Health and Care in Great Britain & Northern Ireland

What you need to know to navigate the system

FINN
PARTNERS

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How to use this guide

This guide is intended to help you get a better understanding of how the NHS works in Great Britain and Northern Ireland. We have included commentary on recent reviews carried out by Patricia Hewitt and Lord Ara Darzi as well as links to help you with further reading. We are very grateful to Andrew Reed, chief executive of the Royal College of Surgeons for his Foreword.

Foreword

The UK National Health Service – universally known as the NHS – is perhaps the best-recognised state-funded health system in the world. Founded in 1948, it is based on the principle of patient need irrespective of social or economic status and delivered free at the point of delivery. From the perspective of patients and their families it removes in an instant the fear that ill health should necessarily result in financial calamity.

I joined the NHS as a graduate management trainee in the early 1980s and was immediately presented with a management restructuring of the whole system on the grounds that it was deemed to have too many administrative layers. I was not to know at that time that this was to be the first of many reorganisations that occurred over the 30 years that I spent in NHS management. Regular concerns about affordability, productivity, accessibility and efficiency goaded successive governments from either side of the political divide into action.

Although a fully state-funded health system offering treatment entirely free-of-charge is a significant upside, there are also many downsides. Demand has spiralled exponentially as the population grows and ages. The NHS has been a victim of our economic success. Costs have increased as new treatments have been developed to tackle problems of ill health that previously had little or no known cure. Health and care providers have struggled to cope, waits for treatment have got longer and the system has become chronically overstretched.

At my point of entry to the NHS, the means of controlling demand was the waiting list: even into the 1990s it would be far from unusual for a patient to wait over two years for a hip replacement having already waited over a year for a specialist assessment. In the 2000s a system of proxy purchasers – health commissioners – was embedded, with family doctors given greater power over the management of demand on hospitals and budgets. For a time the NHS was seen as a brand, with hospitals as franchises, and government sought unsuccessfully to distance itself from the political liability of successive health scandals. More positively, the introduction of health commissioners has also ushered in a period of better data, better costing and a stronger interest in both patient safety and evidence-based medicine alongside much better clinical engagement in healthcare management.

The result is the complex system of arm's length bodies described in this document providing checks-and-balances, oversight and assurance. Satisfaction with the NHS often waxes and wanes in line with national economic prosperity. As recently as July 2024 the UK Secretary of State for Health declared the NHS "broken" and another reorganisation now seems to be in the offing. However, the NHS remains a totemic institution for the British public, arguably delivering consistently more for its national spend than many other health systems but with a perpetual anxiety about its future.

Andrew Reed
Chief Executive, Royal College of Surgeons England

Universality

How is the National Health Service (NHS) funded?

In Great Britain (England, Scotland, and Wales) and Northern Ireland, healthcare is delivered free of charge at the point of care by the National Health Service (NHS).

The health system is largely funded through general taxes and national insurance contributions, ensuring that everyone is guaranteed access to the same level of care regardless of income. According to the OECD, the NHS regularly ranks among the world's largest public health systems for spending per capita. Responsibility for health and care provision has been decentralised since 1999 when the power to administer local health systems was transferred to each individual nation. This decentralisation process was known as 'devolution'.

The devolved authorities in each nation have responsibility for organisational control and funding of the NHS systems and the provision of health services, including family planning and the prevention, treatment and alleviation of disease, illness, injury, disability, and mental disorder. The UK Government has retained responsibility for these powers in England.

How do each of the four nations in the UK raise funds?

Funding, and how it is raised, differs for each nation. In England, general taxation accounts for the vast majority of NHS funding, with some funds being raised by patient fees, such as (means-tested) charges for prescriptions and dental care. In 2022/23, income from patient fees and charges for prescriptions and dental care was £1.4 billion, or 1% of the total Department of Health and Social Care budget.

