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BRIEFING PAPER

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The structure of the NHS in England

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Inside:

1. Background
2. Commissioning
3. Access to treatment
4. Regulation and accountability
5. Education and training
6. Competition and non-NHS providers
7. Public health services
8. Health and Wellbeing boards and Healthwatch
9. Safety of care
10. Integration of health and social care services
11. Mental health policy
12. Health services in Scotland, Wales and Northern Ireland
13. Further information

Contents

Summary **3**

1. Background **6**
1.1 Structural changes 6
1.2 Funding and performance 6
1.3 The Five Year Forward View 8

2. Commissioning **11**
2.1 Clinical Commissioning Groups 11
2.2 NHS England 12
2.3 Duties of CCGs and NHS England 13

3. Access to treatment **15**
3.1 NICE 15
NICE technology appraisals 15
Highly Specialised Technologies programme 15
3.2 Individual Funding requests 16
3.3 The Cancer Drugs Fund 17

4. Regulation and accountability **19**
4.1 NHS Improvement 19
4.1 The Care Quality Commission 19
4.2 The Secretary of State for Health 21
4.3 The Health Select Committee 21

5. Education and training **22**

6. Competition and non-NHS providers **23**

7. Public health services **24**
7.1 Public health and local government 24
7.2 Public Health England and directly commissioned services 25

8. Health and Wellbeing boards and Healthwatch **27**
8.1 Health and Wellbeing Boards 27
8.2 Healthwatch England and local Healthwatch 27

9. Safety of care **29**
Learning from clinical incidents in the NHS 29

10. Integration of health and social care services **32**

11. Mental health policy **33**

12. Health services in Scotland, Wales and Northern Ireland **34**
Scotland 34
Wales 34
Northern Ireland 35

13. Further information **36**

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Summary

This 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 Clinical Commissioning Groups (CCGs), which commission NHS services;
- NHS Improvement, which since April 2016 has brought together Monitor and the NHS Trust Development Authority;
- The Care Quality Commission (CQC), which regulates the safety of services; and
- Health Education England (HEE), which leads workforce planning, education and training.

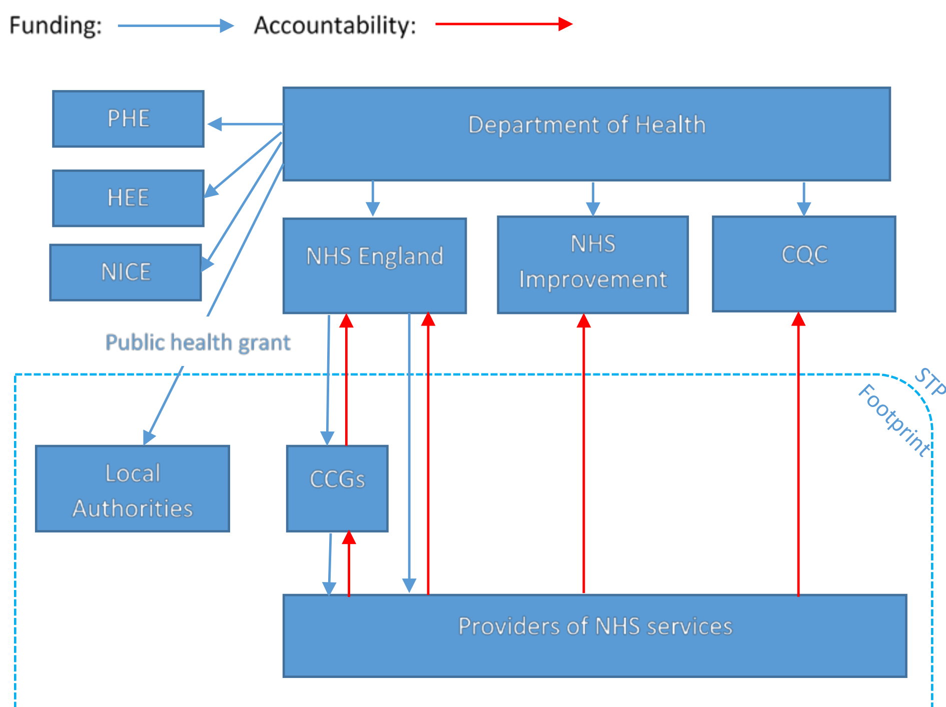
It also covers:

- Public Health England (PHE) and local authorities' public health duties;
- Health and Wellbeing Boards and the co-ordination of health and social care services; and
- The National Institute for Health and Care Excellence (NICE) and access to treatment

This briefing highlights some of the key health policy issues for the current Parliament, including patient safety, funding, and the redesign of services. In 2015, NHS organisations were asked to come together to create local blueprints for delivering the NHS Five Year Forward View (5YFV), known as Sustainability and Transformation Plans (STPs). Forty-four sustainability and transformation partnerships have now formed covering the whole country.

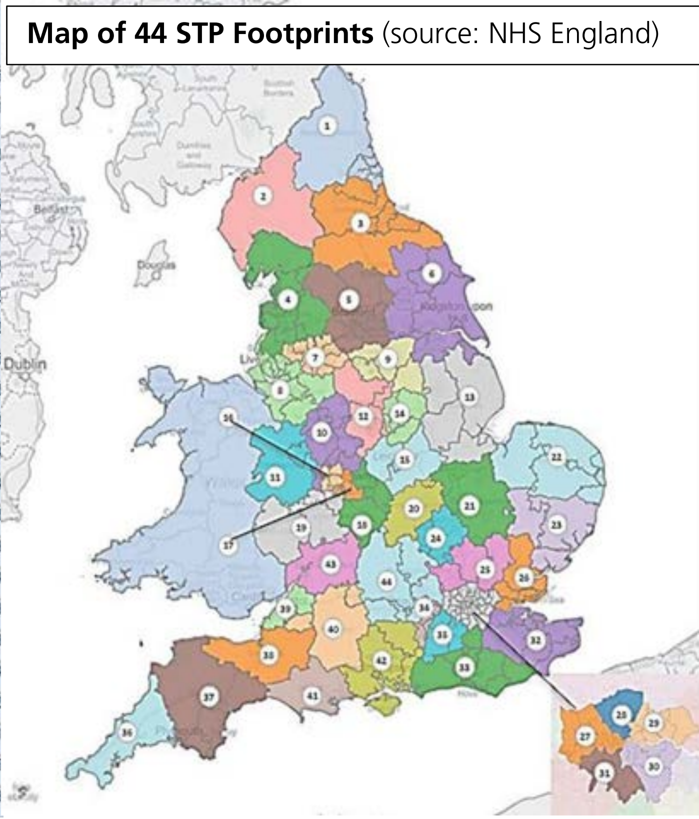
Major reforms to the structure of the health service in England were introduced by the *Health and Social Care Act 2012*, with many provisions under the Act coming into force on 1 April 2013. A simplified diagram showing the post-reform structure of the NHS in England can be found below:

