THE ACP GUIDE TO THE STRUCTURE OF THE NHS

IN THE UNITED KINGDOM

April 2010

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Devolution has had a significant impact on the way health services function in the four countries in the United Kingdom. In England the competitive market reforms that were first introduced following publication of the Conservative's white paper "Working for Patients" in 1989[1] have twenty years later been re-introduced by a Labour government. In contrast the other three countries have developed a more co-operative approach to the delivery of health services. This paper therefore attempts to give a brief outline of the current structure of the NHS in the United Kingdom. As a result of the rapid changes that are occurring in the organisation of NHS it is extremely difficult to produce a review of the structure of the NHS in the United Kingdom that is accurate other than on the day it is written. This document therefore attempts to summarise the structure of the NHS as it existed on the 1st April 2010.

ENGLAND

The NHS plan[2] was published in July 2000 and outlined a 10 year plan of investment in the NHS. The requirement for the additional investment outlined in the NHS Plan was subsequently highlighted in the Wanless reports.[3,4] The current structure of the NHS is shown in Fig.1.

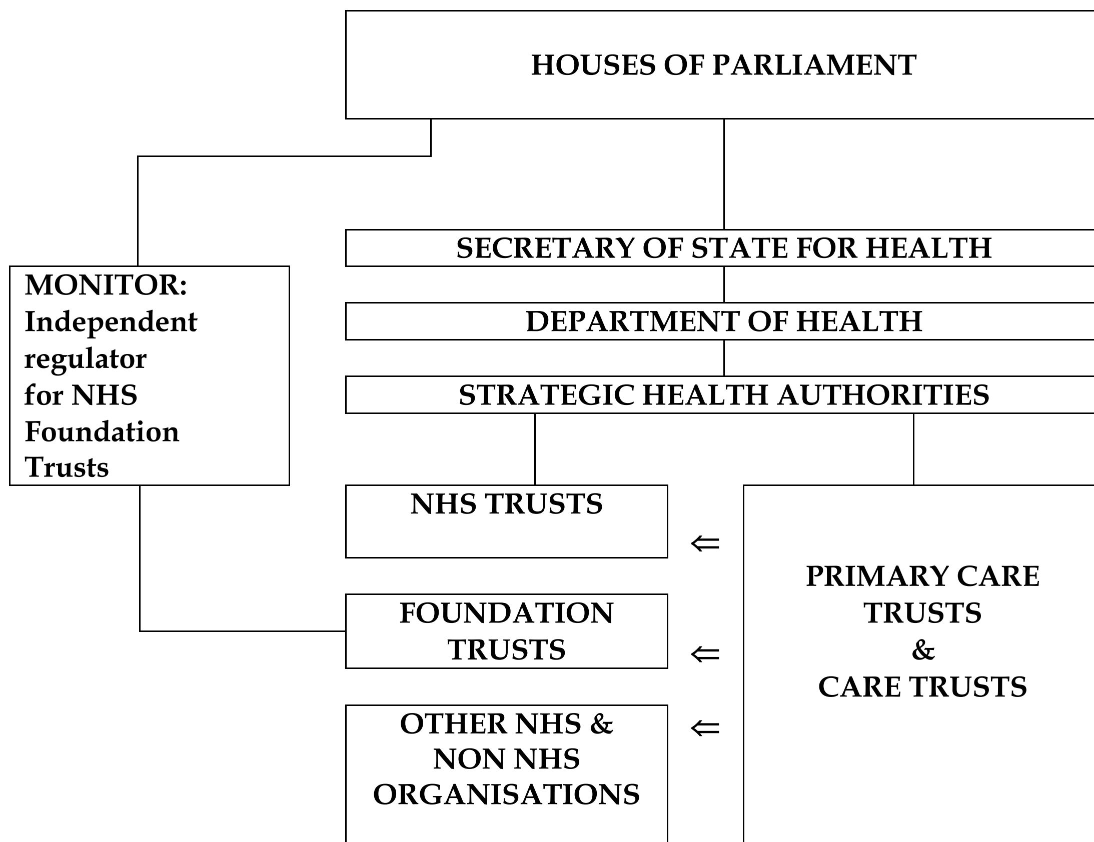

Fig. 1 **The structure of the NHS in England**
⇐ Commissioning of Services

Department of Health

The Department of Health is responsible for leading the NHS on social care as well as improving standards of public health. The Secretary of State for Health, Andy Burnham, works with five Ministers for Health and Sir David Nicholson who is the NHS Chief Executive and Sir Hugh Taylor, the permanent secretary. The Secretary of State for Health is accountable to Parliament for the functioning of the NHS. Sir David Nicholson and Sir Hugh Taylor provide the link between the Secretary of State and the Department of Health. Sir Hugh Taylor as the permanent secretary chairs the departmental board at the Department of Health. Board members include Sir Liam Donaldson Chief Medical Officer, together with a number of other directors. A separate NHS Management Board focuses on the leadership of the NHS. A summary of the structure of the Department of Health is shown in box 1.[5] The department has staff in London and Leeds and also in each of England's nine Government Offices for the regions.

The role of the Department of Health is to provide strategic leadership to the NHS and social care organisations. These roles include:

- Setting overall direction for the NHS e.g. policy, regulation, NHS operating framework, allocating resources.
- Supporting delivery of NHS reforms e.g. performance monitoring, building capacity, ensuring value for money.
- Leading health and well being for the Government e.g. working with the wider public sector and other organisations on health protection

In addition the department has UK wide responsibilities in some areas such as such as international and EU business, licensing and safety of medicines, planning for pandemic flu etc. Within the Department of Health the Clinical Directors are clinical experts in their field who oversee the implementation of the National Service Frameworks in the NHS and Social Care. In 2007 responsibility for these clinical programmes was transferred to a new post of NHS Medical Director currently held by Sir Bruce Keogh.