Individual NHS organisations – such as hospital trusts – can generate additional income through other means such as parking charges, land sales and treating private patients, for example.

After devolution, Scotland, Wales, and Northern Ireland all abolished prescription charges. Each administration receives an annual block grant of funding from the UK government which accounts for any changes in Government spending on devolved policy areas. It is not ring-fenced for health, so devolved administrations can decide how they spend it. Therefore, any change in spending on the NHS in England is not necessarily reflected in the health budgets of the other three nations. NHS spending per capita varies between the four nations: it is highest in Northern Ireland and lowest in England.

Who provides NHS care?

NHS England is responsible for overseeing health provision in England, setting the priorities and direction to improve health and care, commissioning health and care services, as well as contracting with GPs, dentists, and pharmacies. In July 2022, Clinical Commissioning Groups (CCGs), regional bodies responsible for funding and planning care in a particular area, were abolished and replaced by Integrated Care Systems (ICSs). ICSs bring together partnerships of organisations across health, social care, and local authorities (such as housing departments) to help plan and deliver coordinated health and social care.

Integrated Care Systems

There are 42 ICSs in England, and they have two key components:

1. Integrated Care Boards (ICBs): statutory bodies that are responsible for planning and funding most NHS services in the area
2. Integrated Care Partnerships (ICPs): statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for their area

Working through their ICB and ICP, ICSs have four key aims:

1. Improving outcomes in population health and health care
2. Tackling inequalities in outcomes, experience, and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

In Wales, there are seven local health boards and three NHS trusts; local health boards are responsible for planning and delivering NHS services in their areas.

In Scotland there are 14 health boards; each board covers a different region of Scotland and is responsible for the delivery of health and care and services to the local population.

In England, Scotland and Wales, the National Health Service (NHS) provides health care services while local councils provide social care services. In Northern Ireland these services are combined under a system known as Health and Social Care (HSC). In terms of the provision of services, Northern Ireland's Department of Health discharges this duty to the Public Health Agency and several other Health and Social Care (HSC) bodies, including five trusts.

How is care provided?

The NHS is divided into primary care, secondary care, and tertiary care. Primary care includes services such as GPs, dentists, and pharmacists, and, as the name suggests, is the first point of contact for people in need of healthcare.

Most NHS-funded primary care services are provided by practitioners who are not directly employed by the health service, but who sign a nationally agreed contract to provide services to NHS patients. There are currently just over 8,800 GP practices that hold a contract to provide NHS primary care services in England.

Secondary care can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture. Tertiary care refers to highly specialised treatment such as neurosurgery, transplants, and secure forensic mental health services.

Each year NHS providers manage 25 million attendances at the emergency department, more than 123 million outpatient appointments, and provide 68 million contacts in community services such as district nursing. They also provide specialist mental health and learning disability services for 2.7 million people.

In England, there are 215 NHS providers of urgent and planned care (also referred to as secondary care or hospital and community care). There are 154 Foundation Trusts and 75 NHS trusts. Foundation Trusts (FTs) are semi-autonomous organisations with more freedom to raise money. They are also able to operate with greater independence of central government management and oversight. FTs must demonstrate the highest clinical standards and quality of leadership while other non-NHS organisations such as charities and private health companies also provide secondary and tertiary care services. The FT model has been called into question and FTs do not exist in Scotland, Wales, or Northern Ireland.

What is the role of the private sector?

The role of the private sector within the NHS is complex and often controversial. England and Northern Ireland both have a 'purchaser/provider split', with some services either contracted out to other parts of the NHS, independent providers, not for profit organisations, or the voluntary sector. Scotland and Wales abolished this model in 2004 and 2009 respectively and therefore run all their health services directly.

Providers, NHS or independent, can bid for each contract as and when services go out to tender. Each bidder must provide evidence that they can supply quality services and value for money.

