number of patient safety functions, including the National Reporting and Learning System (NRLS).

- Quality of care and outcomes
- Leadership and workforce
- Finance and use of resources.

Where there are concerns that commissioners or providers are failing to meet required standards and have “support needs”, NHS England and NHS Improvement can intervene.<sup>23</sup>

## 2.4 Shared NHS England and NHS Improvement leadership

Since 1 April 2019, NHS England and NHS Improvement have worked together as a single organisation, although they remain legally distinct under the *Health and Social Care Act 2012*.

NHS England and NHS Improvement have proposed that they should be permitted to merge fully to create a single leadership body, combining their respective responsibilities for provider and commissioner performance, finance and care transformation. It is also proposed that the two statutory bodies that make up NHS Improvement, Monitor and the Trust Development Authority, should be formally abolished. Their functions would be added, where they are still necessary, to the existing legislative basis of NHS England.<sup>24</sup>

The Government has said it is “considering the NHS’s recommendations thoroughly and will bring forward detailed proposals shortly”, leading to draft legislation.<sup>25</sup>

NHS England and NHS Improvement are accountable through their boards to the Secretary of State for Health and Social Care. The Secretary of State agrees accountability arrangements that set the strategic direction for NHS England and NHS Improvement. Further information about these accountability arrangements can be found in the Government’s [Accountability Framework to NHS England and NHS Improvement 2019-2020](#) (March 2020). This framework sets out the remit for both bodies, including the Government’s expectations for NHS England and NHS Improvement to deliver the first year of the [NHS Long Term Plan](#) (January 2019) and address the immediate needs associated with EU Exit.

## 2.5 NHS providers

Most hospital, community, mental health, ambulance and specialist NHS care is provided by NHS Foundation Trusts and NHS Trusts. NHS Foundation Trusts (FTs) are self-governing bodies that have greater financial and operational freedom than NHS trusts. All NHS Trusts and Foundation Trusts have a Chief Executive and management board and are accountable to NHS Improvement. FTs also have a board of

<sup>23</sup> NHS England and NHS Improvement, [NHS Oversight Framework 2019/20](#), October 2019, page 9

<sup>24</sup> NHS England/NHS Improvement, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019

<sup>25</sup> UK Government, [Queen’s Speech 2019](#), December 2019, p.30

governors and members. FT's greater financial freedoms include the ability to borrow commercially and generate surpluses to reinvest in services. A directory of NHS Trusts and Foundation Trusts can be found on the [NHS England website](#).

Most primary care services in England (including GPs, dentists, optometrists and pharmacists.) are provided by a range of independent providers, under national contracts with the NHS.

Providers of NHS funded services also include non-NHS bodies, including private companies, charities and voluntary sector bodies. All providers of healthcare services in England are regulated by the Care Quality Commission (CQC).

### 2.6 The Care Quality Commission

The CQC was established in April 2009 and replaced three former regulatory bodies. The CQC is responsible for the registration, inspection and monitoring of health and adult social care providers, including independent providers, under the *Health and Social Care Act 2008*.

All providers of health and adult social care who carry out "regulated activities" are required to register with the CQC and demonstrate they meet fundamental standards. The scope of regulated activities includes treatment of disease, disorder or injury, surgical procedures, maternity and midwifery services, personal care, nursing care and assessment or medical treatment for persons detained under the *Mental Health Act 1983*.

The CQC inspects and monitors the services that it registers. Following an inspection, services receive a rating on a four-point scale: outstanding; good; requires improvement; and inadequate. There is no set interval for inspections; inspections are carried out at variable frequency according to the CQC's judgment of risk. Highly performing services – i.e. those with an outstanding rating – can expect inspections at a five-year interval, while services rated as inadequate are normally inspected within 12 months of their last report.

The CQC made major changes to its inspection and regulatory approach from 2013, primarily following concerns raised in the independent Francis review of failures in care at the Mid Staffordshire NHS Foundation Trust. Key changes included the introduction of regulatory "fundamental standards", including a new specific 'duty of candour'; asking five questions of all services (are they safe? effective? caring? responsive to people's needs? and well-led?); strengthening how the CQC acts on concerns and complaints raised by the public; and the introduction of chief inspectors for hospitals, adult social care and primary medical services and integrated care.

In April 2015, the CQC introduced a new enforcement policy. This enhanced their powers to act where they identify poor care, including acting on breaches of regulations and a new power to prosecute providers directly. The CQC also introduced a special measures

framework, which applies to providers that have major failures in quality of care and/or serious financial problems.

In January 2020, the CQC set out changes following an independent review into how it dealt with concerns about the regulation of Whorlton Hall (an independent hospital providing assessment and treatment for people with learning disabilities and complex needs). The review made recommendations to improve the CQC's processes, including its internal whistleblowing process, all of which were accepted by the CQC. A second upcoming review will make recommendations for how CQC's regulation of similar services can be improved, in the context of a raised level of risk of abuse and harm.

The CQC publishes an annual State of Care report to Parliament, which is its assessment of health and social care in England. The most recent report – an assessment of 2018/19 – found that although across England the state of care is generally good, there are widespread problems with access to care, with many people unable to access appointments. The report also raised concerns about the state of care for people with mental health problems, autism and learning disabilities. The report noted that in September 2019, 10% of inpatient services for people with learning disabilities and/or autism were rated as inadequate, as compared to 1% in 2018.<sup>26</sup>

The CQC has no role to investigate individual complaints made against a specific service, except [certain complaints made in relation to the Mental Health Act 1983](#). However the CQC highlights that it is keen to hear from the public about their experience of care to help inform when and how it regulates and inspects particular services.

Further information can be found in the [Commons Library briefing paper on the CQC](#).

## 2.7 NHS accountability to Government, Parliament and the public

### The Secretary of State for Health and Social Care

One of the stated aims of the 2010 Government's health reforms was to end political interference in the NHS. Under the *Health and Social Care Act 2012* the Secretary of State sets the strategic direction for the NHS in England through a 'mandate' to NHS England. The Government's annual mandate to NHS England for 2019-20 was, for the first time, combined with the annual NHS Improvement remit letter. Further information about these accountability arrangements can be found in the Government's [Accountability Framework to NHS England and NHS Improvement 2019-2020](#).

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<sup>26</sup> Care Quality Commission, [Growing pressures on access and staffing risk creating 'perfect storm' for people using mental health and learning disability services](#), 15 October 2019

The Secretary of State also sets the overall budget for NHS England, which in turn does the same for CCGs.<sup>27</sup> NHS England holds CCGs to account for their financial management. The Chief Executive of NHS England, as Accounting Officer, is accountable both to the Department of Health and Social Care and to Parliament.

The Secretary of State for Health and Social Care and other Departmental Ministers are accountable to Parliament for the provision of the comprehensive health and care service in England.

In the last resort, the Secretary of State also has powers to intervene where he considers that NHS England or any other NHS body is failing to discharge its functions.

Further information about the role and structure of the Department of Health and Social Care (DHSC) can be found in the [DHSC Annual Report and Accounts 2018-19](#), and the [National Audit Office \(NAO\) Departmental Overview for Health and Social Care 2018-19](#).

### Select Committees

Parliamentary select committees, specifically the House of Commons Health and Social Care Select Committee, examine the policy, administration and expenditure of the Department of Health and Social Care (DHSC) and its associated public bodies. In addition to inquiries into specific policy areas, the Health and Social Care Committee holds accountability sessions with health service bodies, and pre-appointment hearings for certain senior leadership posts at national organisations.

