



BRIEFING PAPER

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The structure of the NHS in England

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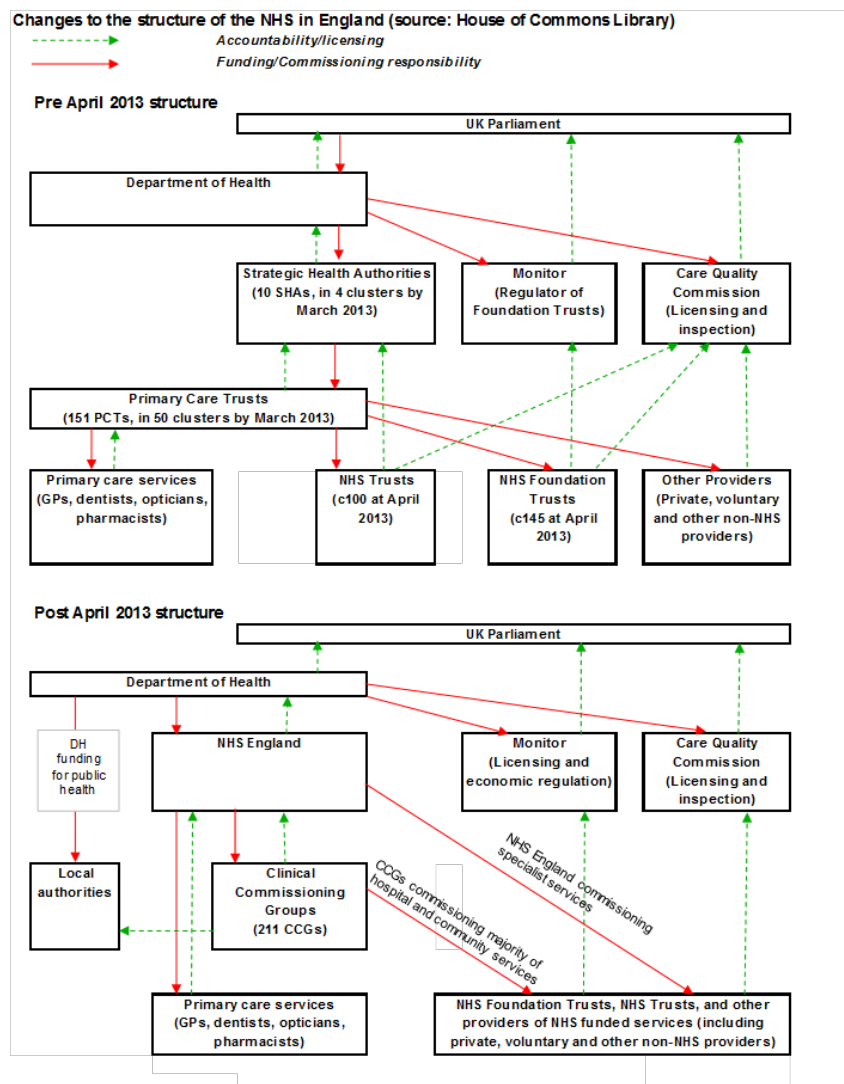
Summary

Major reforms to the structure of the health service in England were introduced by the *Health and Social Care Act 2012*, with many provisions under the Act coming into force on 1 April 2013. This Library briefing provides an overview of the funding and accountability relationships under the new system, and an introduction to the roles of key organisations, including:

- NHS England and Clinical Commissioning Groups (CCGs)
- Monitor and the Care Quality Commission (CQC) and the regulation of health services
- Public Health England and local authorities' public health duties
- Health and Wellbeing Boards and the co-ordination of health and social care services
- The National Institute for Health and Care Excellence (NICE) and access to treatment

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

Below is a simplified diagram showing the pre- and post-reform structure of the NHS in England.



This briefing also highlights some of the key health policy issues for the current Parliament, including patient safety, funding, and the integration of health and social care. The House of Commons Library's Key Issues for the 2015 Parliament also contains sections on [NHS funding and productivity](#) and on [integrating health and social care](#).

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

1. Background

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

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

- NHS England and Clinical Commissioning Groups (CCGs) took on statutory responsibility for commissioning health services;
- local authorities took on new public health responsibilities;
- local Healthwatch organisations came into being;
- and strategic health authorities and primary care trusts were formally abolished.

Part 3 of the *Care Act 2014* also established Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental bodies (NDPBs). This was intended to strengthen the independence of the two recently created bodies, which lead national systems for the education and training of health care professionals, and regulate health and social care research respectively.¹

1.1 Funding

Funding for health services comes from the total budget for the Department of Health (DH). In 2015/16 the total allocated budget for the DH is £115 billion for England.² The majority of this budget (£100.6 billion) was transferred to NHS England with the remainder divided between DH's other agencies and programmes, including funding for Public Health England, and Arm's Length Bodies like the Care Quality Commission, Monitor and NICE.