Some areas of the health service, such as GPs, dentists, pharmacists, and opticians have been provided by the private sector since the inception of the NHS in 1948. Each area of the country is different, but currently around 40% of community services are run by 1,700 non-NHS organisations which cover services such as district and community nursing, health visiting, sexual health services, some outpatient services such as dermatology, care homes and some mental health provision. One in four mental health beds in the NHS are run by independent providers. Inpatient provision for people with learning disabilities and severe mental health problems can also be provided by the private sector.

Independent providers include organisations such as HCRG Care Group, Circle Health Group (which now incorporates BMI Healthcare), Connect Health, Bupa, Capita, Medinet, Mediservices, Nuffield Health and Spire Healthcare. A more detailed list can be found here.

How are patients represented?

The following are considered key stakeholders the NHS must engage with regarding:

- The involvement of individual patients in their own care
- The involvement of users and carers in service design and evaluation
- Engaging communities and public in care prioritisation and planning

Patient engagement and representation is built in at national and local levels and across both primary and secondary care.

Healthwatch England

Healthwatch England is a statutory committee of the independent regulator the Care Quality Commission and a health and social care champion to anyone in England who accesses GPs and hospitals, dentists, pharmacies, care homes or other support services. It:

- Provides leadership, guidance, support, and advice to local Healthwatch organisations;
- Escalates concerns about health and social care services raised by local Healthwatch to CQC;
- Provides advice to the Secretary of State for Health and Social Care, NHS England, and English local authorities, especially when it believes that the quality of services provided are not adequate.

Local Healthwatch

Healthwatch England and local Healthwatch work together to share information, expertise, and learning to improve health and social care services in England. Across England, there are 151 local Healthwatch services, which are funded by and accountable to local authorities. In Scotland, Wales, and Northern Ireland, only the national bodies oversee the work carried out by clinics, hospitals, and care homes etc.

Primary care patient representation

National Association for Patient Participation (NAPP)

The National Association for Patient Participation is a UK-wide champion of the patient voice in health issues, policy development and academic research. The charity operates predominantly in England and Wales. In Scotland and Northern Ireland the charity depends on local volunteers. There are no participants in Northern Ireland but there are volunteers in Scotland.

Patient Participation Groups (PPGs)

A Patient Participation Group (PPG) is a group of patients, carers and GP practice staff who meet to discuss practice issues and patient experience to help improve the service. It is a contractual requirement of NHS England for all GP practices to have a PPG and to make reasonable efforts for this to be representative of the practice population.

These groups are active in Northern Ireland, and various Welsh and Scottish GPs offer this service.

Secondary care patient representation

PALS (Patient Advice & Liaison Service)

Every NHS secondary care (acute) provider has a Patient Advice and Liaison Service (PALS) to offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families, and their careers.

Regulation and approval

Medicines and Healthcare products Regulatory Agency (MHRA)
The Medicines and Healthcare products Regulatory Agency is an executive agency, sponsored by the DHSC. The MHRA regulates medicines, medical devices, and blood components for transfusion in the UK. It is recognised globally as an authority in its field and plays a leading role in protecting and improving public health by supporting innovation through scientific research and development. It is responsible for:

- **ensuring that medicines, medical devices and blood components** for transfusion meet applicable standards of safety, quality and efficacy;
- **ensuring that supply chains** are safe and secure;
- **promoting international standardisation** and harmonisation to assure the effectiveness and safety of biological medicines;
- **helping to educate the nation** and health professionals about the risks and benefits of medicines, medical devices and blood components, leading to safer and more effective use;
- **supporting innovation** and research that's beneficial to public health;
- **influencing UK, EU and international regulatory frameworks** so that they're risk-proportionate and effective at protecting public health.

Manufacturers seeking to introduce new devices and medicines to markets in Scotland and Wales must also get approval from the MHRA. The rules are different for Northern Ireland, approval must come from the European Union Medical Device Regulation (EU MDR) and In Vitro Diagnostic Regulation (IVDR).