### Patients and the public

The NHS Constitution states that the NHS is accountable to the public, communities and patients that it serves. NHS England's [Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England](#) and [Involving people in their own health and care: statutory guidance for CCGs and NHS England](#) set out the context, benefits and principles of involving people in health and care, the relevant legal duties and key actions for Clinical Commissioning Groups (CCGs) and NHS England.

Healthwatch England and the local Healthwatch also aim to represent the views of the local population in the reformed health service.

Healthwatch England—which describes itself as the ‘independent consumer champion for the health sector’—has a duty set out in the *Health and Social Care Act 2012* to provide advice to NHS England, English local authorities, and the Secretary of State. It is a committee of the CQC and has the power to recommend that action is taken by the CQC where it has concerns about health and social care services. Healthwatch is intended to provide local communities with a way of influencing local healthcare provision. It also works at the local level through local Healthwatch organisations (set up by local authorities).

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<sup>27</sup> The Secretary of State also sets an overall limit on the amount that can be spent on administrative costs in the system.

Local Healthwatch organisations took over the role previously carried out by Local Involvement Networks (LINKs).<sup>28</sup>

Local Healthwatch organisations:

- Represent the views of people who use services, carers and the public on the Health and Wellbeing boards set up by local authorities.
- Provide a complaints advocacy service to support people who make a complaint about services.
- Report concerns about the quality of health care to Healthwatch England, which can then recommend that the CQC take action.

The Department of Health commissioned the King's Fund to produce a report on local Healthwatch services; the report [Local Healthwatch: progress and promise](#), was published in March 2015.

[The NHS England website provides further information on patient and public participation](#). Section 6 of this briefing provides more information on the role of local authorities in health scrutiny, and Health and Wellbeing Board's oversight of local commissioning and co-ordination of health and social care services.

## 2.8 Regulation of health and care professionals

In the UK, there are 10 regulators for health and social care professions. Professional regulation is statutory for specified health and social care professions and each regulatory body is governed by a separate piece of legislation. For example, *The Medical Act 1983* (for professions regulated by the General Medical Council), *The Medicines Act 1968* (for professions regulated by the General Pharmaceutical Council), and *The Nursing and Midwifery Order 2001* (for professions regulated by the Nursing and Midwifery Council).

The regulators have four key roles:

- Set standards of competence and conduct that health and care professionals must meet in order to be registered and practise
- Check the quality of education and training courses to make sure they give students the skills and knowledge to practise safely and competently
- Maintain a register that everyone can search
- Investigate complaints about people on their register and decide if they should be allowed to continue to practise or should be struck off the register - either because of problems with their conduct or their competence.<sup>29</sup>

Further information on each of the regulators, and the professions that they regulate, is available here: [Find a regulator](#).

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<sup>28</sup> LINKs were set up in 2008 in each local authority area to involve local people in decisions about how local services are run.

<sup>29</sup> Professional Standards Authority, [About the regulators](#)

The activity of the 10 regulators is overseen by the [Professional Standards Authority](#) (PSA), with powers given under the *Health and Social Care Act 2012*.<sup>30</sup>

## Reform of professional regulation

There have been a number of reports examining reform of professional regulation.

The Law Commissions of England and Wales, Scotland and Northern Ireland published a [comprehensive review](#) of the legal framework and a draft Bill for professional regulation in the UK in 2014. The reforms recommended by the Law Commissions aimed to consolidate and simplify the existing legal framework and introduce greater consistency across the regulatory bodies in some areas, such as the conduct of fitness to practise hearings. The UK and Devolved Governments published a [response to the Law Commission report](#) in January 2015. This accepted a majority of the review's recommendations in full, for example establishing a single statute for all the regulatory bodies, and committed to legislate "in due course".

The UK and Devolved Government's consultation, [Promoting professionalism; reforming regulation](#) (October 2017) set out proposals to reform statutory regulation, with three key aims:

- modern and efficient fitness to practise processes
- better supported professionals
- more responsive and accountable regulation.

The Government said:

The UK's model of professional regulation for healthcare professionals has become increasingly complex, outdated and is seen as adversarial and legalistic. This makes it difficult for regulators to be responsive to the changing needs of the healthcare environment, to support the development of a flexible workforce and to protect the public in the most effective way.<sup>31</sup>

The Government's response to the consultation (July 2019) committed to making legislative change through secondary legislation. Legislation has not yet been introduced.

Some changes have been made to health regulation since this consultation. For example, in December 2019, the regulatory body Social Work England was created, taking over the regulation of social care staff from the Health and Care Professions Council.<sup>32</sup>

The Government has also extended – or proposed extending – professional regulation to further professions, to reflect the changing nature of the health and social care workforce. [The Nursing and Midwifery Order \(2018\)](#) extended regulation to nursing associates in England. In July 2019, the Department of Health and Social Care

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<sup>30</sup> See Professional Standards Authority, [How we work](#)

<sup>31</sup> Department of Health and Social Care, [Promoting professionalism, reforming regulation. Government response to the consultation](#) July 2019, para 2.1

<sup>32</sup> [EXPLANATORY MEMORANDUM TO THE SOCIAL WORKERS REGULATIONS 2018](#), Para 71.

announced that it would be asking the General Medical Council (GMC) to take forward the regulation of physician associates and anaesthesia associates.<sup>33</sup> In 2016, the House of Commons Health Select Committee, which recommended regulation of physician associates, heard evidence why their regulation was supported. This included representations from the Nuffield Trust, who stated that lack of statutory regulation meant that “physician associates are hampered by their inability to prescribe medicines”.<sup>34</sup>

Further comment on the reform of professional regulation is available from:

- NHS Providers, [NHS regulation and oversight: A time of transition](#), August 2019
- NHS Providers, [NHS regulation: a shifting focus](#), September 2019

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<sup>33</sup> [‘Written Statement: The Regulation of Physician Associates and Anaesthesia Associates’](#), HCWS1741, 18 July 2019.

<sup>34</sup> House of Commons Health Committee, [Primary Care](#), HC 408 (April 2016), p. 51.



## 3. Access to treatment

### 3.1 The NHS Constitution

The [NHS Constitution](#) (first introduced in 2009 and last updated July 2015) sets out the principles and values that the NHS is guided by:

- 1 The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.
- 2 Access to NHS services is based on clinical need, not an individual's ability to pay.
- 3 The NHS aspires to the highest standards of excellence and professionalism.
- 4 The patient will be at the heart of everything the NHS does.
- 5 The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
- 6 The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
- 7 The NHS is accountable to the public, communities and patients that it serves.

The Secretary of State for Health and Social Care, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of the NHS Constitution in their decisions and actions.

The NHS Constitution also lists the rights of patients and the public, as well as their responsibilities to use resources responsibly and help the NHS work effectively, as well as the rights and responsibilities of NHS staff. The [Handbook to the NHS Constitution](#) gives detail of what patients, the public and NHS staff can do if they think these rights are not upheld.

The Department of Health and Social Care is required to renew the NHS Constitution at least every 10 years, with the involvement of the public, patients and staff.

The Constitution sets out that patients have the right to access certain services within maximum waiting times or be offered alternatives if this is not possible. These waiting times are explained in the [Handbook to the NHS Constitution](#) (last updated January 2019).