The structure of the NHS in England (as at June 2017)



STP no	Footprint name	Footprint population (million)	Number of CCGs
1	Northumberland, Tyne and Wear	1.4	5
2	West, North and East Cumbria	0.3	1
3	Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	1.3	6
4	Lancashire and South Cumbria	1.6	9
5	West Yorkshire	2.5	11
6	Coast, Humber and Vale	1.4	6
7	Greater Manchester	2.8	12
8	Cheshire and Merseyside	2.4	12
9	South Yorkshire and Bassetlaw	1.5	5
10	Staffordshire	1.1	6
11	Shropshire and Telford and Wrekin	0.5	2
12	Derbyshire	1.0	4
13	Lincolnshire	0.7	4
14	Nottinghamshire	1.0	6
15	Leicester, Leicestershire and Rutland	1.0	3
16	The Black Country	1.3	4
17	Birmingham and Solihull	1.1	3
18	Coventry and Warwickshire	0.9	3
19	Herefordshire and Worcestershire	0.8	4
20	Northamptonshire	0.7	2
21	Cambridgeshire and Peterborough	0.9	1
22	Norfolk and Waveney	1.0	5
23	Suffolk and North East Essex	0.9	3
24	Milton Keynes, Bedfordshire and Luton	0.9	3
25	Hertfordshire and West Essex	1.4	3
26	Mid and South Essex	1.2	5
27	North West London	2.0	8
28	North Central London	1.4	5
29	North East London	1.9	7
30	South East London	1.7	6
31	South West London	1.5	6
32	Kent and Medway	1.8	8
33	Sussex and East Surrey	1.8	8
34	Frimley Health	0.7	5
35	Surrey Heartlands	0.8	3
36	Cornwall and the Isles of Scilly	0.5	1
37	Devon	1.2	2
38	Somerset	0.5	1
39	Bristol, North Somerset and South Gloucestershire	0.9	3
40	Bath, Swindon and Wiltshire	0.9	3
41	Dorset	0.8	1
42	Hampshire and the Isle of Wight	1.8	7
43	Gloucestershire	0.6	1
44	Buckinghamshire, Oxfordshire and Berkshire West	1.7	7
	Total	54.3	210*

Map of 44 STP Footprints (source: NHS England)



Several organisations have produced their own guides and diagrams explaining the structure of the NHS in England, post-2013, including the Department of Health, NHS England, the King's Fund, the National Audit Office, the BBC, and the All Party Health Group.

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 12.

1. Background

1.1 Structural changes

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.

Part 3 of 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.[1]

More recent, non-statutory, changes have included:

- The formation of 44 Sustainability and Transformation Plans across England, with local health and care organisations coming together to create regional plans for accelerating the implementation of the NHS Five Year Forward View from 2016 to 2021.
- Bringing together Monitor and the Trust Development Authority to form NHS Improvement, from April 2016.
- The devolution of the £6 billion health and social care budget in Greater Manchester from April 2016.

1.2 Funding and performance

Funding for health services comes from the total budget for the Department of Health (DH). In 2015/16 the total allocated budget for the DH was £115 billion for England.[2] The majority of this budget (£102 billion) was transferred to NHS England with the remainder divided between DH's other agencies and programmes, including funding for

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1 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).

2 HM Treasury, *Public Expenditure Statistical Analyses 2014, Table 1.10*

Public Health England, and 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 DH. 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 (£73 billion in 2015/16). Of the remaining resources (£29 billion in 2015/16) NHS England directly commissions certain services on a national level, covering specialised services (£15 billion), primary care and 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.[3]

Budget allocations for health in the constituent countries of the UK

The table below shows the 2015/16 budget allocations for health in the constituent countries of the UK. In terms of budget per head of population, allocations in Northern Ireland are highest but it should be noted that its budget includes social care provision. England has the lowest budget allocation per head for health.

2015/16 Health Budgets

	£ billions	Population (millions)	Budget per head £
England	115.1	53.9	2,137
Northern Ireland*	4.7	1.8	2,569
Scotland	12.2	5.3	2,290
Wales	6.6	3.1	2,141

* budget includes social care funding

Sources:

HM Treasury: Public expenditure statistical analyses 2014, Table 1.10

Scottish Government: Scotland's draft budget 2015/16

Welsh Government: Welsh Budget 2015/16

Northern Ireland Executive: Draft Budget 2015/16

ONS Mid-2013 population estimates

Financial challenges

Since 2010 real terms health spending has increased by an average of 1.4% a year, lower than the average annual growth rate of 4% over the past 60 years. The NHS is facing significant financial 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. Although health spending has been protected relative to other public services, there are concerns that increasing demand and costs threaten the financial stability and sustainability of the NHS.

3 *NHS England Annual Report 2015/16*

In 2013 NHS England projected a "funding gap" (a potential mismatch between resources and patient needs) of £30 billion by 2020/21.[4] It suggested that this could be met with £8 billion of additional funding and £22 billion of efficiencies by 2020/21 – implying productivity improvements averaging 2.4% per year.