Departmental Board: provides advice to ministers, setting DH standards, establishing the framework for governance and management of risk

- chaired by the permanent secretary
- members include NHS Chief Executive, CMO, other Departmental Directors etc

Management Boards: provide leadership of the NHS, manage NHS performance and ensures that resources allocated to the NHS are used appropriately

- chaired by the NHS Chief Executive and permanent secretary
- members include SHA Chief Executives, other Directors

National Advisers and Clinical Directors ("Tsars")

Mental Health, Children, Cancer, Diabetes, Heart Disease, Emergency Access, Older People's Services, Primary Care, Pandemic flu preparedness etc

Box 1: Summary of the structure of the Department of Health

Arm's Length Bodies

The Department of Health works with a number of arm's length bodies that carry out specific functions on its behalf such as inspection and regulation, setting standards, protecting the public and providing central services to the NHS. These organisations are separate from government but are funded by the government. There are three types of arm's length bodies:

i) ***Executive agencies –*** for example the Medicines and Healthcare products Regulatory Agency (MHRA)
ii) ***Special Health Authorities*** - these are independent but can be subject to ministerial direction like other NHS bodies. These special authorities include e.g. the National Institute for Health and Clinical Excellence, National Patient Safety Agency, National Blood and Transplant Authority.
iii) ***Non-departmental public bodies –*** for example the Care Quality Commission, Monitor, Human Tissue Authority.

Strategic Health Authorities

Below the Department of Health are ten Strategic Health Authorities (SHAs). Each of the Strategic Health Authorities covers a population of between 2.5 – 7.5 million and their boundaries are co-terminus with local authorities who are responsible for Social Services. The chief executive of each SHA is a member of the NHS Management Board. The main roles of the SHAs are:

- Ensuring coherency of the local health service and developing strategies for improving the local health services that reflect national policy

- Assessing the performance of the Primary Care Trusts on behalf of the Department of Health and to ensure that a financial surplus is delivered

- Supporting NHS Trusts to become NHS Foundation Trusts

- Workforce development including education, training and workforce planning.

The SHAs manage the NHS locally (with the exception of Foundation Trusts) and are the key link between the Department of Health and the NHS. Strategic Health Authorities have no powers to either directly intervene or manage Foundation Trusts. They also ensure that national priorities are integrated into plans for the local health service.

Primary Care Trusts

Primary Care Trusts are the corner stone of the NHS in England. Funding for hospitals (NHS Trusts, Foundation Trusts) and contracts with non - NHS providers now come from primarily from Primary Care Trusts. Each covers a population of approximately 150,000 – 300,000 people. They are responsible for:

- Assessing needs of the local population, reviewing provision of services and deciding priorities. This includes hospital care, mental health services, GP

practices, screening programmes, patient transport, NHS dentists, pharmacies and opticians.

- Designing services in partnerships with practice based commissioners and ensuring effective commissioning of these services

- Managing demand for services so that the PCT works within its cash limited allocation

- Performance management of providers through the contracting process.

Primary Care Trusts have a responsibility for developing practiced based commissioning. Under these arrangements general practices take on the responsibility from the Primary Care Trust for commissioning services that meet the needs of their local population. General practices have their own indicative budgets that cover both acute, emergency and community services. It remains to be seen how these arrangements will fit in with patient choice through the Choose and Book initiative (see below). The PCTs also may also have a provider function that delivers community based services. This provider arm of the PCT now has to be separated from the commissioning side.

Care Trusts

Care Trusts are NHS bodies that work in both health and social care. They can be established when NHS organisations and Local Authorities agree to work together and their functions are determined by this partnership. At present only a small number of Care Trusts have been established. In areas where Care Trusts have not been established, Primary Care Trusts and Social Services work as independent agencies.

NHS Trusts

NHS Trusts continue to run some hospitals and are accountable to Strategic Health Authorities. The Department of Health expects that all NHS Trusts will become Foundation Trusts.

Foundation Trusts

NHS Foundation Trusts were first established in April 2004 and are freestanding organisations with greater freedom within the NHS.[6] They are constituted as separate entities as non-profit making organisations. Foundation Trusts are owned by their members who are local people, employees and other key stakeholders. The Secretary of State for Health in theory does not have the power to direct NHS Foundation Trusts and is not involved in appointing board members. Instead of the accountability arrangements described above, NHS Foundation Trusts are accountable through a number of arrangements. The external accountability arrangements for Foundation Trusts are summarised in Box 2.

- Monitor, the independent regulator issues a license for the Foundation Trust to operate
- Monitor is responsible for ensuring that the terms of the license are upheld
- Inspection by the Care Quality Commission
- Contracts with PCT's

Box 2: External accountability arrangements for Foundation Trusts

Monitor, the independent regulator issues a license for a Foundation Trust to operate. This license covers a number of areas including:

- A requirement to focus on delivery of care to NHS patients
- The clinical services which it must provide to the local community
- A duty to participate in the education and development of health care staff in the NHS
- The financial duties under which it must operate
- Together with other areas including information technology, relationship with other NHS and Social Care bodies.

Monitor is accountable to Parliament for the functioning of NHS Foundation Trusts and is also responsible for ensuring that Foundation Trusts comply with the licensing criteria. Other external accountability arrangements are as for other NHS Trusts such as inspections by the care Quality Commission and contracts with the local PCT's.

Foundation Trusts also have new arrangements for internal governance. A Board of Governors has to be established whom the members of the Foundation Trust elect. Members of the Foundation Trust include members of the public who live in the local area, patients, employees of the Trust and representatives of partner organisations. Members of Foundation Trusts can therefore participate in elections to the Board of Governors, receive information about the Foundation Trust and be consulted e.g. on matters arising on how clinical services can be improved. The main function of the Board of Governors is to work with the Management Board to ensure that the Foundation Trust acts in a way that is consistent with its objectives, with the conditions under which it is licensed to operate and also to help set the strategic direction. The Board of Governors however is not involved in day to day management since these are duties of the Management Board.

The Management Board is similar in structure to existing NHS Trust Boards with a Chief Executive, Director of Finance and a number of non-executive Directors. The Management Board has overall responsibility for the day to day management of the hospital. Clinical services are managed through clinical directorates or similar type structures. The internal governance arrangements for Foundation Trusts are summarised in Box 3.