For example, patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral, including mental health services. They also have the right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals. There are also pledges on maximum waiting times for services such as A&E,

treatment for diagnosed cancer, talking therapies and treatment for psychosis.

## The clinical review of NHS access standards

The NHS has been undertaking a [clinically-led review of access standards](#), including waiting times/clinical standards for urgent and emergency care, elective care, cancer and mental health. The review aims to give greater emphasis to standards that help improve clinical quality and outcomes but [further information on the clinical review of waiting time standards can be found on the NHS England website](#).

Progress reports have been published in March and October 2019:

- [March 2019 interim report](#)
- [October 2019 progress report](#)

A [Parliamentary Question](#) on 17 February 2020, noted that pilot testing is still ongoing and that the final report of the review will be published later this year. Once recommendations are made, following field-testing of the proposals within the NHS, the Government has committed to studying them carefully.

The clinical review's October 2019 progress report committed NHS England and NHS Improvement to a process of public engagement on revised standards and sets out an indicative timetable of changes during 2020/21.<sup>35</sup> The [consultation of the Draft NHS Standard Contract for 2020/21](#) provides further detail on the proposed new operational targets, and notes that the new NHS standard contract will be updated 'as appropriate'.

## 3.2 NICE

The National Institute for Health and Care Excellence (NICE) is an independent body which provides evidence-based guidance on health services, social care and public health. This includes recommendations, in '[technology appraisals](#)' (TA) and '[highly specialised technologies](#)' (HST) guidance, on whether medicines and other treatments represent a clinically and cost-effective use of NHS resources.<sup>36</sup>

The NHS Constitution states that patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if their doctor believes they are clinically appropriate. NHS organisations in England are legally required to make funding available for treatments that NICE recommends, usually within three months of final guidance being published.

NICE has initiated a review of its methods for both TAs and HST appraisals, in line with a commitment made in the 2019 Voluntary Pricing and Access Scheme (VPAS).<sup>37</sup>

<sup>35</sup> NHS England, Draft NHS Standard Contract 2020/21: A consultation, Proposed changes to the NHS Standard Contract for 2020/21, [December 2019](#), page 4

<sup>36</sup> The [NICE website](#) provides guidance on the TA and HST appraisal processes.

<sup>37</sup> The [Voluntary Pricing and Access Scheme \(VPAS\)](#) was agreed by Government and the Association of the British Pharmaceutical Industry (ABPI) in December 2018. Further information about the review of appraisal methods is available on the [NICE website](#). The VPAS states that industry and other relevant stakeholders will be active

NICE also produces advisory clinical guidelines and public health guidance, which commissioners are not required to implement. NICE also publishes [Quality Standards](#) covering the main conditions and diseases, to provide a definition of what high-quality health and social care should look like. NHS England and CCGs must have due regard to these non-mandatory NICE guidelines and quality standards as they fulfil their duties.

In the absence of NICE guidance, NHS organisations can determine their own policy on funding but cannot have a blanket policy to refuse particular treatments and must consider exceptional individual cases (via Individual Funding Requests) where funding should be provided.

## Technology appraisals

The technology appraisal process involves looking at:

- evidence from clinical trials and peer reviewed research showing how well a medicine or treatment works, including its likely impact on mortality and quality of life (such as pain or disability);
- economic evidence on how much it costs the NHS; and,
- the views of clinicians, patients and other stakeholders.

As well as looking at the clinical effectiveness of a treatment, technology appraisals assess a treatment's cost effectiveness. This is usually measured in terms of the cost per additional Quality-Adjusted Life Year (QALY) that the treatment provides. QALYs are a measure of the years of life remaining for a patient, weighted on a quality of life scale. One QALY is equal to one year of life in perfect health.

NICE does not decide on the topics for guidance and appraisals. Instead, topics are referred to NICE by the Department of Health and Social Care. Topics are selected on the basis of a number of factors, including the burden of disease, the impact on resources, whether there is inappropriate variation in practice across the country, and factors affecting the timeliness or urgency for guidance to be produced. Around 40% of drugs new to the UK market are evaluated by the NICE technology appraisal process each year.

## Highly Specialised Technologies programme

NICE carries out evaluations for selected high-cost low-volume drugs under its Highly Specialised Technologies programme. As with other NICE technology appraisals NHS England is required to fund treatments that have been evaluated and recommended by this programme within three months of the guidance publication.<sup>38</sup>

The methods used to develop NICE's highly specialised technology (HST) guidance acknowledges that, given the very small numbers of patients living with these very rare conditions, establishing value for money is not straightforward. In particular, the HST guidance recognises the

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participants in the review. NICE's updated methods guide will also be subject to a public consultation.

<sup>38</sup> [NICE Highly-Specialised Technologies Guidance](#)

particular circumstances of these very rare conditions –the vulnerability of very small patient groups with limited treatment options, the nature and extent of the evidence, and the challenge for manufacturers in making a reasonable return on their investment because of the very small populations treated. In evaluating these drugs, NICE considers a greater range of criteria about the benefits and costs of highly specialised technologies than is the case with its appraisals of mainstream drugs and treatments.

[Following changes introduced in April 2017](#), NICE set a maximum additional QALY threshold of £300,000 for highly specialised treatments, under which they will automatically be approved for routine commissioning. This is ten times higher than the standard NICE threshold of £30,000 for non-specialised treatments.

### 3.3 Cost-effectiveness and drug pricing

NICE does not directly negotiate drug prices. The prices of branded medicines for the NHS are regulated in the UK through price regulation agreements between Government and the pharmaceutical industry. On 1 January 2019 a 5-year Voluntary Pricing and Access Scheme (VPAS) for branded medicines was introduced with the aim to give patients in the UK faster access to new medicines.<sup>39</sup> There is also a Statutory Scheme to control the prices of branded medicines. Manufacturers and suppliers of branded medicines can choose to sign up to VPAS or will automatically fall under the control of the Statutory Scheme for their branded medicines. The prices of unbranded generic medicines are not controlled, competition within the market is relied upon to control prices. The *Health Services Medical Supplies (Costs) Act 2017* amended the *NHS Act 2006* in a number of areas, and included powers to make a statutory scheme for branded medicines requiring companies to pay a percentage of their sales. The *Branded Health Service Medicines (Costs) Regulations 2018* entered into force on 1 April 2018 but the Department has not yet used its statutory powers to limit prices of generic medicines.

In April 2018, the King’s Fund reported on [The rising costs of medicines to the NHS](#). This report noted that while NICE is not directly involved in negotiating drug prices, its cost-effectiveness assessments may inform pharmaceutical companies’ pricing strategies.

Where medicines have not been able to meet the requirements for cost-effectiveness, the NHS may enter into negotiations with the manufacturer to supply the drug at a different price – sometime referred to as a Patient Access Scheme. The negotiations and resulting agreement around the supply of a medicine in these cases is deemed commercially sensitive and remains confidential.

Although NICE technology appraisals and HST evaluations assess cost effectiveness, they do not assess affordability in terms of overall cost to the NHS of routinely commissioning a treatment. However, following changes introduced in April 2017, NICE can now allow for a phased

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<sup>39</sup> VPAS replaced the previous Pharmaceutical Price Regulation Scheme (PPRS).

introduction of any new treatment that may have a substantial impact on the NHS budget, for a period of usually no more than three years (as opposed to the three month standard set out in the NHS Constitution).