Since Brexit, the MHRA no longer bases its decisions on the findings of the European Medicines Agency (CHMP) alone. It has developed its own International Recognition Procedure which means that its decisions can take into account approvals in other countries such as the Unites States, Canada and Japan amongst others.

National Institute for Health and Care Excellence (NICE)

The National Institute for Health and Care Excellence evaluates new health technologies for NHS use, considering clinical effectiveness and value for money. It also produces useful and usable guidance, helping health and care practitioners deliver the best care. Reducing health inequalities is one of its core principles; its guidance supports strategies that improve population health while offering particular benefits to the most disadvantaged.

Its role is to improve outcomes for people using the NHS and other public health and social care services. It does this by:

- **producing evidence-based guidance** and advice for health and social care practitioners;
- **developing quality standards** and performance metrics for those providing and commissioning health, public health and social care services;
- **providing a range of information services** for commissioners, practitioners and managers across health and social care.

Arms-Length Bodies (ALBs)

NHS England (NHSE) is overseen by the Department of Health and Social Care (DHSC), the UK Government department responsible for policy on health and adult social care matters in England. The department develops guidelines to improve the quality of care and to meet patient expectations. Alongside NHSE, it carries out some of its work through agencies and partner organisations known as Arms-Length Bodies (ALBs).

In Scotland, the equivalent is Healthcare Improvement Scotland, the Welsh equivalent is Health Education and Improvement Wales (HEIW), in Northern Ireland it is the Regulation and Quality Improvement Authority (RQIA) - see below.

Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator of health and adult social care in England. It registers, monitors, and regulates services to ensure health and social care services provide people with safe, effective, compassionate, high-quality care. The CQC publishes its findings in inspection reports and gives a performance rating (Inadequate, Requires Improvement, Good or Outstanding). Where it finds poor care, it has the power to place a provider in special measures, where it closely supervises the quality of care while working with other organisations to help them improve within set timescales.

The Scottish equivalent of the CQC is the Care Inspectorate and services aren't allowed to operate unless they are registered with it. Hospitals and hospices are regulated by Healthcare Improvement Scotland.

In Wales, Healthcare Inspectorate Wales inspects NHS services and regulates independent health providers against a range of standards, policies, guidance, and regulations to highlight areas requiring improvement.

In Northern Ireland, services are regulated by the Regulation and Quality Improvement Authority.

UK Health Security Agency (UKHSA)

The UK Health Security Agency is an executive agency, sponsored by the DHSC. It was established on 1 October 2021, following the disbanding of Public Health England (PHE). It took on PHE's health protection functions and is responsible for protecting the UK from the impact of infectious diseases, chemical, biological, radiological, and nuclear incidents and other health threats.

Health Education England (HEE)

HEE merged with NHS England in 2023. The Scottish counterpart is NHS Education for Scotland (NES), the Welsh comparable is Health Education and Improvement Wales (HEIW) and the Northern Ireland equivalent is the Northern Ireland Medical & Dental Training Agency.

Health Research Authority (HRA)

The Health Research Authority (HRA) is an executive non-departmental public body, sponsored by the DHSC. The HRA exists to provide a unified national system for the governance of health research which protects and promotes the interests of patients. It does this by:

- **Ensuring that researc**h is ethically reviewed and approved;
- **Promoting transparency** in research;
- **Overseeing a range of committees and services**
- **Coordinating and standardising** research regulatory practice
- **Providing independent recommendations** on the processing of identifiable patient information where it is not always practical to obtain consent, for research and non-research projects.

The HRA only applies to the NHS in England and Wales, there is no equivalent in Scotland or Northern Ireland.

NHS Blood and Transplant (NHSBT)

NHS Blood and Transplant is a special health authority, sponsored by the DHSC, which provides a blood and transplantation service to the NHS, looking after blood donation services in England and transplant services across the UK. This includes managing the donation, storage and transplantation of blood, organs, tissues, bone marrow and stem cells, and researching new treatments and processes.