Board of Governors
¦
Management Board
¦
Clinical Directorates

Box 3: Internal Governance Arrangements for Foundation Trusts

Other NHS and Non NHS Organisations

One of the aims of the current reforms has been to increase the capacity of the NHS by developing other types of NHS providers and allowing an increasing number of non-NHS providers to contract for services. In addition the white paper on the future of community services – Our health, Our Care, Our say[7] emphasizes that in future more care will be provided closer to the patients home. One of the main recommendations is that much of the outpatient and day case work undertaken in areas such as dermatology, ENT, general surgery, orthopaedics, urology and gynaecology will in future be delivered in community facilities rather than in acute hospitals. Therefore in response to this white paper a number of other organisations have developed that will be delivering healthcare in the future. These include:

Clinical Assessment, Treatment and Support services (CATS) – these services may be operated by the NHS or the independent sector. Referrals from general practitioners are assessed in these centres before being referred to hospital. On completion of the assessment the decision may be not to refer to hospital but manage the patient either by referring to another general practitioner with a special interest or to another provider or to another part of the CATS service. This is one of the more contentious developments in managing referrals by general practitioners and it may have a significant impact on the number of referrals a hospital may receive.

Treatment centres – these are stand alone organisations usually providing elective surgery and some diagnostics such as radiology and endoscopy. These centres may be run by the NHS but more typically there are operated by the independent sector.

Primary care centres – provide services such as out patient clinics, urgent care (as an alternative to Accident and Emergency Departments for non trauma patients), renal dialysis , endoscopy, radiology. They may also include walk in centres that focus on emergency care.

Independent hospitals – increasingly NHS patients are being referred to independent hospitals for NHS care.

Polyclinics – these are primary care centres that include many of the services that are seen in a primary care centre but will also include general practitioners. It is likely that many of theses clinics will be owned and run by the independent sector. This is a contentious development since the organization of the traditional British general practice based in local general practices may be fundamentally changed.

Social enterprise ventures and the third sector – these are organizations that are run along business lines but where any profits are reinvested into the community or service developments. These are part of the third sector (non-NHS, non-independent sector that includes the voluntary and non profit making organisations). The Department of Health is encouraging the formation of these organisations with dedicated funding as a way of delivering innovative health and social care. The types of services that these organizations provide include alcohol and substance misuse programmes, services for vulnerable adults, and other community based services. Voluntary organizations and charities may run these organizations. The long term viability of these types of organizations is as yet unknown.

Development of Clinical Services

A number of strategies have been developed that ensure that the national priorities are implemented. These strategies include:

1. National Service Frameworks

A definition of National Service Frameworks is summarised in Box 4. Each National Service Framework is developed with the assistance of an external reference group, which brings together health professionals, service users, carers, health service managers and other agencies.

- Set national standards and define the way in a service should be provided
- Put in practice strategies to support implementation.
- Establish performance milestones against which progress within an agreed time scale can be measured.
- Form one of a range of measures to raise quality and decrease variations in service in the NHS.

Box 4: A summary of the definition of National Service Frameworks

National Service Frameworks were launched in 1998 and were based on the Calman Hine report on cancer, together with the report on paediatric intensive care. To date a number of National Service Frameworks have been published (Box 5).

- Mental Health 1999
- Coronary Heart Disease 2000
- National Cancer plan 2000
- Older people 2001
- Diabetes 2001
- Children's services 2004
- Renal Service part 1 2004, part 2 2005
- Long-term conditions 2005
- Stroke 2007
- Chronic Obstructive Pulmonary Disease 2008

Box 5: National Service Frameworks

2. Planning Framework

The Department of Health has increasingly focussed national priorities on a limited number of priorities. These priorities are a series of rights for patients and the public that were outlined in a five year vision for the NHS. [8] These rights have been enshrined in the NHS Consitution.[9] Delivery of these priorities is supported on an annual basis by the publication of the Operating Framework for the NHS.[10] This framework outlines what are the key priorities for the NHS for the forthcoming year (Box 6). These priorities (called Vital Signs) are set at three levels Tier 1 must dos, Tier 2 national priorities for local delivery e.g. abolition of mixed sex accommodation, improving end of life care and Tier 3 locally agreed targets. These are the top priorities that Primary Care Trusts, as commissioners of services, have to achieve. Delivery of these targets is monitored through the quality account that is agreed between the PCT and the Trust (see below)

- Improving cleanliness and reducing healthcare associated infections
- Improving access through achievement of the 18 week referral to treatment pledge and improving access to GP services
- Keeping adults and children well, improving their health and reducing health inequalities
- Improving patient experience, staff satisfaction and engagement
- Preparing to respond in a state of emergency such as an outbreak of pandemic flu

Box 6: The five national priorities for 2010-11

3. NHS performance framework

From 2001 to 2005 the Department of Health published NHS performance ratings. In these performance ratings NHS organisations in England were allocated either 0,1, 2 or 3 stars. From April 2005 – March 2010 the star rating was replaced by the Annual Health Check, this being the way healthcare organisations in England were previously assessed by the Healthcare Commission. On the 1st April 2009 the Healthcare Commission was abolished and was replaced by the Care Quality Commission (CQC) which is an amalgamation of the three previously separate regulators for heath, social services and mental health. From 1st April 2010 all providers of health care must be registered with the Care Quality Commission. The process of registration involves each organisation making a declaration that they are compliant with the CQC 16 essential standards.[11] The roles of the Care Quality Commission are summarised in box 7.