A budget impact test, also introduced in April 2017, means that where medicines will cost more than £20 million in any one of their first three years of use this will trigger commercial discussions between the company and NHS England to mitigate the impact on the rest of the NHS.

### 3.4 Accelerated and early access to medicines

Following recommendations of the [Accelerated Access Review](#) in 2016, the Government established the [Accelerated Access Collaborative](#) (AAC). This brings together representatives from Government, the NHS and industry to drive the uptake and adoption of the most effective new treatments. NHS England can directly negotiate with pharmaceutical companies, in conjunction with NICE where appropriate, on fast track reimbursement arrangements for selected drugs.

In April 2014, the Government announced the launch of the [Early Access to Medicines Scheme](#) (EAMS). The scheme gives people with life threatening or seriously debilitating conditions from across the UK early access to new medicines that do not yet have a marketing authorisation when there is a clear unmet medical need. Prior to market authorisation, companies provide their products for free to the NHS.

#### The Cancer Drugs Fund

NICE may recommend new cancer drugs for use in the [Cancer Drugs Fund](#) (CDF) where there is potential for the drug to be considered for routine commissioning but there is significant remaining clinical uncertainty which needs more investigation through data collection in the NHS or clinical trials.

The UK Government established the CDF in 2010 to help improve access to cancer drugs in England. Before July 2016 the CDF was used to fund cancer drugs that were not routinely funded by the NHS in England, whether or not they had been assessed by NICE. Since July 2016 the CDF covers treatment costs for patients for drugs that have not yet been assessed by NICE. The [2016 change to the CDF operating model](#) was made to ensure that promising and innovative cancer medicines get to patients as quickly as possible. Under this model, the CDF is a transitional fund that pays for new drugs in advance of NICE carrying out a full assessment of whether the drugs should be recommended for routine commissioning. After assessment, the drug will either be approved by NICE for routine commissioning on the NHS, or be removed from the CDF.<sup>40</sup> The 2016 changes to the CDF were in

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<sup>40</sup> Further information on the current CDF and NICE operating model for cancer drugs can be found on the [NICE website](#).

line with the recommendation of the 2015 independent Cancer Taskforce report.<sup>41</sup>

Following the changes to the CDF in July 2016 all Individual Funding Requests (IFR) relating to cancer drugs are considered using NHS England's single, national IFR system. The NHS England [specialised services key documents page](#) provides details on its IFR system, and how clinicians can apply on behalf of patients.

#### **Box 6: The Medicines and Healthcare products Regulatory Agency (MHRA)**

The MHRA regulates medicines, medical devices and blood components for transfusion in the UK. The MHRA is an executive agency of the Department of Health and Social Care and acts as the UK's licensing authority. Its responsibilities include:

- ensuring that medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy;
- ensuring that the supply chain for medicines, medical devices and blood components is safe and secure.

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<sup>41</sup> Independent Cancer Taskforce, [Achieving world-class cancer outcomes – a strategy for England 2015–2020](#) (July 2015)

## 4. Education and training

[Health Education England](#) (HEE) was established in 2013 as a non-departmental body of the Department for Health and Social Care (DHSC). It is responsible for securing a workforce in England that meets the needs of local service users, providers and commissioners of healthcare. The HEE annual workforce plan for England sets out its view of demand and supply across all healthcare professions, including doctors and nurses. One of HEE's main methods of securing a sufficient workforce is through its commissioning of education and training places.

HEE has four 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 are committees of HEE, made up of representatives from local providers of NHS services. LETBs are the vehicle for providers and professionals to work with HEE to improve the quality of education and training outcomes so that they meet the needs of service providers, patients and the public.

DHSC continues to set the education and training outcomes for the system as a whole, securing the resources necessary and continuing to set the regulatory, policy and legal framework. It holds the HEE Board to account for delivery of its strategic objectives.

The bodies that regulate health and social care professionals, such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC), also have a role in determining education and training policies. These professional regulators perform the following key functions:

- Setting standards of education and training.
- Approving and assuring institutions delivering training, including the programmes they provide and also the practice placements where students develop the skills, competencies and experience they need.

Although NHS staff numbers have increased, in many areas there are problems recruiting enough nurses, GPs, and a number of other specialist healthcare professions. Health and social care staff report increasing pressure and lower morale. There are also concerns that the UK leaving the EU will make it harder to retain and recruit EU staff. There is a growing consensus that one of the biggest challenges facing the NHS is finding and keeping the right number of people with the right skills needed to deliver high quality care.

The [Interim NHS People Plan](#), published in June 2019, set out proposals to grow and support the NHS workforce, including commitments to:

1. Make the NHS the best place to work
2. Improve the NHS leadership culture
3. Prioritise urgent action on nursing shortages
4. Develop a workforce to deliver 21st-century care

5. Develop a new operating model for workforce
6. Take immediate action in 2019/20 in addition to developing a full five-year plan

The interim plan also highlighted an immediate need to improve retention, particularly in nursing. A full five-year NHS People Plan is expected later in 2020.

The [Commons Library published an Insight article on the health and social care workforce gap](#) on 10 January 2020. A [National Audit Office \(NAO\) report on the NHS nursing workforce](#) was published on 5 March 2020, which sets out:

- the scale of the NHS nursing workforce challenge;
- the challenges to the main entry routes to NHS nursing and more general workforce-related challenges that any future plans will need to address; and
- the progress made on the People Plan



## 5. Public health services

### 5.1 Public health and local government

The *Health and Social Care Act 2012* transferred responsibility for a range of public health services from the NHS to local authorities; the first time councils have had a statutory role in the provision of healthcare since 1973.<sup>42</sup> From 1 April 2013 the duty to improve the health of their populations transferred to all upper tier and unitary authorities in England, backed by a ring-fenced grant.

Under the reformed system, local authorities commission or provide public health services, including those for children between 5 and 19 years old, some sexual health services, public mental health services, physical activity, anti-obesity provision, drug and alcohol misuse services and nutrition programmes. A [2013 guide from Department of Health](#) set out the commissioning responsibilities of local authorities under the new arrangements.

From October 2015, local authorities have taken over full responsibility from NHS England for commissioning public health services for children up to the age of 5. Since then, local authorities have been required to carry out five mandated child development reviews, providing a national, standardised format to ensure universal coverage and ongoing improvements in public health.

Local authorities commission or provide public health and social care services, including those for children and young people up to 19 years old, some sexual health services, public mental health services, physical activity, anti-obesity provision, drug and alcohol misuse services and nutrition programmes. Local authorities' public health duties are carried out by local Directors of Public Health. A [list of current Directors of Public Health](#) by area is maintained on the Government website.

### 5.2 Public Health England and directly commissioned services

In addition to transferring local health improvement functions from primary care trusts (PCTs) to local authorities in 2013, Public Health England (PHE) was established as an Executive Agency of the Department of Health. PHE has responsibility for overseeing the local delivery of public health services and to deal with national issues such as flu pandemics and other population-wide health issues. The Health Protection Agency, an independent UK organisation set up in 2003 to protect the public from threats to their health from infectious diseases and environmental hazards, also became part of PHE on 1 April 2013.

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<sup>42</sup> *The National Health Service Reorganisation Act 1973* transferred responsibility for community services (with the exception of environmental health) from local authorities to the NHS. The *Local Government Act 2000* gave local authorities a statutory responsibility to improve the economic, social and environmental circumstances in their area; the *Health Act 2001* also gave councils health scrutiny powers.