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 Commons Library briefing on the financial sustainability of the NHS. The National Audit Office and the House of Lords' Inquiry on the Long-Term Sustainability of the NHS has also reported on this issue.[5]

While the CQC's *State of Care* report for 2015/16 found that most health and services in England are providing good quality care, waiting time performance has worsened across a large majority of hospital trusts. NHS Improvement has stated that "sustained operational and financial challenges continued to affect adversely the performance of the NHS provider sector".[6] Data on NHS demand and performance indicators for England can be found in the Commons Library's quarterly NHS Indicators: England publication.

1.3 The Five Year Forward View

The NHS *Five Year Forward View* (FYFV), published on 23 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. Early results from parts of the country that have started doing this – so called 'vanguard' areas – have seen slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country, particularly for over-75s.

Sustainability and Transformation Plans (STPs) are intended to accelerate the implementation of the NHS FYFV. The 44 STPs across England are expected to show how local services will improve quality of care, promote population health, and become more financially sustainable. There is likely to be a good deal of variation in the speed and scale change across different STP areas, with Greater Manchester (Devo Manc) providing the most advanced test-bed for devolution and integration. The Chief Executive of NHS England, Simon Stevens has commented that several STP areas may, over time, become "accountable care systems", fully integrating their services and funding for the population in their area. Further information on the integration

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4 Technical annex to NHS England's *A Call to Action* (2013)

5 NAO, Financial sustainability of the NHS, November 2016; and House of Lords Select Committee on Long-Term Sustainability of the NHS Committee, *The Long-term Sustainability of the NHS and Adult Social Care*, 31 March 2017

6 NHS Improvement Board Paper for meeting on 26 May 2016: Performance of the NHS provider sector: year ended 31 March 2016

of health and social care services can be found in Section 10 of this briefing.

Box 1: Sustainability and Transformation Plans (STPs)

Sustainability and Transformation Plans (STPs) have been published for 44 footprint areas across England. The proposals in them are wide ranging, covering hospital, community, mental health and primary care services as well as 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). In many cases, different areas are proposing similar changes but, there is also significant variation between them and examples of innovative ideas. Many of the plans set out the changes they want to see but, lack detail on how these changes will be achieved and the evidence underpinning them. As such, subsequent guidance from national bodies has emphasised that the next phase of the process is to convert these proposals into concrete plans, in collaboration with local people.

Responding to coverage in the media, and concerns about possible cuts to services, and a perceived lack of transparency, NHS England has said that plans being published at the moment are "a starting-point for local conversations." On 15 September 2016, NHS England published advice for local health and care leaders on how to put the communities they serve at the heart of their work.

STPs have attracted significant attention from Parliament and political parties. The House of Lords Committee on the Long-term Sustainability of the NHS and the Public Accounts Committee both recently commented on the STP process.

Each STP has a lead individual, who come from a mixture of NHS commissioners, providers and local authorities. A list of STP areas and leads is available on NHS England's website.

Next Steps on the NHS Five Year Forward View, published 31 March 2017, concentrates on what will be achieved over the next two years, and how the Forward View's goals will be implemented. Within the constraints of the requirement to deliver financial balance across the NHS, the *Next Steps* report outlines a number of national service improvement priorities for 2017/18; these are:

- 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 sets out plans to:

- tackle areas of waste or low value care;
- accelerate service redesign and integration through Sustainability and Transformation Partnerships and Accountable 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.

Box 2: proposals to increase efficiency

Next Steps on the NHS Five Year Forward View, published 31 March 2017, sets out plans for the use of innovation and technology within health services in order to deliver better care, support people in managing their own health, and meet rising demands. A number of recent reviews have also looked at potential ways to improve NHS efficiency:

- 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.

2. Commissioning

The Department of Health has defined commissioning as:

> The process of ensuring that the health and care services provided effectively meet the needs of the population.[7]

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. Such objectives are partly achieved through allocating resources 'fairly' among the population. How the resources are divided among the population is determined by a resource allocation funding formula.

The Library briefing *NHS commissioning before 2013* contains background on the development of commissioning of NHS services.

2.1 Clinical Commissioning Groups

On 1 April 2013, 212 Clinical Commissioning Groups (CCGs) took on statutory responsibilities for commissioning the majority of NHS services, including[8]:

- 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).[9]

The NHS's *Five Year Forward View* (October 2014) states that it intends progressively to offer CCGs more influence over the total NHS budget for their local populations, including greater responsibility for commissioning 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.[10] 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 join the CCG for their area. The Act also requires that CCGs have a published constitution and

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7 DH, commissioning, webpage archived on 6 May 2010

8 The number of CCGs has subsequently reduced to 207 through a number of mergers (as at June 2017)

9 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 has also produced a factsheet explaining the services that are commissioned by CCGs.

10 However, CCGs can buy in support from external organisations including the NHS commissioning support services and private and voluntary sector bodies, although responsibility for commissioning decisions remains with the CCG. The detailed strategy is set out in Developing Commissioning Support: Towards Service Excellence, February 2012.

that CCG Boards must have at least six members (including a chair), with Boards including at least one of each of the following:

- 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.[11]

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).[12]

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

In May 2014 the Chief Executive of NHS England, Simon Stevens, invited CCGs 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*.

As of 1 April 2017, 197 (out of 207) CCGs have some form of co-commissioning agreement with NHS England. 174 CCGs have delegated commissioning arrangements and 23 CCGs have joint commissioning arrangements – view the list of CCGs here.[13]

2.2 NHS England

NHS England is responsible for:

- ensuring that there is an effective and comprehensive system of CCGs;
- providing commissioning support and guidance;
- commissioning some services centrally including primary care and specialist services; and
- administering the Cancer Drugs Fund.

[11] NHS England produces quarterly reviews on how CCGs are meeting authorisation conditions.

[12] 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.