The Judgement Framework

Each organisation is assessed against the sections in the Judgement Framework (box 8). The organisation makes a self declaration against each of the standards: compliant, minor concern, moderate concern or major concern. The CQC then notifies the provider if they are registered. This registration may have conditions attached to it. After registration is complete the CGC monitor compliance with the essential standards as outlined in the judgement framework. [12]

- Registering and licensing health care providers and monitoring the quality of care delivered by all health care providers in England
- Improving the quality of health care by undertaking regular and special reviews of services
- Protecting the interests of people held under the Mental health Act
- Publish information on the quality of health care services

Box 7: Roles of the care Quality Commission in relation to health services in England

Information & Involvement:

- Respecting and involving people who use services*
- Consent to care and treatment*

Personalised care, treatment and support

- Care and welfare of people who use services*
- Meeting nutritional needs*
- Cooperating with other providers*

Safeguarding and safety

- Safeguarding people who use services from abuse*
- Cleanliness and infection control*
- Management of medicines*
- Safety and suitability of premises*
- Safety, availability and suitability of equipment*

Suitability of staff

- Requirements relating to workers*
- Staffing*
- Supporting workers*

Quality and management

- Assessing and monitoring the quality of service provision*
- Complaints*
- Records*
- Notification of death of a person who uses the services
- Notification of death or unauthorized absence of a person who is detained under the mental health Act 1983

Suitability of management

- Requirements relating to registered managers
- Registered person : training
- Financial position

Box 8: Components of the Care Quality Commission's Judgement Framework
* These are the 16 essential standards of quality and safety

4. Quality Contracts & Quality Accounts

The review of the NHS in England that was undertaken by the health minister Lord Darzi has led to a significant change in health policy in England. The final report has placed a greater emphasis on the quality of services as commissioned by Primary Care Trusts.[13] The review covered a number of areas in relation to the delivery of services and one key change is the requirement for all healthcare providers to publish a quality account.

As part of the contact with health care providers Primary Care Trusts have to agree a quality contract with the Trust or provider. Outcomes that are included in these contracts are influenced by the National Quality Board and Regional Quality Observatories that provide support to PCTs. Part of the contract is linked to a payment the so called CQUIN scheme (Commissioning for Quality and Innovation payment framework).[14] For 2009/10 this amounted to 0.5% of a trusts total income and this increased to 1.5% in 2010/11. If a trust fails to deliver the outcomes that are agreed in the CQUINs part of the contract then a financial penalty is levied on that organisation.

Pathology Modernisation

The Department of Health initiated a modernisation programme for pathology in 2004. An independent review of progress of the programme was then initiated in 2006 under Lord Carter and the final report was published in 2008.[15] This report identified a number of recommendations for the future delivery of the pathology services in the areas of improved quality and patient safety, improving efficiency and identifying mechanisms for delivering change. The Department of Health has supported many of these recommendations and implementation will be taken up via the commissioning route by Strategic Health Authorities and Primary Care Trusts.[16]

Clinical Governance arrangements at a national level

At a national level, the National Institute for Health and Clinical Excellence (NICE) publishes four types of guidance: (i) clinical guidelines on particular clinical conditions, (ii) technology appraisals on drugs and other procedures, (iii) guidance on the safety and effectiveness of interventional procedures (iv) guidance on the promotion of good health and the prevention of ill health (www.nice.nhs.uk). Compliance with these guidelines is evaluated by the Care Quality Commission as described above.

Financing of the NHS in England

Primary Care Trusts are responsible for commissioning services from NHS Trusts, Foundation Trusts, independent hospitals or other non-NHS providers. The commissioning arrangements between Primary Care Trusts and providers of the service is through a nationally agreed contract. For Foundation Trusts these are legally binding contracts. These specify the number of cases to be treated, the quality standards (set by the Care Quality Commission) to be achieved and the price of the treatment, which is based on a national tariff price. These national tariff prices (introduced in April 2004) have some regional variation to take into account local labour market costs etc (called the market forces factor - MFF). The tariff is based on

the average cost of a coded episode of patient care called a Healthcare Resource Group (HRG).

For the future, the vision for the NHS in England is that of a service that delivers more care closer to home, has fewer acute beds, has reduced costs, more standardised pathways of care and earlier interventions.[10] In order to achieve these objectives significant changes to the tariff were made for 2010/11. These included the introduction of 4 best practice tariffs (for cataracts, cholecystectomy, hip fracture and stoke). The aim of these tariffs is to reduce variation by either reducing length of stay, increasing day case rates or delivering care to agreed quality standards. The funding for emergency care was reduced. All emergency activity above the 2008/09 baseline level will be funded at a reduced rate of 30% of the tariff. In addition the tariff is now the maximum price that a commissioner will pay rather then the mandated price i.e. this suggests that commissioners will be attempting to negotiate a local, lower price for episodes of care . Clearly these changes will add significantly to the financial pressure facing trusts in England.

Therefore until 2010/11competition between providers was based on access to (waiting time) and the volume and quality of the services that Trusts provide rather than the price. However with the changes that have been made to the tariff for 2010/11 competition on price will be a factoring the agreement of contracts. This framework for the way the financial system in England works is called '**payment by results (PbR)'.**[17] As described above in addition to this PbR payment each trust also contracts for 1.5% of its income via the CQUIN payment scheme. Another factor that will influence the market is patient choice.[18] At the point a general practitioner decides a patient needs referring for treatment the patient is offered the choice of hospitals (including independent hospitals and treatment centres etc). These appointments are booked electronically from the GP's surgery using the **Choose & Book** software. From April 2008 the majority of referrals to secondary care are through the Choose and Book system with patients having a choice of any provider. Therefore patient choice together with 'payment by results' will determine how successful Trusts are financially in the future.

To date pathology has not been included in the national tariff. In the absence of a national tariff it is up to local negotiation to agree the price for pathology tests from GPs.

WALES

Improving Health in Wales[19] was launched in February 2001 and was the equivalent to the NHS Plan in England. This has subsequently been followed by the publication of the Wanless report[20] and the 10 year vision for the future of the health services in Wales – Designed for Life.[21] The Government of Wales Act in 1998 gave devolved responsibility for health to the National Assembly for Wales. The NHS in Wales has been through two major structural changes since 2001, the most recent being on the 1st April 2009 that has resulted in the abolition of commissioning and the creation of unified local health organisations rather than the separate Health Boards who previously commissioned services from Trusts (Fig.2).

The National Assembly

The Minister for Health and Social Services, Edwina Hart, is responsible to the National Assembly for the NHS in Wales. The NHS in Wales is managed by the Health and Social Services Department of the Welsh Assembly Government. Paul Williams is the current head of the department and also acts as chief executive of NHS Wales. Dr Tony Jewell is the Chief Medical Officer. The Health and Social Services Department is responsible for implementing the Assembly's policies and strategies for the management and development of the NHS. The department has regional offices in South East Wales, Mid and West Wales and North Wales.