The public health services that NHS England commissions directly, on behalf of PHE, include:

- The national immunisation programmes.
- The national screening programmes.
- Public health services for offenders in custody.
- Sexual assault referral centres.
- Child health information systems.

As an Executive Agency of the Department of Health and Social Care, PHE is expected to act with operational autonomy as set out in the Framework Agreement. The Framework setting out strategic priorities for PHE in 2019/20 include:

- Tackling particularly among children
- Tackling the growth of Antimicrobial Resistance (AMR)
- Reducing smoking and stopping children starting
- Promoting sexual and reproductive Health
- Promoting good mental health and preventing mental health problems<sup>43</sup>

### 5.3 Recent developments in public health policy

Chapter 2 of the [NHS Long Term Plan](#) (January 2019) sets out action the NHS will take to strengthen its contribution to prevention and to tackling health inequalities, with a specific focus on:

- cutting smoking
- reducing obesity
- combating Type 2 diabetes
- limiting alcohol-related A&E admissions

The Plan noted that the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses.<sup>44</sup> However, the Government subsequently confirmed current commissioning arrangements would continue.<sup>45</sup>

In November 2018 the Government launched its 'Prevention is better than cure' vision for how it plans to transform the approach to prevention. On 22 July 2019 the Government published its Prevention Green Paper, [Advancing our health: prevention in the 2020s](#). This included Chapter 3 of the Childhood Obesity Strategy and driving forward policies in Chapter 2, such as ending the sale of energy drinks to children.

Further background on policy in this area can be found in Commons Library briefings prepared ahead of Opposition day debates on [public health funding](#) in May 2019 and on [health inequalities](#) in March 2020.

<sup>43</sup> DHSC, [PHE remit letter: 2019 to 2020](#), 27 March 2019

<sup>44</sup> [NHS Long Term Plan](#), January 2019, para 2.4

<sup>45</sup> Gov.uk, [Government review confirms local authorities will continue to commission public health services](#), 7 June 2019

The latter refers to the landmark report [Health Equity in England: The Marmot Review 10 Years On](#) (25 February 2020). To mark the 10 year anniversary of the publication of the 2010 Marmot Review (Fair Society, Healthy Lives) the Health Foundation commissioned Professor Sir Michael Marmot and his team at the UCL [Institute of Health Equity](#) to examine progress in addressing health inequalities in England, and to propose recommendations for future action. The report found that while there had been progress in some areas since 2010 there was also evidence of widening health inequalities.<sup>46</sup>

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<sup>46</sup> UCL, [Health Equity in England: The Marmot Review 10 Years On](#) (25 February 2020)

## 6. Local authority scrutiny and Health and Wellbeing Boards

### 6.1 Local authority scrutiny of health services

In 2014 the Department of Health published guidance on [Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny](#). The requirements to consult in relation to NHS service change are laid down in the general guidance [Planning, assuring and delivering service change for patients](#) which was first published by NHS England in 2013 and updated in 2018. This guidance describes how NHS bodies should interact with local authorities when service changes are proposed. It also provides further information on referral of a proposed substantial development or variation in local health services to the Secretary of State (and information on the role of the Independent Reconfiguration Panel (IRP) in advising the Secretary of State).

### 6.2 Health and Wellbeing Boards

In addition to their public health duties and health scrutiny functions, local authorities are responsible for statutory Health and Wellbeing Boards (HWBs). HWBs oversee local commissioning, and the co-ordination of health and social care services. A [Department of Health guide](#) sets out the key responsibilities of HWBs as well as the statutory requirements for their core membership – which must include at least one elected representative. There are more than 130 HWBs, a geographical directory containing details and contact information for each of them is maintained by the [King's Fund](#).

HWBs were introduced as statutory committees of all upper-tier local authorities under the *Health and Social Care Act 2012*. They are intended to: improve the health and wellbeing of the people in their area; reduce health inequalities; and, promote the integration of services.

The primary responsibility of HWBs is to produce Joint Strategic Needs Assessments (JSNAs) to identify the current and future health and social care needs of the local community, which feed into a Joint Health and Wellbeing Strategy (JHWS) setting out joint priorities for local commissioning. Local authority, CCG and NHS England commissioning plans are then informed by these documents.

HWBs do not hold a budget, and allocating funding for services remains the responsibility of CCGs and local authorities, in line with their commissioning plan.

In November 2019 the King's Fund published a 'long read' article considering the role of HWBs, in the development of Integrated Care Systems.<sup>47</sup>

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<sup>47</sup> King's Fund, [Health and wellbeing boards and integrated care systems](#), November 2019

## 7. Safety of care

The [NHS Patient Safety Strategy](#) was published in July 2019 and includes national and regional actions to continue to improve patient safety. It also says that hospitals, general practices and other healthcare providers are responsible for the safety of their patients. Clinical Commissioning Groups (CCGs), integrated care systems (ICs) and sustainability and transformation partnerships (STPs) also need to ensure the provision of safe care and lead evidence-based quality improvement across regions. National bodies such as NHS England, NHS Improvement, the Care Quality Commission (CQC), NICE, and the Medicines and Healthcare products Regulatory Agency (MHRA) set standards to maintain safety. Further information on the role of the CQC and NICE can be found in the relevant sections of this briefing.

The National Reporting and Learning System (NRLS), launched in 2003, provides an incident reporting, review and response system launched in 2003. As outlined in the [NHS Patient Safety Strategy](#) the NHS in England is also in the process of developing a new Patient Safety Incident Response Framework (PSIRF) to replace the current [Serious Incident Framework](#). The expectation is that all parts of the NHS in England will be using the new framework by Autumn 2021.

High-profile investigations and inquiries such as those at [Mid Staffordshire](#), [Gosport](#) and [Morecambe Bay](#) have found serious failings in hospital care, and highlighted that patients, families, carers and staff can experience closed and defensive cultures when things go wrong in the NHS. More recently, the Paterson Review found particular failures within the NHS and private sector to deal with individual malpractice. Long-standing failings identified in care provided to people with mental illness and learning disability have also led to a particular focus on these areas.<sup>48</sup>

Sir Robert Francis QC's 2013 [Report into the failings at Mid Staffordshire NHS Foundation Trust](#) led to a range of policy responses intended to improve patient safety. For example, the health related provisions in the [Care Act 2014](#) largely addressed specific recommendations from the Francis Report about transparency and care standards.<sup>49</sup> Provisions in the 2014 Act also responded to wider concerns about how regulatory systems are co-ordinated to ensure patient safety. These had been raised by Francis, and the subsequent [Keogh](#) and [Berwick](#) reviews. Specifically Part 2 of the [Care Act 2014](#) allowed for the introduction of an "Ofsted-style" rating system for hospitals and care homes, creating a single regime to deal with financial and care failures at NHS hospitals. The 2014 Act also introduced a duty of candour for health and social care providers and made it a criminal

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<sup>48</sup> Further background can be found in the Commons Library briefings on [learning disability](#) and [mental health policy](#).

<sup>49</sup> The Commons Library briefing [The Francis Report \(Report of the Mid-Staffordshire NHS Foundation Trust public inquiry\) and the Government's response](#) provides background to the public inquiry led by Robert Francis QC, and the Government's response.

offence for care providers to give false and misleading information about their performance. In February 2015 the Department of Health published [Culture change in the NHS](#), setting out the progress made in applying the lessons learned from the failings at Mid Staffordshire (the [supporting annex](#) to the report set out action on each of the 290 specific recommendations).