The Scottish equivalent is the Scottish National Blood Transfusion Service (SNBTS); the Welsh comparable is the All Wales Blood Service (AWBS), and in Northern Ireland it is the Northern Ireland Blood Transfusion Service (NIBTS).

NHS Business Services Authority (NHSBSA)

The NHS Business Services Authority is a special health authority, sponsored by the DHSC. It provides a range of critical central services to NHS organisations, NHS contractors, patients, and the public, which facilitate the day to day running of the NHS and its priorities.

These services are grouped into three operational areas:

- Platforms and services provided to the NHS to best support its people
- Services provided to support essential primary care functions
- Services direct to the public to enable citizens to gain access to health and help with health costs to which they are entitled

NHS Resolution (NHS Litigation Authority)

NHS Resolution is a special health authority, sponsored by the DHSC. Its purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care.

Its main functions are:

- **Claims management:** dealing with compensation claims on behalf of NHE
- **Practitioner performance advice:** managing concerns raised about the performance of doctors, dentists and pharmacists
- **Primary care appeals:** dealing with appeals and disputes between primary care contractors and NHSE
- **Safety and learning:** helping providers of NHS care to understand their own claims to target safety activity and share learning across the health service nationwide.

Human Tissue Authority (HTA)

The Human Tissue Authority is an executive non-departmental public body, sponsored by the DHSC. The HTA ensures that human tissue is used ethically- with proper consent. It regulates organisations that remove, store and use tissue for research, medical treatment, post-mortem examination, teaching and display in public. It approves organ and bone marrow donations from living people.

NHS Counter Fraud Authority (NHSCFA)

The NHS Counter Fraud Authority is a special health authority, sponsored by the DHSC. The NHSCFA identifies, investigates, and prevents fraud and other economic crime within the NHS. It uses information from a wide range of sources to build a better understanding of risks faced by the NHS and develops proportionate solutions to tackle fraud. It is independent from other NHS bodies but is directly accountable to the DHSC.