Fig. 2 **The structure of the NHS in Wales**

The National Delivery Group

The chief executive of the NHS leads this group. Members include other senior directors such the Medical director, Nurse Director and Director of Public Health. The groups role is to provide strategic leadership and management of the NHS. The group is also responsible for planning and performance management. The National Delivery Group is required to produce an overall national plan for the NHS to cover a three year period. An Annual Operating Framework is then prepared and Local Health Boards use this as the basis for the development of their own Local Delivery Plan. Local health Boards are then performance managed by the National Delivery Group against these plans.

National Advisory Board

This group is chaired by the Minister and provides independent advise to the Minister.

Local Health Boards

Following the abolition of most trusts in Wales the seven Local Health Boards now have the responsibility for both the planning and delivery of local health services including primary, secondary and tertiary care and community services. Local Health Boards are funded on a capitation basis of their own resident population adjusted for cross boundary flows. The Boards are responsible for ensuring that services for primary and community care are co-ordinated with social services through locality networks or partnerships. The resources for specialised services remain with the Local Health Boards although many of these services will still be delivered by the Velindre NHS Trust as a separate NHS organisation. The Boards are accountable to the Minister via the NHS Chief Executive.

Development of Clinical Services

Improving Health in Wales outlined a ten-year programme of improvement in development of the NHS in Wales. As in England a number of strategies have been implemented so that Improving Health in Wales is delivered. These have included the development and implementation of National Service Frameworks in Wales and the Priorities and Planning Framework, which has an equivalent document in Wales. However as described above from 1st April 2009 a new approach to planning of the services has been introduced.

Pathology modernisation

The national review of pathology services has reported on the future arrangements for the delivery of pathology in Wales.[22] As in England there are a number of recommendations about the development of pathology networks, improved delivery of point of care testing and improvement in IT links. This review was also linked to the publication of the national pathology framework.[23]

Clinical governance arrangements at a national level

The arrangements for Wales are similar to England. The National Institute for Health and Clinical Excellence carries out the same functions in Wales as is undertaken in England. From the 1st April 2004 the Healthcare Inspectorate Wales (HIW) became responsible for independently reviewing Welsh NHS bodies to ensure quality, patient safety and national healthcare standards are being achieved. Each healthcare organisation is required to comply with the Healthcare Standards for Wales.[24,25] Compliance with the standards is assessed by HIW in a similar way to that of the Care Quality Commission in England.

Financing of the NHS in Wales

The financing of the NHS in Wales is quite different to that in England. Local Health Boards are funded on a capitation basis adjusted for cross boundary flow. The Boards then plan for delivery for all services across primary and secondary care in their area.

SCOTLAND

The document Our National Health[26] is the equivalent to the NHS Plan in England and was followed by the white paper in 2003.[27] The plan establishes similar priorities for the NHS in Scotland as described above for England. Following the Scotland Act, 1998 powers were devolved to the Scottish Executive that since August 2007 has been called the Scottish Government. As a result a revised structure of the NHS in Scotland was been implemented, which saw the abolition of all Trusts in Scotland in 2004 (Fig. 3).

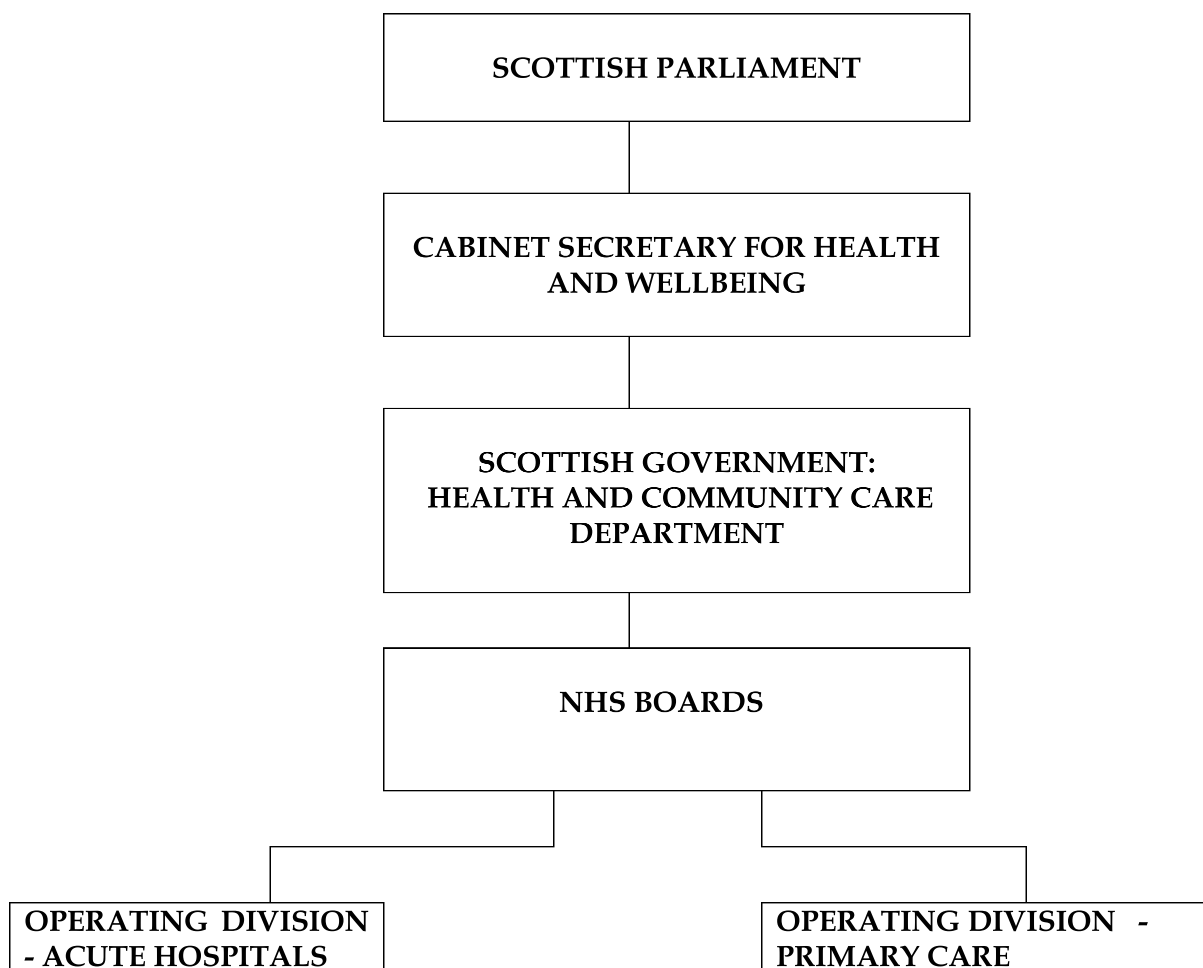

Fig. 3 **The structure of the NHS in Scotland**

Scottish Government : Health & Community Care Department

The Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, is responsible for the NHS in Scotland. The Cabinet Secretary is supported by the Scottish Government Health & Community Care Department which is divided up into a number of Directorates. The responsibilities of the Department are shown in Box 10.