[13] https://www.england.nhs.uk/commissioning/pc-co-comms/pc-comms/

While CCGs now commission the majority of NHS services, including most hospital services, NHS England commissions directly certain services at a national or regional level such as primary care services (including GP services, where this has not been delegated) and specialist services (see box 5). It also directly commissions services for the armed forces and for offenders (including prison health services).

Box 5: Specialised services

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but 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.

In September 2014 NHS England published *Commissioning Intentions for prescribed specialised services for 2015/16*, which included proposals for future devolution of some commissioning responsibilities for specialised services from NHS England to CCGs including, from April 2015, responsibility for commissioning renal dialysis and surgery for morbid obesity.

Any transfer of responsibilities would require an amendment to secondary legislation listing the prescribed specialised services to be commissioned by NHS England.

NHS England is the body responsible for ensuring that there is an effective and comprehensive system of CCGs. It also provides national leadership on commissioning and allocates funding.[14] 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.

2.3 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;

[14] NHS England allocates funding to NHS Trusts and NHS Foundation Trusts and providers of primary care and other services as well as CCGs.

- reducing inequalities;
- enabling choice and promoting patient involvement;
- securing integration; and
- promoting innovation and research.[15]

[15] A number of these duties are the result of amendments to the legislation made in response to recommendations of the NHS Future Forum made in June 2011.

3. Access to treatment

3.1 NICE

The National Institute for Health and Care Excellence (NICE) provides evidence-based information for the NHS in England and Wales on the effectiveness and cost-effectiveness of healthcare interventions. It publishes mandatory technology appraisal guidance (stipulating clinical interventions – mainly medicines – which must be funded by NHS commissioners in England (primarily CCGs and NHS England). NHS England and CCGs are legally required to make funding available for drugs and treatments recommended by NICE as part of a technology appraisal within three months of its final guidance being published. NICE also produces advisory clinical guidelines and public health guidance, which commissioners are not required to implement.

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 where funding should be provided (see Section 3.2).

NICE has also published around 150 Quality Standards, covering the main conditions and diseases, to provide a definition of what high-quality health and social care should look like. These standards play a key role in the development of the Commissioning Outcomes Framework, which measures the health outcomes and quality of care achieved by CCGs. The *Health and Social Act 2012* requires NHS England and CCGs to have due regard to these quality standards as they fulfil their duties.

NICE 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.

It is important to note that NICE does not negotiate drug prices and only around 40% of drugs new to the UK market are evaluated by the NICE technology appraisal process each year. NICE does not decide on the topics for guidance and appraisals. Instead, topics are referred to NICE by the Department of Health, 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.

Highly Specialised Technologies programme

NICE also 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.[16]

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 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 takes into account 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.

NICE review of process for evaluating drugs

NICE announced on 15 March 2017 that it was introducing a new approach to evaluating drugs, and that this would apply to those treatments that are reviewed from 1 April 2017 onwards.

The introduction of the changes followed a joint NHS England and NICE public consultation. The consultation sought view on a number of proposed changes, these included a speeded up process of evaluating drugs, and the introduction of a 'budget impact threshold' of £20 million. This threshold would mean that where any drugs that receive a positive NICE decision, but would exceed this cost in any of the first three years of use, NICE would indicate the need for a commercial agreement between the company and NHS England. NHS England could also apply for an extended period to introduce the treatment- this could mean that rather than the current three month deadline for NHS England to follow the technology appraisal guidance, this could be extended to three years. The consultation document highlighted that only a small number of new treatments would exceed this threshold- and stated that between June 2015 and June 2016, around 80% of all recommended treatments fell below the threshold.[17]

3.2 Individual Funding requests

Although commissioners of NHS services can have a policy not to fund certain treatments, they cannot impose a "blanket ban" and they must consider exceptional individual cases where funding should be provided. They have to have procedures in place for deciding what are known as Individual Funding Requests (IFRs). The handbook to the NHS Constitution states:

> If a CCG, a local authority or NHS England has decided that a treatment will not normally be funded, it needs to be able to consider whether to fund that treatment for an individual patient on an exceptional basis.[18]

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16 NICE Highly-Specialised Technologies Guidance
17 The changes introduced in April 2017 were outlined in a NICE press release:
18 The handbook to the NHS Constitution for England, July 2015, page 49

Doctors, on behalf of patients, can make an IFR for treatment to NHS England for treatments that are not routinely be funded. Patients cannot apply directly to the NHS. Decisions will be considered by an IFR panel in NHS England. Patients can appeal against the decision of an IFR panel but if a review panel upholds an IFR panel's decision, the patient and his/her clinician will usually be advised that no further considerations can be made through the IFR process.

NHS England has published information on Individual funding requests - A guide for patients and service users.

Box 6: Patient rights, waiting times, choice and the NHS Constitution

The *NHS Constitution* sets out a number of patients' rights, including a right to a maximum 18-week waiting time from referral to consultant-led treatment. The NHS has recently introduced the first maximum waiting times for mental health treatment (see Section 10). There are plans to roll out access and waiting time standards to all mental health services by 2020.

Patients have a right to choose their provider and their consultant-led team care when they are referred for their first outpatient appointment with a service led by a consultant. To further strengthen patient choice, a legal right to have a personal health budget was introduced for adults receiving NHS Continuing Healthcare and children and young people receiving Continuing Care in October 2014. The *NHS Mandate* also provided for CCG's to further roll out personal health budgets to individuals who could benefit from April 2015.

The Commons Library briefing paper *Overview of NHS maximum waiting time standards and patient choice policies* provides further information.

3.3 The Cancer Drugs Fund

The UK Government established the CDF in 2010 to help improve access to cancer drugs in England and its budget has been increased a number of times to meet demand; the CDF budget in 2016-17 was £340 million. 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 aim of the Cancer Drugs Fund (CDF) is to cover treatment costs for patients for drugs that have not yet been assessed by NICE.