Following recommendations in the Francis review in November 2013, NICE was asked to put together guidance on safe staffing levels. It published guidance on nursing in adult acute wards (July 2014) and maternity services (January 2015). NICE was also developing guidance for nursing in A&E when a decision was taken in June 2015 to transfer responsibility for safe staffing guidance to NHS England and NHS Improvement.<sup>50</sup> In December 2016 NHS Improvement published [Safe staffing for adult inpatients in acute care](#), a guide to help standardise staffing decisions in adult inpatient wards in acute hospitals.

The January 2019 [NHS Long Term Plan](#) commits to improving patient safety and reducing patient harm and the substantial costs associated with it. While primary care activity is lower risk than secondary care, the Long Term Plan describes the development of new ways of working in primary and community care that can increase the focus on safety.

## Learning from clinical incidents in the NHS

In March 2015, the Public Administration Select Committee (PASC) published a report calling on the Secretary of State for Health to establish a national independent patient safety investigation body.<sup>51</sup> The Committee said the new investigative body should provide national leadership, to serve as a resource of skills and expertise for the conduct of patient safety incident investigations, and to act as a catalyst to promote a just and open culture across the whole health system.

In July 2015, the Government published a response, [Learning not blaming](#), in which it accepted PASC's recommendation. The 2015 Government response outlined five guiding principles for the new body; objectivity, transparency, independence, expertise and learning for improvement. The July 2015 response also announced the creation an Expert Advisory Group (EAG) to advise the Secretary of State and the Department of Health on the purpose, role and operation of the new investigative body. In its 2016 report, the EAG states that "[t]he purpose of this new safety investigation body is to act as an enabler, exemplar and catalyst for learning-oriented safety investigation" and that "[t]he primary goal of the Healthcare Safety Investigation Branch is to generate learning and to support improvements in the safety of healthcare."<sup>52</sup> The Secretary of State published Directions in 2016 setting out HSIB's investigatory functions to conduct high-level investigations of serious patient safety incidents in the NHS in England with a specific focus on

<sup>50</sup> Further background on this issue can be found in section 3 of a [House of Lords Library briefing on the NHS and social care workforce](#) (November 2016).

<sup>51</sup> PASC, [Investigating clinical incidents in the NHS](#) (HC 886 2014-15)

<sup>52</sup> [Report of the Healthcare Safety Investigation Branch Expert Advisory Group](#) (May 2016)

system-wide learning and improvement.<sup>53</sup> On 1 April 2016 the new body was established as an independent unit within NHS Improvement, and began its work in April 2017.

The 2017 Queen's Speech announced plans for a draft *Patient Safety Bill*, which would bring forward proposals to establish the HSIB in statute, providing it with powers to conduct investigations into patient safety risks in the NHS in England.<sup>54</sup> The [Draft Health Service Safety Investigation Bill](#) was introduced in September 2017. A [Joint Committee on the Draft Bill](#) was established in 2018 and accepted the main aim of the legislation, to establish HSIB as an independent arms-length body. However, there were a number of measures in the Draft Bill which the Joint Committee recommended should be removed or changed, and areas where provisions should be added, or extended. The [Health Service Safety Investigations \(HSSI\) Bill 2019-20](#) was introduced in the Lords in October 2019. Further information on the changes introduced in the HSSI Bill, including background on how these differ from the Draft Bill (and the recommendations of the Joint Committee), can be found in the [Lords Library briefing prepared for the Lords stages of the Bill](#).<sup>55</sup> The Health Minister, Baroness Blackwood, also addressed some of these issues in her opening speech during the Lords Second Reading on 29 October 2019, where she noted that the Government had accepted the majority of the Committee's recommendations.<sup>56</sup>

The [Government factsheet accompanying the HSSI Bill](#) (October 2019) states its main objectives are to:

- establish the Health Service Safety Investigations Body (HSSIB) as a new independent arm's-length body with powers to conduct investigations into patient safety incidents that occur during the provision of NHS-funded services;
- create a 'safe space' whereby participants can provide information to the HSSIB safe in the knowledge the information will not be shared with others, and only disclosed under certain limited circumstances as set out in legislation; and
- amend the *Coroners and Justice Act 2009* to allow for NHS bodies, rather than local authorities, to appoint medical examiners; and place a duty on the Secretary of State to ensure the system is properly maintained.

Further background can be found in the [Lords Library briefing on the Lords stages of the HSSI Bill](#) (October 2019).

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<sup>53</sup> The *Directions* also stipulated that HSIB must commence its activities by 1 April 2017 (Department of Health, [NHS Trust Development Authority \(Healthcare Safety Investigation Branch\) Directions 2016](#)).

<sup>54</sup> [Briefing notes accompanying the Queen's Speech, June 2017](#)

<sup>55</sup> In particular, see the section on the 'Draft Bill and Initial Scrutiny' (pages 8 to 11).

<sup>56</sup> [HL Deb Hansard, 29 October 2019, cc887-943](#); see also the Government's [Factsheets](#) and [Explanatory Notes](#) to the Bill (October 2019).

## 8. Competition and non-NHS providers

Part 3 of the *Health and Social Care Act 2012* sets the framework for choice and competition in the provision of NHS services. In particular, the 2012 Act allows the Department of Health and Social Care (DHSC) to set regulations giving Monitor (now part of NHS Improvement), as the sector regulator for health services, the power to investigate and remedy anti-competitive behaviour by Clinical Commissioning Groups (CCG) or NHS England. Regulations on competition and procurement have been introduced under section 75 of the 2012 Act (and sometimes known as section 75 regulations).

The 2010 Government said CCGs should decide when to use competitive tendering as a means of improving NHS services. However, there have been concerns that commissioners are unclear about when to put services out to competitive tender and that more NHS contracts are being awarded to private companies now than was previously the case.<sup>57</sup> In particular, it has been alleged that the *Health and Social Care Act 2012* has extended competition law to the NHS and led to greater private sector involvement.<sup>58</sup> The 2010 Government said their reforms did not extend pre-existing competition and procurement rules but rather created a framework within which competition can operate on the basis of quality, not price.<sup>59</sup> There have been a number of reports analysing the impact of NHS competition policies, and the extent of private sector involvement in the provision of NHS funded health services in England. See for example:

- The [Office of Health Economics report on competition in the NHS](#) (January 2012) (this provides a useful summary of NHS competition and patient choice policies from 2000, and references to further reading).
- The Nuffield Trust, [Into the red – The state of NHS finances](#) (2014) (this provides a breakdown of NHS spending by independent providers, NHS bodies, and voluntary and other providers, in the areas of community health services (page 14), mental health services (page 16) and hospital services (page 18).
- The Health Foundation, [Evolution, revolution or confusion?: competition and privatisation in the NHS](#) (March 2015)
- The British Medical Association, [Hidden figures: private care in the English NHS](#) (March 2017)
- The King’s Fund, [Is the NHS being privatised?](#) (dated October 2019 although first published in 2017).
- The Nuffield Trust, [Privatisation in the English NHS: fact or fiction?](#) (November 2019)

<sup>57</sup> “NHS contracts 'going to private firms'”, [Health Service Journal](#), 16 January 2014; [“Is the great NHS sell-off under way?”](#), *BMJ*, 29 April 2014

<sup>58</sup> [“Labour calls for freeze on NHS contracts with the private sector until after general election”](#), *BMJ*, 30 July 2014

<sup>59</sup> The key provisions of the 2012 Act are set out in a Department of Health factsheet on [choice and competition](#).