The Chief Executive of NHS Scotland, Dr. Kevin Woods, leads the central management of the NHS in Scotland and is accountable to the Cabinet Secretary for the efficiency and performance of the service. He is also the Director General responsible for health services in Scotland and he is a member of the Strategic Board

that supports the work of the cabinet. The department includes a number of directorates, one of which is lead by the Chief Medical Officer (Dr. Harry Burns).

- Determine national objective and policies for health protection, health improvement and health services, setting targets and offering guarantees on behalf of patients
- Provide a clear statutory and financial framework for NHS Scotland
- Hold NHS Scotland to account for its performance against national priorities and targets, and within the context of increased funding provided by the taxpayer
- Intervene when serious problem or deficiencies in service arise which are not being resolved quickly enough at local level

Box 10: Responsibilities of the Scottish Government Health & Community Care Department.

NHS Boards

There are 14 NHS boards in Scotland that cover specific geographical territories. The role of NHS Boards is the improvement of health for the resident population by developing a Local Health Plan, together with responsibility for operational issues through its operating divisions - see Box 11.

- Strategy development – to develop and implement a single local health plan which addresses the health priorities and health care needs of the resident population.
- Resource allocation
- Performance management of the local NHS system
- Operational management - devolved through the operating divisions

Box 11: Role of NHS Boards

The Scottish Government Health Department monitors the performance of NHS Boards through the performance assessment framework. This framework is organised at a national level and covers four themes (HEAT): Health improvement, Efficiency, Access to services and Treatment appropriate to individuals. The performance of NHS Scotland against these targets is published on the Scotland Performs website: (http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance).

Operating Divisions

Following the abolishment of NHS Trusts and Primary Care Trusts, operational management was transferred on the 1st April 2004 to Operating Divisions of NHS Boards. Each Board has set up a number of operating divisions. This includes Operating Divisions for secondary care and primary care. For primary care this may be organised through a Community Health Partnership that includes both primary care and social services. With the abolishment of Trusts the previous Trust management teams have evolved into a sub-committee of the NHS Board.

Development of Clinical Services:

***Managed Clinical Networks* -** One of the aims of the NHS reforms in Scotland was to develop integrated services by removing artificial boundaries between primary and secondary care. In addition, in some geographical areas there are problems in maintaining a comprehensive range of services. Managed Clinical Networks are linked groups of health professionals and organisations from primary, secondary and tertiary care working together in a co-ordinated manor, unconstrained by professional and NHS Board boundaries to ensure equitable provision of high quality, clinically effective services throughout Scotland.[28,29] The concept of Managed Clinical Networks evolved from Scotland and has now been adopted in other parts of the United Kingdom. Managed Clinical Networks are now seen in, for example, the delivery of cancer services, diabetes, and coronary heart disease.

Pathology modernisation
There has been no formal pathology modernisation programme in Scotland. The national review of specialised pathology was published in 2007 and indicated a managed network may be the most appropriate structure for the organisation of these services.[30] Histopathology and cervical cytology are co-ordinated via the Scottish Pathology Network (SPAN).

Clinical Governance arrangements at national level

The arrangements for Clinical Governance at national level in Scotland are quite different to that of England and Wales. The National Institute for Health and Clinical Excellence and the care Quality Commission do not have remits within Scotland. However recommendations of the National Institute for Health and Clinical Excellence are disseminated by Quality Improvement Scotland (see below).

In January 2003 the Clinical Standards Board for Scotland, Health Technology Board for Scotland, Clinical Resource and Audit Group (CRAG), together with the Nursing and Midwifery Practice Development Unit and the Scottish Health Advisory Service joined together to form NHS Quality Improvement, Scotland which is one of several Special Health Boards in Scotland. The function of NHS Quality Improvement, Scotland therefore is to provide advice on effective clinical practice, set national standards and inspect and publish reports on performance. NHS Quality Improvement Scotland also has a key role in ensuring that NHS Boards are implementing the standards of care outlined in Better Health, Better Care.[31] Many of the standards outlined in Better Health, Better care are included in the Patient Rights (Scotland) Bill 2010. From April 2011 NHS Quality Improvement Scotland, the Care Commission (scrutinises independent healthcare) and the Mental Welfare Commission will merge to form a single new organisation that will scrutinise all

healthcare - Healthcare Improvement Scotland. The Scottish Medicines Consortium (SMC) provides advice to health Boards on new drugs. This is similar to the technology appraisals that are published by NICE.

Financing of the NHS in Scotland

The financing of the NHS in Scotland is quite different to that in England. As described above the NHS Boards are responsible for funding both primary and secondary care. Funding is like Wales provided on a capitation basis for each health Board. Cross boundary flow of patients between Health Boards is however funded via the National Tariff. This Scottish Tariff is similar to the English Tariff in that it is also based on Healthcare Resource Groups. However one of the differences is that the spell of patient care relates to the time spent in an individual specialty rather than the total spell of care in the hospital as is used in England. This information also allows for comparison of costs between NHS Boards.

