

**YCFM Introductory session: “A Crash Course on the NHS”  
24<sup>th</sup> November 2009  
Royal Society of Medicine, 1 Wimpole Street, London**

Welcome to Young Civitas for Medics! This is the information pack for the first event in the YCFM series on 24<sup>th</sup> November at the Royal Society of Medicine. We are providing you with an overview of the structure and organisation of the NHS as well as a few suggested readings that will help you to understand some of the issues that will be discussed.

**The Structure of the NHS**

The NHS in England provides health care for approximately 51 million people, an enormous organisational task.

The Secretary of State for Health is head of the Department of Health (DH), a government department, and has overall political responsibility for the nation's health care. The DH does not *deliver* health care services but is responsible for the overall policy direction of the NHS and supporting its leadership. It also *oversees* the delivery of services through liaising with local Strategic Health Authorities (SHAs).

In England, the NHS is divided into 10 SHAs by geographical region (for example, Yorkshire and the Humber), each of which has responsibility for the strategic direction of health services in their area.

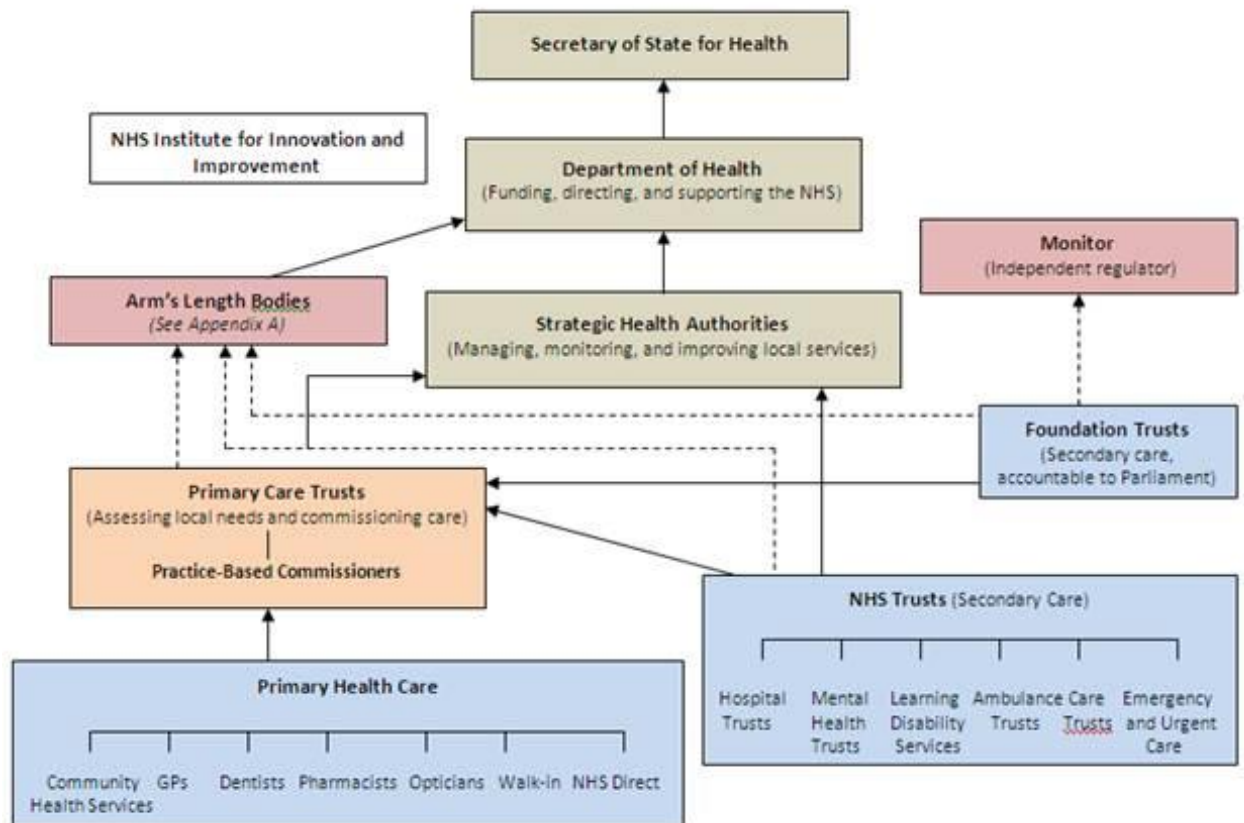
Day-to-day, Strategic Health Authorities oversee the work of 152 local Primary Care Trusts (PCTs), which are organisations responsible for *spending* money (allocated to them by the DH) to *purchase* services for their populations.

PCTs are expected to assess health needs (for example, by looking at historical and comparative service usage, epidemiological data and future projections of population growth) and ensure appropriate services are available to meet them (for example, employing enough GPs, or setting up mental health outpatient facilities). They do the latter by ‘commissioning’ (buying) services from a variety of provider organisations, including general practice, NHS hospital trusts, foundation trusts (NHS hospitals that have been granted a degree of regulatory freedom from the DH), private and voluntary providers. PCTs must then monitor the contracts they hold with providers to ensure requirements on such things as volume and quality are met.