The new arrangements for the CDF, introduced on 29 July 2016, are aimed to ensure that promising and innovative medicines get to patients as quickly as possible. Under the new model, the CDF becomes a transitional fund that will pay 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.[19]

The drugs that remain on the list from the previous CDF (drugs that had previous negative NICE recommendations in final guidance) have been

[19] Further information on the current CDF and NICE operating model for cancer drugs can be found here:
https://www.england.nhs.uk/ourwork/cancer/cdf/
https://www.england.nhs.uk/2016/07/open-for-business/
https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/cancer-drugs-fund
The most recent version of the national CDF list is available here: https://www.england.nhs.uk/ourwork/cancer/cdf/list/

planned into the NICE work programme for a rapid reconsideration, to be concluded by end of 2017.

NHS England note that the 2016 changes to the CDF are in line with the recommendation of the 2015 independent Cancer Taskforce report, which proposed that the new CDF should operate with NHS England and NICE.[20]

Following the changes to the CDF in July 2016 all Individual Funding Requests relating to cancer drugs will now be 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.

The Accelerated Access Review

The Coalition Government announced an external review of the development, assessment and adoption of innovative medicines and medical technologies in November 2014.[21] The Accelerated Access Review (AAR) made recommendations to Government in October 2016, on speeding up access for NHS patients to cost-effective, innovative medicines, diagnostics and medical technologies. The review focused on new types of products such as medicines based on a stratified approach, new diagnostics, and digital health technologies.[22] A PQ response from 20 March 2017 noted that Ministers are considering the AAR's recommendations and will provide a formal response shortly [PQ 67897].

[20] Independent Cancer Taskforce, *Achieving world-class cancer outcomes – a strategy for England 2015–2020* (July 2015)
[21] House of Commons Written Statement, Innovative medicines and med-tech review, 20 November 2014
[22] Gov.uk website on Accelerated Access Review

4. Regulation and accountability

4.1 NHS Improvement

In June 2015 the Government announced that Monitor (previously the independent regulator of Foundation Trusts) and the NHS Trust Development Authority would come together under a single chief executive, and operate under the name 'NHS Improvement'.[23] This change means that all NHS providers, whether they are foundation trusts, NHS trusts or independent providers of NHS-funded care, are now overseen by a single body. 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.[24]

Box 7: Foundation Trusts

NHS foundation trusts are self-governing bodies that have greater financial and operational freedom from government than NHS trusts. They are directly accountable to Parliament and Monitor (which is now part of NHS Improvement). FTs also have a board of governors and members. FT's greater financial freedoms include the ability to borrow commercially and generate surpluses to reinvest in services.

4.1 The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator for quality in health and social care in England (including private providers).[25] It registers and inspects hospitals, care homes, GP surgeries, dental practices and other healthcare services. It publishes ratings of each trust and its core services. If services are not meeting fundamental standards of quality and safety, CQC has powers to issue

23 Jim Mackey became Chief Executive of NHS Improvement on 1 November 2015.
24 NHS Improvement also brings together Patient Safety, the National Reporting and Learning System, the Advancing Change team and Intensive Support Teams.
25 The CQC replaced three existing regulators (the Mental Health Act Commission, the Commission for Social Care Inspection, and the Healthcare Commission) and took up its statutory powers in April 2009.

warnings, restrict services, issue a fixed penalty notice, suspend or cancel registration, or prosecute the provider.

The CQC also has a role in protecting the rights of vulnerable people, including those whose rights are restricted under the *Mental Health Act*.

The CQC's methodology does not prescribe a set frequency for inspections. In line with its principles of intelligent monitoring, the CQC carries out visits in line with its judgment of risk. The CQC also rates services it inspects. These ratings are intended to help people to compare services and rate care as outstanding, good, requires improvement or inadequate.

Where services are found not to meet certain fundamental standards, action that the CQC can take includes:

- Using *requirement notices* or *warning notices* to set out what improvements the care provider must make and by when.
- Making changes to a care provider's registration to limit what they may do, for example by imposing conditions for a given time.
- Placing a provider in *special measures*, where we closely supervise the quality of care while working with other organisations to help them improve within set timescales.
- Hold the care provider to account for their failings by:
  - issuing simple cautions
  - issuing fines
  - prosecuting cases where people are harmed or placed in danger of harm.[26]

Box 8: How the regulators work together to address serious failures in care

The *Health and Social Care Act 2008* as amended by the *Health and Social Care Act 2012*, places a specific duty on the CQC and Monitor (now part of NHS Improvement) to co-operate in the exercise of their respective functions. In addition, the *Care Act 2014* sets out specific areas where co-ordination of their respective functions is necessary. The Mid Staffordshire NHS Foundation Trust Public Inquiry and a number of subsequent reports have also emphasised the importance of co-ordinated regulation across the health sector. A memorandum of understanding set out how NHS Improvement and the CQC will work together and share information effectively to ensure patients' interests are protected.

The CQC and NHS Improvement also work together to take regulatory action where NHS trusts and foundation trusts have serious failures in quality of care. A number of hospital trusts have since been placed into special measures, following advice from the CQC.

The special measures regime was introduced for when there are serious and systemic failings at a trust in relation to quality of care, and where it has been identified that the trust is unable to resolve the problems without intensive support. There are a number of different types of intervention that can take place, and different statutory basis for taking regulatory action apply to NHS trust and foundation trusts, but the main features of the special measures regime are that:

- NHS Improvement appoint an improvement director to help a trust to turn around its performance and improve patient care;
- failing trusts are partnered with high-performing trusts to provide expert advice and support; and
- each trust is required to develop a detailed action plan, which it must update regularly.

In addition, NHS Improvement reviews the leadership of trusts in special measures and, if necessary, it can use its powers to ensure trusts have the right leadership in place.[27]

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26 Further information is available from the CQC website.

27 The CQC, Monitor and the NHS TDA have published further details in *A guide to special measures (2015).*

4.2 The Secretary of State for Health

One of the 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 the *Mandate to NHS England* and the *NHS Outcomes Framework*.

The Secretary of State also sets the overall budget for NHS England, which does the same for CCGs.[28] 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 to Parliament. 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.