NORTHERN IRELAND

Investing for Health[32] is the equivalent in Northern Ireland of the NHS Plan in England and was first published in November 2000. In June 2002 Developing Better Services was published.[33] This consultation document made a number of proposals on changing the organisation of acute hospital services and also changing the structural organisation of services in Northern Ireland. Following re-establishment of devolution a further consultation exercise was carried out.[34] The changes that have occurred since these consultations has resulted in a new structure for the NHS (Fig. 4). One of the most striking differences of the structure of the NHS in Northern Ireland is that, unlike the rest of the UK, health and social services since 1972 have been integrated into one structure. Michael McGimpsey is the Minster for Health, Social Services and Public Safety. The Department of Health, Social Services and Public Safety is led by the permanent secretary Dr Andrew McCormick. The Chief Medical Officer is Dr Michael McBride.

The Department of Health, Social Service and Public Safety

The Department of Health, Social Service and Public Safety (DHSSPS) has a number of responsibilities. These include:

- To support the minister in advising on policy and legislation for hospitals, primary and community care and social services.

- Public health policy, which includes responsibility for policy and legislation to promote and protect the health and well being of the population of Northern Ireland as well as emergency planning.

- Public safety which covers policy and legislation for fire and rescue services.

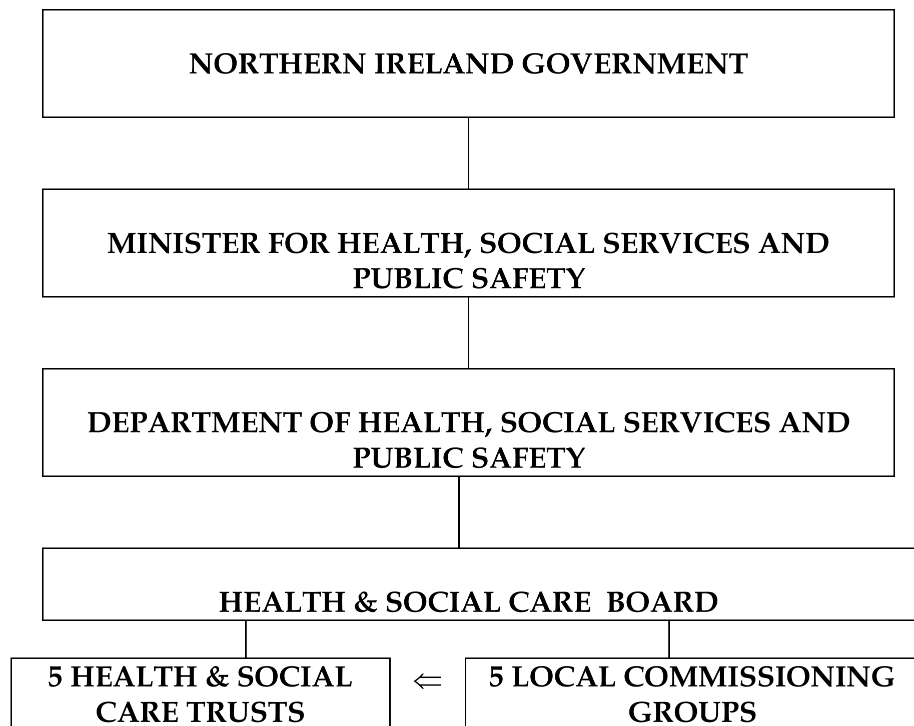

Fig. 4 **Structure of the NHS in Northern Ireland**
⇐ Commissioning of Services

Health & Social Care Board

The main roles of the Board are performance management and improvement of the NHS, financial management and in conjunction with the Local Commissioning Groups to locally commission services that also take into account national priorities. The commissioning arrangements take advantage of the unique opportunity in the UK to commission both health and social care services together.

Local Commissioning Groups

There are five local commissioning groups (LCGs) that cover the same geographical area as the five Health and Social Care. The LCGs act as committees of the Health & Social Care Board .

Health & Social Care Trusts

These five Trusts are responsible for the delivery of health and social care services in Northern Ireland.

Pathology Modernisation

In 2006 the DHSSPS published a consultation document on the future of pathology services in Northern Ireland.[35] The DHSSPS response to this consultation document has also been published.[36] The key recommendations include the establishment of a managed clinical network for pathology, that all pathology services should be

accredited by CPA(UK)Ltd and all laboratory activity is benchmarked using the National Pathology Benchmarking Service at Keele University.

Clinical Governance arrangements at national level.

The Northern Ireland Health and Personal Social Services Regulation and Improvement Authority (The Regulation and Quality Improvement Authority) has overall responsibility for monitoring and regulating the quality of health care services delivered in Northern Ireland. This responsibility includes powers to review and inspect the quality of services that underpin the arrangements for clinical governance. Since July 2006 all recommendations from the National Institute for Health and Clinical Excellence are considered for implementation in Northern Ireland.

Financing of the NHS in Northern Ireland

Each Local Commissioning Group agrees a Service and Business Agreement with each local trust that outlines the volume of work, quality standards and payment that is made if the relevant outcomes are met.

Summary

There are now significant differences in how the NHS operates in the four countries of the United Kingdom. Perhaps the most striking difference is that in England where the internal market that was developed by the last Conservative government (that was in theory abolished by the new Labour Government in 1997) has been re-invented. Trusts now have contracts with Primary Care Trusts that are based on the national tariff. The financial consequences of this are that money follows the patient since, if a Trust increases capacity so that more patients are treated, then the Trust should receive increased funding from the Primary Care Trust. In contrast, for those Trusts that do not deliver the appropriate volume of patients to be treated according to the contract will loose income. So there is competition between Trusts and other non-NHS providers for services. Another major feature of these reforms is that of practice based commissioning where general practitioners take on a budget to manage their referrals, this being very similar to GP fund holding that was a key part of the internal market that was abolished following the 1997 general election.

From 2010/11 there will also be competition on price between providers. Although this will not be a major factor for this year, this is likely to become an increasing factor in the way the market for health services in England develops in the future. The five year vision for the NHS stated that there was to be 0% increase in the tariff for 2010/11 and the uplift for the following 3 years is to be a maximum of zero%.[8] This equates to savings on between £15-20 billion by 2013/14 if current services are to be maintained. Therefore it is not surprising to hear from leaders in the Department Health that the NHS now faces a decade of financial challenge. This financial challenge for acute trusts will become a significant issue since not only will public sector spending be reduced but more care will be delivered outside of hospital so further reducing the trust's income.