Some PCTs also opt to provide certain services, such as primary care and specialist community-based services, themselves.

Overlaying this basic structure are a number of “Arm’s Length Bodies” that work with the DH to provide regulatory and support functions, such as monitoring patient safety or evaluating the cost-effectiveness of NHS services. The role of these organisations will be discussed in future sessions, but the most important are: the [Care Quality Commission \(CQC\)](#), which monitors quality of care in and out of hospitals; [Monitor](#), the financial regulator of foundation trusts; and the [General Medical Council \(GMC\)](#), which regulates the medical profession.

The diagram below illustrates how the direction of responsibility flows in the NHS today; full arrows represent explicit (upward) contractual responsibility, whereas dotted arrows represent responsibility to regulators. Bodies that are shaded brown are strategic; pink are regulatory; orange are commissioners; and blue are providers.



(Image provided by Civitas, 2009)

We recommend reading “[A Junior Doctor's Guide to the NHS](#)” (2009), recently published by the DH. It provides information for junior doctors and medical students about NHS structure and policy, an overview of the organisational units of the health service and who is responsible for them.

## **NHS Reforms**

Since being elected to power in 1997, the Labour government has introduced several policy initiatives with wide-ranging implications for the delivery of health services. The King's Fund reports, "[Health and ten years of Labour government: achievements and Challenges \(2007\)](#)" and "[Briefing on the NHS Next Stage Review Final Report \(2008\)](#)" detail the rationale of these reforms and how they have affected/are expected to affect the way the NHS is run. In brief, there have been two main foci; first on increasing competition between providers and second, following Lord Darzi's "[Next Stage Review of the NHS \(2008\)](#)", on introducing incentives (including financial) to improve quality of care.

However, since devolution in 1999, England, Northern Ireland, Scotland and Wales have followed different reform paths. These are summarised in the Health Service Journal article "[10 years on - what has devolution meant for the NHS?](#)"

"[Devolution and health policy in the UK](#)", found on pages 22-24 of this European Health Observatory bulletin, illustrates some principles of health policy analysis and evaluation in this context.

## **Our Guest Speakers**

[Julian Le Grand](#) is a Richard Titmuss Professor of Social Policy at the London School of Economics and a former senior health policy advisor to Tony Blair. His most recent research, "[Equity, waiting times and NHS reforms](#)" examines whether NHS policy changes has affected the socioeconomic profile of patients seeking elective surgery.

He is also the author of *Motivation, agency, and public policy: of knights and knaves, pawns and queens (2003)*, which discusses motivations of public sector workers and their behaviour in response to different economic incentives.

Professor Le Grand has recommended Chapters 1,2, and 4 of his most recent book, *The Other Invisible Hand (2007)* as relevant reading for the upcoming forum.

[Martin Marshall CBE](#) is Director of Clinical Quality at the Health Foundation. He was previously the Deputy Chief Medical Officer and Director General at the Department of Health with responsibility for clinical quality and safety, and medical education. With a background as a practising GP for more than 17 years, Martin has also been Head of Primary Care and Professor of General Practice at the National Primary Care Research and Development Centre, University of Manchester.

His interests include policy-related quality of care, the measurement of quality, the use of incentives and the public availability of performance indicators. He

wrote a recent editorial in the BMJ, "[Applying quality improvement approaches to healthcare.](#)"

He is a fellow of the Royal College of General Practitioners, the Royal College of Physicians and the Faculty of Public Health Medicine and has been advisor to international organisations including the Organisation for Economic Co-operation and Development (OECD) and World Health Organisation.

## References

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- **High Quality Care for All: NHS Next Stage Review Final Report.** Lord Darzi. Department of Health. 30 June 2008. Available at [[http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/DH\\_085825](http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationpolicyandguidance/DH_085825)]
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- Le Grand, Julian (2003) **Motivation, agency, and public policy: of knights and knaves, pawns and queens.** Oxford University Press, Oxford, UK. ISBN 0199266999
- Le Grand, Julian (2007) **The other invisible hand: delivering public services through choice and competition.** Princeton University

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- **Applying quality improvement approaches to healthcare.** Marshall M. BMJ 2009; 339;b3411. Available at [http://www.bmj.com/cgi/content/extract/339/sep02\_1/b3411]

Further useful links can be found at: [www.civitas.org.uk/ycfm/links.php](http://www.civitas.org.uk/ycfm/links.php).

### **Abbreviations**

DH = Department of Health

SHA = Strategic Health Authority

PCT = Primary Care Trust

NHS = National Health Service

CQC = Care Quality Commission

GMC = General Medical Council

OECD = Organisation for Economic Co-operation and Development

### **YCFM Steering Committee**

**November 2009**