Information on the proportion of NHS resource expenditure allocated to non-NHS providers is shown in the [DHSC Annual Report and Accounts](#). In particular, table 37 of the [DHSC Annual Report and Accounts for 2018-19](#) (the most recent available) shows that in 2018/19 11% of resource expenditure was spent on purchase of healthcare from all non-NHS providers (including voluntary sector providers and local authorities). 7.3% of overall NHS resource expenditure in 2018/19 spent on private sector providers - a total of £9,180 million.<sup>60</sup>

### **Box 7: Background to competition law in the NHS and spending on non-NHS providers**

Competition law is a complex area but, in brief, organisations are subject to competition rules if they are “undertakings” for the purposes of those rules. Whether or not an NHS body is an undertaking will depend on its specific circumstances and in particular on whether it is engaged in economic activity, offering goods or services on a given market.

There had been some contracting out of NHS support services, such as cleaning and catering, during the 1980s but the first major reforms to introduce competition to the NHS came in 1991 with the first internal market reforms. These saw the introduction of NHS trusts and the “purchaser-provider split” (although the term commissioner is now preferred to purchaser). From 2002, a number of policies were introduced to strengthen the role of competition and patient choice within the NHS. NHS spending on non-NHS providers in England grew from around 3% in 2002/03 to 11% in 2018/19.<sup>61</sup>

The [NHS Long Term Plan](#), published in January 2019, proposed changes to the ‘system architecture’ of the NHS, to increase the coordination of services. This has been seen as a move away from some of the market-based reforms of the *Health and Social Care Act 2012*, and also a shift from the commissioner/provider split introduced in the early 1990s.

Following a process of engagement and consultation, NHS England and NHS Improvement published recommendations for an NHS Bill in September 2019. Their proposals aim to remove barriers to joint working between NHS organisations and their partners. They proposed replacing the existing NHS competition and procurement framework to ensure that commissioners can exercise more discretion about when to carry out a formal procurement process. Specifically NHS England and NHS Improvement have proposed the repeal of section 75 of the *Health and Social Care Act 2012* and the removal of the NHS from the Public Contract Regulations 2015.<sup>62</sup>

The Health and Social Care Committee’s report [NHS Long-term Plan: legislative proposals](#) (HC2000, 24 June 2019) supported the intent behind NHS England and NHS Improvement’s proposals to ensure that commissioners can exercise greater discretion over when to conduct a

<sup>60</sup> Please note, this represents the proportion of expenditure allocated to non-NHS providers, not the proportion of contracts currently held by the private sector, or the number of contracts secured following a competitive tender (not all NHS services are put out to competitive tender and those that are will vary widely in size). PQ responses note that information on the proportion of NHS contracts secured by private sector providers is not collected centrally (see for example, [PQ 135922, 24 April 2018](#)).

<sup>61</sup> Information on the proportion of NHS resource expenditure allocated to non-NHS providers is shown in the [DHSC Annual Report and Accounts](#).

<sup>62</sup> NHS England/NHS Improvement, [The NHS’s recommendations to Government and Parliament for an NHS Bill](#), September 2019

procurement process. However, the Committee also noted that the way the NHS in England operates may mean the proposals to change how procurement rules apply could face legal difficulties. The Committee's report also noted the varied views about the extent and impact of competitive tendering within the English NHS.<sup>63</sup>

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<sup>63</sup> Health and Social Care Committee, [NHS Long-term Plan: legislative proposals](#) (HC2000 2017-19, June 2019) paras 42 to 48

## 9. Technology and data

The use of data offers the potential to improve the health and care system and develop new treatments. Chapter 5 of the [NHS Long Term Plan](#) (January 2019) set out how upgrades to technology will be used to enable digital access to NHS services, and improve clinical care and population health.

The Government is implementing data security standards for local health and care organisations, and introduced a national data opt-out for the use of confidential patient data beyond an individual's direct care in May 2018.

The *Health and Social Care (National Data Guardian) Act 2018* put the role and office of the National Data Guardian (NDG) on a statutory footing from 1 April 2019. The Act gives the NDG the power to publish formal guidance, and give advice, assistance and information, about the processing of health and adult social care data in England. The Act also imposes a duty on health and adult social care organisations to have regard to the NDG's formal guidance.

In October 2018, the Department of Health and Social Care (DHSC) published the Secretary of State's [Technology Vision The future of healthcare: our vision for digital, data and technology in health and care](#). In July 2019 NHSX became operational as a joint unit between NHS England, NHS Improvement and the Department of Health and Social Care to:

- speed up the transformation of the NHS and social care, driven by technology, in line with the NHS Long Term Plan and the Secretary of State's Tech Vision;
- support people to stay well and drive their own care by giving them easy access to great digital services and their data;
- enable NHS staff to focus on the patient, by reducing other demands on their time through the use of technology;
- make the NHS the best place for health and care technology entrepreneurs by creating an environment where innovation flourishes.

In August 2019 the DHSC also announced a new artificial intelligence laboratory to research the application of Artificial Intelligence (AI) in healthcare.

Actions taken to improve the cyber security of the health and social care system, particularly since the WannaCry cyber attack, are described in [Securing cyber resilience in health and care: A progress update](#), published by the Department in February 2018.

[NHS Digital](#) is a non-departmental public body, and provides information, data and IT systems for the health and care system in England.

## 10. Integration of health and social care services

Health and adult social care services in England have traditionally been funded, administered and accessed separately. Health has been provided free at the point of use through the NHS, whilst local authorities have provided means-tested social care to their local populations.

As a result of demographic trends, including an ageing population, an increasing number of people require support from both health and social care services. It is argued that these patients can be badly served by the traditional health and social care model, and that by integrating the two services, the patient can be put at the centre of how care is organised.

As well as improving the experience for the patient, it is argued that integration can save money by cutting down on emergency hospital admissions and delayed discharges. This is particularly significant in light of current funding pressures for the NHS and local authorities, although the scope of potential savings has been disputed.

Successive Governments have sought to better integrate health and social care by focusing on care outside of hospital, instead delivering care as close to the patient as possible, either at home or in their community.

Recent Government policies to promote integration have included the creation of Health and Wellbeing Boards, local strategic planning forums with representatives from health and social care services, and the Better Care Fund, a pooled budget between the NHS and local authorities, to which the Government committed £7.8 billion in 2018/19. In 2019, the Government and NHS England announced a review of the Better Care Fund, which will look at concerns including the complexity of its funding mechanism and actual returns on investment.

[The NHS Long Term Plan](#) (January 2019) emphasises new models of integrated health and social care delivered via Integrated Care Systems (ICSs), which are developing from the current Sustainability and Transformation Plans (STPs) (see section 1.2 of this briefing).

A [House of Commons Library briefing paper on health and social care integration](#) (updated December 2019) analyses recent policy and debate on the integration of health and social care in England. The four UK nations have taken different policy paths with regards to integration. Scotland and Wales have both passed recent legislation promoting integration, including moves towards fully integrated health and social care commissioning in Scotland, whilst Northern Ireland has had an integrated health and social care system since the 1970s. The policy landscape in Scotland, Wales and Northern Ireland is explored in section 11 of this briefing.