This competitive approach to the financing of clinical services that has been developed in England has not been followed in any of the other three countries, where a more co-operative approach between commissioners and providers of

service is evolving. In addition the involvement of the independent sector is unlikely to evolve to any significant degree outside England, other than in the short term to help to reduce waiting times. In addition to "payment by results" the "choose and book" initiative will combine to facilitate a market based, in theory, on patient choice. One of the implications of this new market is that some Trusts will succeed financially while others will fail.

In contrast to England, in both Wales and Scotland the internal market has been completely dismantled with the abolition of both commissioning of services and the commissioner/provider split. The approach to the planning of services in Wales and Scotland is now based on central planning with capitation based budgets. Northern Ireland in has retained commissioning but within a more co-operative approach to the delivery of services than compared to England. One important question of these variations in the organisation of healthcare between the four countries is the impact on the quality and costs of delivering healthcare. One recent study has reported that the reforms in England have been associated with shorter waiting times for outpatient and inpatient care in England compared to the other three countries and with higher clinical productivity in England.[37]

Foundation Trusts have only been introduced in England. The increased freedom that these Trusts will have, such as the freedom to introduce local pay bargaining, change terms and conditions of work, to use funds released from the sale of land and to raise capital for developments have caused some concern for NHS staff. It is interesting to reflect that these type of freedoms and the concerns they generate are almost identical to the issues that were raised prior to the establishment of first-wave NHS Trusts that replaced directly managed units on the 1st April 1991. However many of these freedoms may be more apparent than real. Foundation Trusts have just completed the implementation of the revised terms and conditions of service for non medical staff as part of Agenda for Change. So the freedom to alter these at least in the short term appears to be limited. Similarly the new consultant contract has only recently been implemented. However with the reduction in public sector spending that will start after the 2010 general election the ability of Foundation Trusts to reduce staff costs through local pay bargaining may become more of an issue.

Other differences between the countries are also equally obvious e.g. NICE does not have a remit in Scotland, Health and Social Services are fully integrated in Northern Ireland. However some areas where there appear to be differences may not be the case e.g. the NHS Plan applies to England, however each of the three other countries has published a locally equivalent document. Some of the other documents such as National Service Frameworks, Planning & Priorities Framework seem only to apply to England, but in fact each of the three other countries has a similar set of documents. This apparent difference highlights one of the aspects of devolution.

As described in the introduction it is almost impossible to publish a structure of the NHS, which is accurate other than on the day of publication. However it is hoped that this brief guide to the structure of the NHS in the United Kingdom will be a useful starting point for those who are interested in developing a more detailed understanding of how the NHS works.

References:

1 Secretary of State for Health. Working for Patients. HMSO, London 1989
2 Secretary of State for Health. The NHS Plan. HMSO, London 2000
3 Wanless, D. Securing our future health. Taking a long term view. HM Treasury 2002
4 Wanless, D. Securing good health for the whole population. Final Report. HM Treasury 2004
5 The DH Guide. A guide to what we do and how we do it. Department of Health, 2007
6 Secretary of State for Health. A Guide to NHS Foundation Trusts. Department of Health, 2002
7 Our Health, Our Care, Our say. Department of Health, 2006.
8 Secretary of Sate for Health. NHS 2010-2015: from good to great. Preventative, people-centred, productive. Department for Health,2009.
9 The NHS Constitution. Department of Health,2010.
10 Nicholson, D. The operating framework for the NHS in England 2010/11. Department of Health 2009.
11 Care Quality Commission. Essential standards of quality and safety. Care Quality Commission 2010.
12 Care Quality Commission. Judgement framework. Care Quality Commission,2009.
13 Department of Health. High Quality Care For All. Department of Health, London 2008
14 Department of Health. Using the Commissioning for Quality and Innovation (CQUIN) payment framework. Department of Health, 2008.
15 Report of the Second Phase of the review of NHS Pathology Services in England. Lord carter of Coles, 2008
16 The Department of health's response to the Report of the Second Phase of the Independent Review of NHS Pathology Services in England. Department of Health, 2008
17 Department of Health. Reforming NHS Financial Flows. Introducing Payment by Results. Department of Health, London 2002.
18 Department of Health. Choose & book – patient's choice of hospital and booked appointment. Department of Health, London, 2004.
19 Minister for Health & Social Services. Improving Health in Wales. The National Assembly for Wales, 2001
20 Wanless, D. The review of Health & Social Care in Wales 2003. Welsh Assembly Government 2003
21 Designed for life. Welsh Assembly Government. 2005
22 The future delivery of pathology services in Wales. Welsh Assembly Government, 2008
23 National pathology framework. Welsh Assembly Government, 2008
24 Healthcare Standards for Wales. Welsh Assembly Government 2005
25 Doing well, doing better. Standards for Health Services in Wales. NHS Wales,2010
26 Minister for Health & Community Care. Our National Health. NHS Scotland, 2000
27 Minister for Health and Community Care. Partnership for Care. Scotland's Health White Paper. NHS Scotland 2003
28 MEL (1999) 10. Introduction of Managed Clinical Networks. NHS Management Executive, Edinburgh 1999

29 HDL (2002) 69. Promoting the development of Managed Clinical Networks in NHS Scotland. Scottish Executive Health Department, Edinburgh 2002
30 Review of specialised pathology and laboratory medicine services in Scotland. Scottish Government, 2007
31 Better Heath, Better Care. Action plan. Scottish Government,2007
32 Minister for Health, Social Services and Public Safety. Investing for Health. DHSSPS,Belfast,2002
33 Minister for Health, Social Services and Public Safety. Developing Services, Modernising Hospitals and Reforming Structures. DHSSPS, Belfast 2002
34 Minister for Health, Social Services and Public Safety. Proposals for Health & Social Care Reform. DHSSPS, Belfast 2008.
35 Allen, I. The future of pathology services in Northern Ireland. DHSSPS, 2006.
36 Recommendations for the future of Pathology Service in Northern Ireland. DHSSPS,Belfast,2007.
37. Connolly S, Bevan G & Mays n Funding and performance of healthcare in the four countries of the UK before and after devolution. The Nuffield Trust,2009.