4.3 The Health Select Committee

The House of Commons Health Select Committee examine the policy, administration and expenditure of the Department of Health and its associated public bodies. The Committee holds regular accountability hearings with the Care Quality Commission (CQC), NHS Improvement, the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), and other regulatory bodies, as part of its on-going scrutiny of these related bodies.

[28] The Secretary of State also sets an overall limit on the amount that can be spent on administrative costs in the system.

5. Education and training

The Department for Health established Health Education England (HEE) in 2013 with the responsibility of securing a health and healthcare 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.[29] One of HEE's main methods of securing a sufficient workforce is through its commissioning education and training places.[30]

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.

The Department of Health 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 GMC and 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 and GPs. Health and social care staff report increasing pressure and lower morale after a prolonged period of pay restraint. There are also fears that Brexit will make it harder to retain and recruit EU staff. There appears to be 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.

[29] The 2016/17 workforce plan can be found on the HEE website.
[30] For more background information on HEE's role in workforce planning, see here.

6. Competition and non-NHS providers

Part 3 of the *Health and Social Care Act 2012* creates a framework for choice and competition in the provision of NHS services. In particular, the 2012 Act allows the DH 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 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 has said clinical commissioning groups will 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.[31] 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.[32] The 2010 Government responded that their reforms do not extend pre-existing competition and procurement rules but rather create a framework within which competition can operate on the basis of quality, not price.[33] See the further information section at the end of this note for links to reports analysing the impact of NHS competition and choice policies.

Box 9: Background to competition law in the NHS

Competition law is a complex area but, in brief, organisations are subject to EU and UK competition rules if they are "undertakings" for the purposes of those rules. Whether or not an NHS body is an undertaking will depend on the circumstances and in particular on whether they are engaged in economic activity, offering goods or services on a given market. EU law prohibits anti-competitive agreements, concerted practices or abuses of a dominant position by undertakings that affect trade between member states. Anti-competitive practices are also prohibited by the *Competition Act 1998*.

There had been some contracting out of 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 and the introduction of NHS trusts and the "purchaser-provider split" (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 and NHS spending on non NHS providers in England grew steadily from around 3% in 2002/03 to 10.7% in 2015/16.[34]

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31 "NHS contracts 'going to private firms'", *Health Service Journal*, 16 January 2014; "Is the great NHS sell-off under way?", *BMJ*, 29 April 2014

32 "Labour calls for freeze on NHS contracts with the private sector until after general election", *BMJ*, 30 July 2014

33 The key provisions of the 2012 Act are set out in a Department of Health factsheet on choice and competition.

34 Source: DH Annual Report 2015/16. Around £12 billion of the total NHS budget in England is spent on care from non-NHS providers, around 11% of total NHS expenditure. See DH Accounts 2002/03 onwards and DH data presented in Nuffield Trust, *Into the red – The state of NHS finances* (2014). The DH figure for spending on independent sector providers as a percentage of total NHS revenue is 7.6% in 2015/16, up from 4.4% in 2009/10. This refers only to NHS spending on independent/private sector providers, whereas the 11% figure encompasses all non-

7. Public health services

7.1 Public health and local government

The *Health and Social Care Act 2012* transferred responsibility for the provision of 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.[35]

The 2010 White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, stated that tackling health inequalities and improving health and wellbeing would be driven by local government and local communities.[36] The White Paper was responding to the Marmot Review of health inequalities, commissioned in 2008 by the previous Labour Government.[37]

Since 1 April 2013 upper-tier and unitary authorities are responsible for improving the health of their populations, backed by a ring-fenced grant.[38]

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.

Under the reformed system, 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. A Department of Health guide sets out the commissioning responsibilities of local authorities under the post-2013 arrangements. Provision by local authorities of five universal health visitor reviews for children aged 0-5 was required by Regulations which came into force on 1 October 2015. The Department commissioned Public Health England (PHE) to undertake a review of the Regulations at 12 months and PHE is expected to publish this shortly.[39]

The Comprehensive Spending Review document, from December 2015, included the following key points on public health:

NHS providers of care; including those from the independent sector, voluntary sector and local authorities.

35 *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.

36 HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, CM7985, November 2010, p4

37 The Marmot Review, *Fair Society Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, February 2010 and DH, *The new public health role of local authorities*, October 2012

38 The Department of Health has allocated a ring-fenced public health budget to local authorities of £2.7 billion and £2.8 billion for 2013-14 and 2014-15.

39 PQ 62941 9 February 2017

- The government will make savings in local authority public health spending, delivering average annual real-terms savings of 3.9% over the next 5 years.
- The government will consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention.
- The ring-fence on public health spending will be maintained in 2016-17 and 2017-18.[40]

Background on the statutory responsibilities for public health services can be found in the Library briefing *Local authorities' public health responsibilities (England)*.

7.2 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 a directorate within the Department of Health. PHE has taken on responsibilities to oversee the local delivery of public health services and to deal with national issues such as flu pandemics and other population-wide health threats. 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.

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

- The national immunisation programmes.
- The national screening programmes.
- Public health services for offenders in custody.
- Sexual assault referral centres.
- Public health services for children aged 0-5 years (including health visiting, family nurse partnerships, and much of the healthy child programme - from 1 October 2015 the responsibility for commissioning public health services for children aged 0-5 will transfer from NHS England to local authorities).
- Child health information systems.
- Military health, and specialised services.

In October 2014 PHE published a strategic document setting out its priorities for the next five years. *From evidence into action: opportunities to protect and improve the nation's health* set out the following seven priorities using the evidence to determine where it could most effectively focus its efforts on securing improvements:

- tackling obesity particularly among children
- reducing smoking and stopping children starting
- reducing harmful drinking and alcohol-related hospital admissions
- ensuring every child has the best start in life

[40] A DH Circular from February 2016 (Local Authority Public Health Grant Allocations and Conditions 2016/17) provides further information.