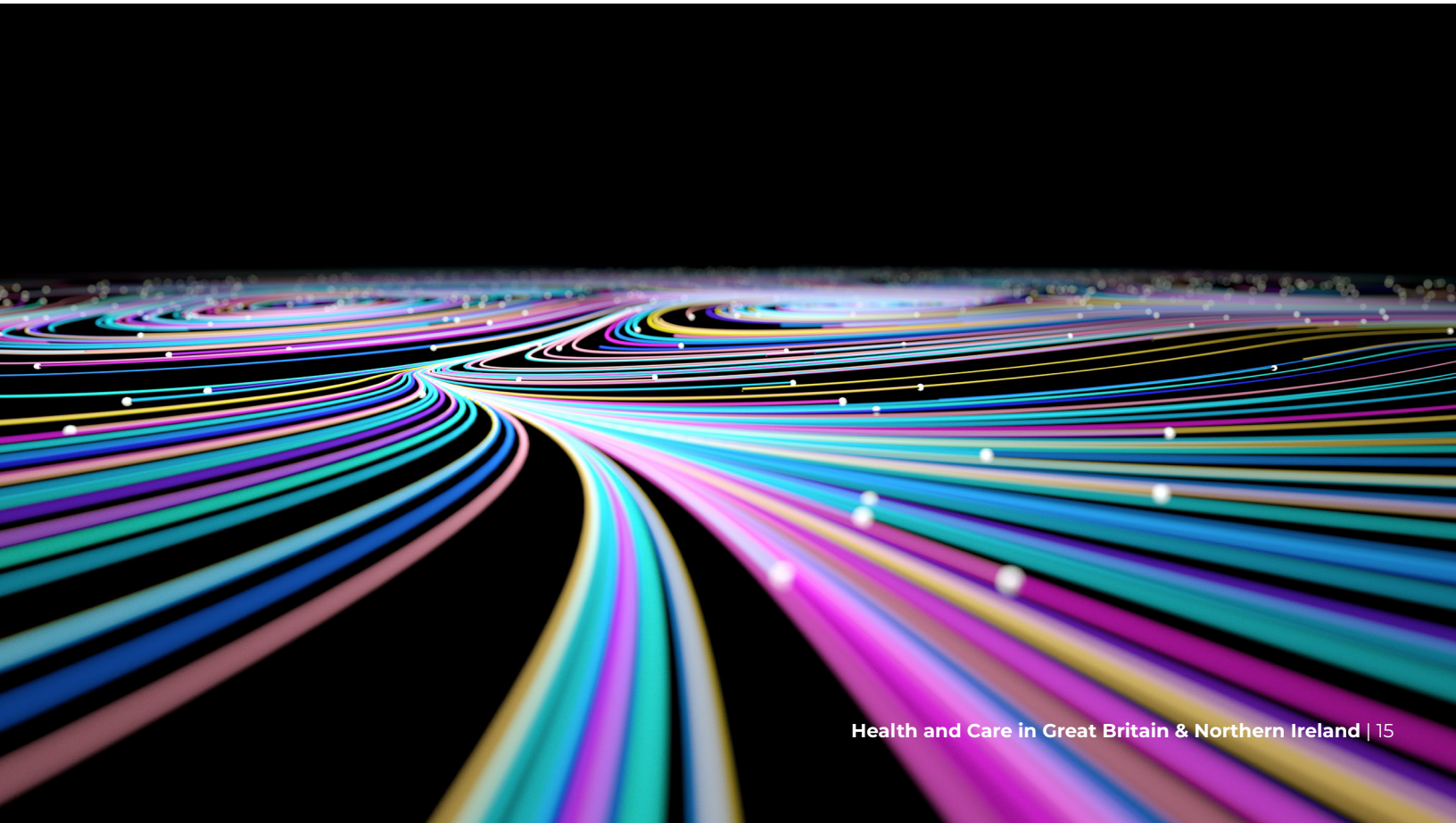
The path to digital in the NHS

Digital transformation is taking place alongside competing pressures on the NHS. Pressures on the workforce, the need to reduce care backlogs contribute to 'crowding out' digital transformation as a priority.

At present only 20% of NHS organisations are digitally mature according to NHS England's 2023 Digital Maturity Assessment, although 86% have a form of electronic patient record in place, although this figure is the subject of much speculation. In England, the Plan for Digital Health and Social Care sets out a vision for a digitally enabled health and social care system and how the NHS will achieve it, it collates existing digital strategies, plans and guidance into one single action plan.

The House of Commons committee produced a report in 2023 setting out the advances to date and steps that remain to quicken the pace of digital transformation in the NHS. Though the government previously stated that all NHS hospital trusts should have electronic patient records by the end of 2025, the target was declared unachievable by the Infrastructure and Projects Authority in July 2023.

Most primary care GP patient record systems are provided by two companies: EMIS and TPP. In 2022 NHS England announced funding for a Technology Innovation Framework (TIF) to enable GPs practices to buy new GP clinical systems. The aim is to provide a greater choice for GP practices. In 2024, the government announced a doubled investment in digital transformation over previous levels: £3.4 billion over the three years to 2028/29.



The Hewitt Review

Over a year has passed since the government's formal response to Patricia Hewitt's review of integrated care systems (ICSs), which focused on enhancing autonomy and accountability within these relative new systems. The review's proposals have garnered strong support from ICS leaders and national partners, who view them as crucial for improving population health, reducing health inequalities, enhancing patient care, and maximising value for money. Key strategies highlighted include greater integration, devolution of powers, digitisation, and a shift in resources toward preventive care to ensure the long-term sustainability of the NHS.