# 11. Health services in Scotland, Wales and Northern Ireland

Health services are largely devolved and this House of Commons Library briefing is concerned with reformed structures in the NHS in England. However, the following section provides a very brief overview of health service structures in the rest of the UK, with links to further information. The further information section at the end of this note also provides some information on differences between the health systems in the different parts of the UK.

## 11.1 Scotland

NHS Scotland consists of:

- Fourteen regional NHS Boards that are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services.
- Seven Special NHS Boards that support the regional NHS Boards by providing a range of specialist and national services.
- [Healthcare Improvement Scotland](#), which supports the delivery of high quality, evidence-based care.

The Seven Special NHS Boards are:

- [NHS Education for Scotland](#)
- [NHS Health Scotland](#)
- [NHS National Waiting Times Centre](#)
- [NHS24](#)
- [Scottish Ambulance Service](#)
- [The State Hospitals Board for Scotland](#)
- [NHS National Services Scotland](#)

Each NHS Board is accountable to Scottish Ministers, supported by the Scottish Government Health and Social Care Directorates.<sup>64</sup>

### Box 8: The integration of health and social care in Scotland

The *Public Bodies (Joint Working) (Scotland) Act 2014* is an Act of the Scottish Parliament that puts in place a requirement on NHS Boards and Local Authorities to integrate health and social care. Since 2016, work has been underway across Scotland to integrate health and social care services in line with the requirements of the Act

In particular, the Act allows Health Boards and Local Authorities to integrate health and social care services in two ways (it is up to Health Boards and Local Authorities to agree which of these models is best for local needs):

- Model 1: The Health Board and Local Authority delegate the responsibility for planning and resourcing service provision for adult health and social care services to an Integration Joint Board.
- Model 2: The Health Board or the Local Authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services

The Scottish Government website provides [further information and guidance](#) on the integration of health and social care and the measures in the Act.

<sup>64</sup> See [www.show.scot.nhs.uk](http://www.show.scot.nhs.uk) for further information.

## 11.2 Wales

In Wales, seven Local Health Boards are responsible for planning and delivering healthcare services, and aim to integrate specialist, secondary, community and primary care and health improvements. There are three all-Wales NHS Trusts: the Welsh Ambulance Service, Velindre NHS Trust (provides specialist services in cancer and other national support) and Public Health Wales.<sup>65</sup>

As well as being accountable to Welsh Ministers, the NHS in Wales is also accountable to Community Health Councils, which provide a link between patients and the organisations that plan and deliver services.

## 11.3 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, which are committees of the Health and Social Care Board.

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 region-wide trust

A separate Public Health Agency has responsibility for improving health and wellbeing and health protection.<sup>66</sup>

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<sup>65</sup> See [www.wales.nhs.uk](http://www.wales.nhs.uk) for further information.

<sup>66</sup> See <http://www.dhsspsni.gov.uk/> for further information. The further information section at the end of this briefing paper provides further information on differences between the health systems in the different parts of the UK.

## 12. Further information

### Health service reform in England before 2015

The Department of Health published a series of [factsheets](#) on the *Health and Social Care Act 2012* explaining particular topics contained in the Act, including clinical commissioning.

The Library briefing [The reformed health service, and commissioning arrangements in England](#) provides an overview of the key funding, commissioning and accountability structures under the old and new systems, and focuses on new health service commissioning arrangements and the formal powers and duties of NHS England and CCGs under the 2012 Act.<sup>67</sup>

In July 2012 the King's Fund and the Institute for Government published [Never Again? The story of the Health and Social Care Act 2012](#). Written by former Financial Times public policy editor Nicholas Timmins, it explains why and how the Act became law; from the legislation's origins 20 years ago, through the development of the 2010 White Paper *Liberating the NHS* to the passage of the Bill through Parliament.

The King's Fund report, [The NHS under the coalition government \(part one: NHS reform\)](#) (February 2015), provides a more detailed account of the 2010 Government's health reforms, with sections on commissioning, regulation, competition and choice, governance and accountability and integration of care.

For an assessment of the 1997-2010 Labour and the 2010-2015 Coalition Government's records on health please refer to two recent reports by academics at the LSE:

- [Labour's Record on Health 1997-2010](#) (2013)
- [The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015](#) (2015)<sup>68</sup>

The National Audit Office (NAO) has produced reports on, [Managing the transition to the reformed health system](#) (July 2013) and on [Progress in making NHS efficiency savings](#) (December 2012).

Both the [Nuffield Trust](#) and the [Health Foundation](#) have published timelines of NHS reform.

### Reports on health services across the UK

A useful overview of the health systems in the different parts of the UK can be found in three reports: from the National Assembly of Wales in 2015, from the Nuffield Trust/Health Foundation in 2014 and the National Audit Office (NAO) in 2012.

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<sup>67</sup> Further information about the way in which health commissioning operated prior to the changes enacted by the *Health and Social Care Act 2012* can be found in this Library Standard Note [SN05607](#) on *NHS Commissioning*.

<sup>68</sup> Vizard and Obolenskaya, [Labour's Record on Health 1997-2010](#), LSE (2013); and [The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015](#), LSE (2015).

The National Assembly of Wales Research Service published [The organisation of the NHS in the UK: comparing structures in the four countries](#) in May 2015. This paper compares the organisation of health care systems in different parts of the UK and outlines the main areas of differences.

In April 2014 the health think-tanks the Nuffield Trust and the Health Foundation published: [The four health systems of the UK: How do they compare?](#) Although the report did not specifically address health inequalities, it considered the performance of the four countries across a number of key indicators. The research found that the performance gap between the NHS in England and the rest of the UK has narrowed in recent years, with no single country consistently ahead of the others. This is despite considerable policy differences between each country.

In June 2012 the NAO published [Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland](#). Part 1 of this report provides a summary of health outcomes and spending, while part 2 covers the performance of health services themselves. Appendix 2 gives an overview of the organisation of health services in each country. The NAO noted the increasing divergence in health services across the UK, in particularly the removal of the NHS internal market in Wales and Scotland and the increasing role of competition in England:

In the last decade there has been notable divergence in policy and performance management between the nations, particularly in the use of competition between healthcare providers. Since devolution, the commissioners and providers of health services have been reintegrated in Scotland and Wales, thus removing the internal market. In contrast, the internal market remains in Northern Ireland and the role of competition has increased in England.<sup>69</sup>

## Contacting NHS England and Clinical Commissioning Groups

Website addresses and contact details for individual CCGs, including names of clinical leads and accountable officers, are available on the [NHS England website](#), including a [map of CCGs](#).

Correspondence can be sent to the NHS England contact centre for the attention of the relevant regional office (who will respond directly):

**Telephone:** 0300 311 22 33

**Email:** [england.contactus@nhs.net](mailto:england.contactus@nhs.net)

**General Post (including complaints):** NHS England, PO Box 16738, Redditch, B97 9PT

Customers who are deaf, hard of hearing or speech impaired can contact NHS England using the Next Generation Text (NGT) service. You can find more information on the [NGTS website](#).

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<sup>69</sup> NAO, [Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland](#), June 2012, p8 para 12



To call us using the Next Generation Text service, dial 18001 followed by 0300 311 22 33.

**You** can find regional contact details on the [NHS England regional team pages](#).

## Raising concerns

The [NHS website](#) provides information on how to complain about the NHS. Further information on raising concerns can be found in the Commons Library briefing paper [NHS complaints procedures in England](#).

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