- reducing the risk of dementia, its incidence and prevalence in 65 to 75 year olds
- tackling the growth in antimicrobial resistance
- achieving a year-on-year decline in tuberculosis incidence

In March 2015 the Public Accounts Committee (PAC) published a report on PHE's grant to local authorities. The Report states that PHE has made a good start in its efforts to protect and improve public health.[41] However, the PAC had a number of concerns about the slow progress in tackling health inequalities:

> There are still unacceptable health inequalities across the country, for example healthy life expectancy for men ranges from 52.5 years to 70 years depending on where they live. These inequalities make PHE's support at a local level particularly important but we are concerned that PHE does not have strong enough ways of influencing local authorities to ensure progress against all of its top public health priorities. Finally, given how important it is to tackle the many wider causes of poor public health, PHE needs to influence departments more effectively and translate its own passion into action across Whitehall."[42]

In February 2014 the Health Committee published a report on *Public Health England* and in September 2016 it published *Public health post-2013*.[43]

41 PAC, *Public Health England's grant to local authorities* (HC 893, 6 March 2015)
42 *Ibid,* summary
43 See also: Communities and Local Government Select Committee, *The role of local authorities in health issues*, (HC 694, Eighth Report of Session 2012-13, March 2013).

8. Health and Wellbeing boards and Healthwatch

8.1 Health and Wellbeing Boards

In addition to their public health duties, local authorities are responsible for statutory Health and Wellbeing Boards (HWBs), which 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.

8.2 Healthwatch England and local Healthwatch

Healthwatch England and the local Healthwatch 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 2012 Act to provide advice to NHS England, English local authorities, Monitor 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.

Healthwatch also works at the local level through local Healthwatch organisations (set up by local authorities) which have taken over the role of Local Involvement Networks (LINks).[44]

[44] LINks were set up in 2008 in each local authority area to involve local people in decisions about how local services are run.

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 LGA and Healthwatch published, *Delivering effective local Healthwatch: Key success factors* in September 2013, which sets out the purpose of local Healthwatch organisations and the role of local authorities.

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.

A Library briefing provides further information on Health and Wellbeing Boards and Healthwatch.

9. Safety of care

A major driver of change in the NHS in recent years has been Sir Robert Francis QC's Report into the failings at Mid Staffordshire NHS Foundation Trust, which was published in 2013. The health related provisions in the *Care Act 2014* largely address specific recommendations from the Francis Report – specifically about transparency and care standards. [45] Provisions in the 2014 Act also respond to wider concerns about how regulatory systems are co-ordinated to ensure patient safety, raised by Francis and the subsequent Keogh and Berwick reviews. Specifically Part 2 of the *Care Act 2014* allows for the introduction of an "Ofsted-style" rating system for hospitals and care homes, creates a single regime to deal with financial and care failures at NHS hospitals, introduces a duty of candour for health and social care providers and makes it a criminal offence for care providers to give false and misleading information about their performance. On 11 February 2015 DH 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.[46]

On 21 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. This guidance:

- outlines a systematic approach for identifying the organisational, managerial and ward factors that support safe staffing
- makes recommendations for monitoring and taking action if not enough staff are available on the ward to meet patients' needs
- builds on NICE guidelines on safe staffing for nursing in adult inpatient care in acute wards.

Learning from clinical incidents in the NHS

In March 2015, the Public Administration Select Committee published its report, *Investigating clinical incidents in the NHS* (HC 886 2014-15), which called on the Secretary of State for Health to establish a national independent patient safety investigation body. The Committee said the new investigative body should provide national leadership, to serve as a

[45] The 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.

[46] Further background on this issue can be found in a House of Lords Library briefing published in November 2016 (see Section 3):

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, agreeing that "there should be a capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out certain investigations itself". 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. The EAG is comprised of experts in patient experience, safety, healthcare and investigation and is chaired by Mike Durkin, NHS National Director for Patient Safety. The EAG published its report and recommendations on 12 May 2016. In its 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." (*Report of the Healthcare Safety Investigation Branch Expert Advisory Group* (May 2016)). The Secretary of State's *Directions* set out HSIB's investigatory functions as:

> a)the investigation of incidents or accidents which in the view of the Chief Investigator evidence, or are likely to evidence, risks affecting patient safety;
>
> b)the ascertaining of facts relevant to such risks and analysis of those facts;
>
> c)the identification of improvements or areas for improvement, if any, which may be made in patient safety in—
>
> > i)the provision of services as part of the health service, or
> >
> > ii)the conduct of other functions carried out for purposes of the health service, and where appropriate, the making of recommendations in relation to such improvements;
>
> d)the publication of reports;
>
> e)encouraging the development of skills used to investigate local safety incidents in the health service and to learn from them, including suggesting standards which may be adopted in the conduct of such investigations.

The *Directions* stipulate that HSIB must be in a position to commence its activities by 1 April 2017 (Department of Health, *NHS Trust Development Authority (Healthcare Safety Investigation Branch) Directions 2016*).

On 1 April 2016 the new body was established as an independent unit within NHS Improvement, and Keith Conradi has subsequently been appointed as the Chief Investigator of the HSIB. Mr Conradi was previously Chief Investigator for the Air Accidents Investigation Branch. The successor Committee to the PASC, the Public Administration and

Constitutional Affairs Committee has approved the appointment of Mr Conradi but has raised concerns that HSIB has been established without primary legislation to underpin the independence of the new body.

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;
- create a prohibition on the disclosure of information held in connection with an investigation conducted by the HSIB, to enable participants to be as candid as possible.

Briefing notes accompanying the Queen's Speech note that this prohibition would not apply where there is an ongoing risk to the safety of patients or evidence of criminal activity, in which case the HSIB would inform the relevant regulator or police.[47]

[47] Briefing notes accompanying the Queen's Speech, June 2017

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 National Health Service, whilst local authorities have provided means-tested social care to their local populations.

It is argued that patients with both health and social care needs are badly served by the current model, and that by integrating the NHS and local authorities, the patient can be put at the centre of how care is organised.