However, with only two years into the statutory governance arrangements established by the Health and Care Act 2022, the implementation of these changes remains in its early stages. The review emphasises that legal changes alone are insufficient to bring about the desired shifts in services, behaviours, and collaborative working practices across systems. ICSs need time, structural stability, and continued support to successfully deliver the reforms outlined.

Some progress has been made towards aligning with the principles of the Hewitt review, including the embedding of accountability measures in system oversight and the creation of a national Integrated Care Partnership (ICP) forum to foster cross-government collaboration. Additionally, initial steps have been taken to reallocate resources towards preventive services. However, the pace of implementing many critical recommendations has been slow, particularly in areas like data streamlining, reducing the burden of top-down management, and improving financial efficiency by minimising the reliance on small, in-year funding allocations.

The slow progress is attributed to short-term political pressures and a climate that often prioritises immediate concerns over long-term health outcomes. As a result, many of the review's recommendations, which are designed to drive significant improvements in NHS productivity and care quality, have yet to be fully realised.

Despite the change in government following the 2024 UK general election, ICS leaders continue to view the Hewitt review as a vital blueprint for reform. They urge the new Labour government to adopt and advance the recommendations to create the conditions necessary for ICSs to effectively reform public services and deliver the best possible care for patients.

The review points out that while the Health and Care Act 2022 provided the statutory framework for ICSs, true transformation requires a cultural shift in behaviours and attitudes, which cannot be achieved through legislation alone. The Department of Health and Social Care (DHSC) and NHS England, in collaboration with partners like the NHS Confederation and the Local Government Association (LGA), have developed various guidance and policies to support this transformation, but more work is needed.

The Darzi Review and 10-Year Health Plan

The change of government after the 2024 UK general election created an opportunity to draw a line under a period where public satisfaction with the health service has been at record lows, according to national surveys.

One of the new Labour government's first actions was to commission Lord Ara Darzi, a respected surgeon and former health minister, to conduct a review into the current state of the NHS. The investigation's findings were stark. It concluded that the service is facing an unprecedented crisis, seen in 'ballooning' waiting lists, deteriorating quality of care in certain areas and increased pressure on health staff.

Despite the scale of the challenges faced, the report notes that once patients do 'enter the system' and receive treatment, the quality of care they receive remains generally of high quality. It goes on to conclude that while the NHS is in critical condition, its vital signs remain strong. Lord Darzi puts forward a series of recommendations for reform to pull the system out of its current dire situation.

These recommendations have informed the major themes for the forthcoming 10-year plan for health and care. The UK government's intent is to put forward a programme of radical change to improve patients' experience of care and to reform the health and social care system to make it fit for the future.

The government has yet to outline a detailed strategy. While it is consulting with the public, clinicians and experts to inform its plans ahead of publication in Spring 2025, it has already signalled its approach to change in three key principles: Shifting parts of care out of hospital and closer to patient's homes and communities; harnessing technology, including the adoption of a single digital health record; and an increased focus on preventing ill health before it happens.

Endnote

As Andrew Reed highlights in his Foreword, navigating the NHS in Great Britain and Northern Ireland is complex. It is a publicly funded health system with care provided by many different layers, from primary care to hospital care and community services. The challenge for any government is to ensure the NHS provides the best value for the public purse, but at the same time uses the latest advances in medicines and technology for the benefit of those who need them free at the point of care. This sees governments often champion large-scale initiatives such as system reorganisations and IT overhauls like the National Programme for IT which was estimated to have cost the taxpayer £9.8 billion before it was abandoned.

However, advances in treatment are often inspired and brought to fruition by frontline clinical staff who see where change and improvements can be made. Examples of success are not hard to find, but it is significantly harder to share these ideas and embed change throughout the NHS.

From the outside, understanding the structures and roles of organisations involved in NHS provision takes time and requires effort. That is why we have put together this short guide to help in this process. There are many links within for further reading and as developments inevitably shift the landscape, we will issue updated versions of this publication.

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