Policy on integration has focused on delivering care outside of hospital, instead delivering care as close to the patient as possible, either at home or in their community. It has also sought to reduce problems caused by the ineffective interaction of health and social care, such as unnecessary hospital admissions and delayed discharges.

Recent 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 2015 Government committed £3.9 billion in 2016/17. There have also been a number of smaller, pilot projects to improve integration. A Commons Library briefing paper, *Health and Social Care Integration*, provides further information on this issue.

The NHS *Five Year Forward View* proposed a new central-local partnership to support and stimulate the creation of a number of new care models. Plans for devolution in Greater Manchester include the pooling of its £6 billion health and social care budget and there are a number of "integrated care pioneers" across England. NHS England is also backing plans to integrate primary, community and acute care in 29 "vanguard" areas across England.[48]

[48] Information on recent local developments to integrate care in Manchester and in 29 "vanguard" areas can be found on the NHS England website.

11. Mental health policy

Around one in four people in the UK suffer from a mental health problem each year, but mental illness often goes untreated, and historically, treatment options for mental health compare unfavourably with those for physical conditions. While mental illness is estimated to accounts for almost a quarter of the total burden of disease, only 13 per cent of the NHS budget is spent on mental health services.

The NHS has set out that it wants to achieve "parity of esteem" between mental and physical health in the NHS, in terms of access to services, quality of care and allocation of resources. While the achievement of parity of esteem has been a long term-policy goal, since 2010 this aim has increasingly featured in legislation and in government and NHS policy statements.

In October 2014, NHS England and the Department of Health jointly published Improving access to mental health services by 2020. This set out a vision to ensure mental and physical health services are given equal priority in terms of access times and service quality. In April 2016 the NHS in England extended the 18-week referral to treatment waiting time standard to the improved access to psychological therapies (IAPT) programme, and introduced a new standard that 50% of people experiencing their first episode of psychosis will begin treatment within two weeks of referral.

In February 2016 an Independent Mental Health Taskforce published *The Five Year Forward View for Mental Health*, which made a series of recommendations for the NHS and government to improve outcomes in mental health by 2020/21. In July 2016, NHS England published *Implementing the Five Year Forward View for Mental Health*, confirming that the NHS had accepted the recommendations, and included a breakdown of the additional funding that will be made available. In particular, the 2015 Government committed to an additional £1 billion by 2020/21 to support implementation of the Taskforce's recommendations.

In January 2017 the Government published its response to the work of the Mental Health Taskforce, accepting its recommendation in full, and committing to a number of cross-government reviews and initiatives, applying to the NHS, to education, employment and the wider community.

A Commons Library briefing paper, *Mental health policy in England*, provides an overview of policy on mental health in England, focusing on measures taken since 2010. Further information on policy on child and adolescent mental health services (CAMHS), including work to improve the provision of mental health services in schools, is available in the Library briefing *Children and young people's mental health – policy, CAMHS services, funding and education.*

12. 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.

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 and one public health body that support the regional NHS Boards by providing a range of specialist and national services.

Each NHS Board is accountable to Scottish Ministers, supported by the Scottish Government Health and Social Care Directorates.

Regional NHS Boards are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services. Special NHS Boards support the regional NHS Boards by providing a range of important specialist and national services.[49]

Box 10: 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.

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.

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

49 See www.show.scot.nhs.uk for further information.

(provides specialist services in cancer and other national support) and Public Health Wales.[50]

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.

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.[51]

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50 See www.wales.nhs.uk for further information.

51 See http://www.dhsspsni.gov.uk/ for further information. The further information section at the end of this note provides further information on differences between the health systems in the different parts of the UK.

13. Further information

Heath service reform in England

The NHS *Five Year Forward View* (October 2014) *Next Steps on the NHS Five Year Forward View* (March 2017) are the key document setting out the future of NHS reform in England; the following links provide further information on recent changes:

The Department of Health has 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.[52]

NHS England, the King's Fund and the All Party Health Group have all published useful guides to understanding the new health service structure in England:

- NHS England, *Understanding the new NHS* (June 2014)
- King's Fund, *How is the new NHS structured?* (updated April 2015)
- The All Party Parliamentary Health Group, *A guided tour of the new NHS* (essay collection) (2013)

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)

[52] 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*.

- *The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015* (2015)[53]

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).

The Office of Health Economics report on competition in the NHS (January 2012) provided a useful summary of NHS competition and patient choice policies from 2000, and references to further reading.

The Nuffield Trust report *Into the red – The state of NHS finances* (2014) provides a breakdown of NHS spending by independent providers, NHS bodies, and voluntary & other providers, in the areas of community health services (page 14), mental health services (page 16) and hospital services (page 18).

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 in 2012.

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 notes 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

53 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).

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.[54]

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 here:

http://www.england.nhs.uk/ccg-details/

A map of CCG names and boundaries can be found here:

http://www.england.nhs.uk/wp-content/uploads/2012/07/a3-ccg-proposed-boundaries.pdf

You can either send correspondence to the NHS England contact centre for the attention of the relevant Area Team Director (who will respond directly):

NHS England

PO Box 16738

Redditch

B97 9PT

Or you can email: england.contactus@nhs.net

The phone number to follow up on any enquiries is: 0300 311 22 33

Correspondence for the Chair or Chief Executive of NHS England should be sent directly to their offices at Quarry House, Leeds:

Professor Sir Malcolm Grant

Chair

NHS England

4W20 Quarry House

Leeds LS2 7UE

Or by email to: malcolm.grant@nhs.net

Simon Stevens

Chief Executive

NHS England

4W12 Quarry House

Leeds LS2 7UE

Or by email to: england.ce@nhs.net

[54] NAO, Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland, June 2012, p8 para 12

The phone number to follow up on any enquiries about correspondence to the Chair or Chief Executive is: 07900 715 195

Raising concerns

The Department of Health report *Culture change in the NHS* (Cm 9009, February 2015), provides information on developments in patient complaints and staff whistleblowing policies.

Further information can be found in the Library briefings *NHS complaints procedures in England*, and *NHS whistleblowing policies in England*.

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