NHS England's budget is used to deliver its [mandate](#) from the DH.³ NHS England is responsible for allocating resources to local commissioners of health services: clinical commissioning groups (CCGs) and local authorities. Most of the commissioning resource allocations go to CCGs, £69.2 billion in 2015/16. NHS England also directly commissions certain services on a national level for which it has a budget of £29.7 billion in 2015/16, covering specialised services, primary care and military and offender services. The remainder of NHS England's budget is spent on centrally administered projects and services, including its public health

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

² [HM Treasury, Public Expenditure Statistical Analyses 2014, Table 1.10](#)

³ DH, [A mandate from the Government to NHS England: April 2015 to March 2016](#), December 2014

responsibilities on behalf of Public Health England, which broadly comprise immunisation, screening and health visiting.⁴

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

2015/16 Health Budgets

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

* budget includes social care funding

Sources:

[HM Treasury: Public expenditure statistical analyses 2014, Table 1.10](#)

[Scottish Government: Scotland's draft budget 2015/16](#)

[Welsh Government: Welsh Budget 2015/16](#)

[Northern Ireland Executive: Draft Budget 2015/16](#)

[ONS Mid-2013 population estimates](#)

⁴ [NHS England Business Plan 2015/16](#)

2. Commissioning

The Department of Health has defined commissioning as:

The process of ensuring that the health and care services provided effectively meet the needs of the population.⁵

Commissioning is seen as a key means of helping achieve a wide range of policy objectives in the NHS, including improving the safety and quality of services; creating better value for money and wider patient choice; and reducing inequalities in health. Such objectives are partly achieved through allocating resources 'fairly' among the population. How the resources are divided among the population is determined by a resource allocation funding formula.

Library briefings [Clinical Commissioning Group \(CCG\) Funding](#) and [NHS commissioning](#) contain more information on the commissioning of NHS services.

2.1 Clinical Commissioning Groups

On 1 April 2013, 212 [Clinical Commissioning Groups](#) (CCGs) took on statutory responsibilities for commissioning the majority of NHS services, including⁶:

- Urgent and emergency care (for example, A&E);
- Elective hospital care (for example, outpatient services and elective surgery);
- Community health services (for example community mental health services and health visiting).⁷

The NHS's *Five Year Forward View* (October 2014) states that it intends progressively to offer CCGs more influence over the total NHS budget for their local populations, including greater responsibility for commissioning primary care and specialised services (See boxes 3 and 4).

The *Health and Social Care Act 2012* sets out the functions, duties, and governance structures for CCGs. The Act makes CCGs directly responsible for commissioning NHS services they consider appropriate to meet reasonable local needs.⁸ In assessing local needs and developing commissioning plans to meet them, CCGs must work with the new local authority Health and Wellbeing Boards. In addition, [Strategic Clinical Networks](#), hosted by NHS England, provide advice to CCGs on

⁵ DH, [commissioning](#), webpage archived on 6 May 2010

⁶ The number of CCGs has subsequently reduced to 209 through a number of mergers.

⁷ NHS England has published a document, [The functions of clinical commissioning groups](#) (March 2013), which sets out the range of core CCG functions as set out in legislation. NHS England has also produced a [factsheet](#) explaining the services that are commissioned by CCGs. Further information and guidance is provided by the [CCG Learning Network](#).

⁸ However, CCGs can buy in support from external organisations including the NHS commissioning support services and private and voluntary sector bodies, although responsibility for commissioning decisions remains with the CCG. The detailed strategy is set out in [Developing Commissioning Support: Towards Service Excellence](#), February 2012.

single areas of care that they must have regard to. New [Clinical Senates](#), based in twelve areas of England, provide multi-professional advice.⁹ Some of the back-office administrative functions of CCGs are provided by [regional Commissioning Support Units](#).¹⁰

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

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

NHS England keeps CCG authorisation conditions under review to ensure they continue to fulfil the duties and governance arrangements required under the *2012 Act*.¹¹

Box 1: From GP consortia to clinical commissioning

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

Provisions establishing GP commissioning consortia were included in the *Health and Social Care Bill* introduced in January 2011. Following recommendations from the Government-established NHS Future Forum that there should be wider clinical involvement in commissioning the Government introduced amendments to the Bill to specify that commissioning consortia governing bodies must include at least one nurse and one specialist doctor. As a result of these changes it was announced that GP commissioning consortia would be known as Clinical Commissioning Groups (CCGs).¹²

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

In May 2014 the Chief Executive of NHS England, Simon Stevens, invited CCGs to take an increased role in the commissioning of primary care services and in November 2014 a CCG/NHS England co-commissioning programme group published [Next steps towards primary care co-commissioning](#).

⁹ NHS Commissioning Board, *Clinical Senates update*, <http://www.england.nhs.uk/wp-content/uploads/2013/01/cs-update.pdf>. Page 5 of the document contains a map showing the geographical area covered by each Clinical Senate.

¹⁰ NHS Commissioning Board, *Commissioning support: Key facts*, <http://www.england.nhs.uk/wp-content/uploads/2012/11/csu-fact-oct.pdf>

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

¹² The Library note, [NHS Commissioning](#), contains information on how commissioning within the health service in England had been organised prior to the *Health and Social Care Act 2012* reforms.

2.2 NHS England

NHS England is responsible for:

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

While CCGs now commission the majority of NHS services, including most hospital services, NHS England [commissions directly](#) certain services at a national or regional level such as primary care services (including GP services) and specialist services (see box 3). It also directly commissions services for the armed forces and for offenders.

Box 5: Specialised services

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. Specialised services account for approximately 14% of the total NHS budget for England.

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

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

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

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

NHS England is also the body responsible for ensuring that there is an effective and comprehensive system of CCGs. NHS England also provides national leadership on commissioning and allocates funding.¹³ It has a duty to publish commissioning guidance, to which CCGs must have regard, and will use the [Commissioning Outcomes Framework](#) to assess the performance of CCGs. CCGs are ultimately accountable to NHS England for their performance and under the *Health and Social Care Act 2012*, NHS England has powers to direct a CCG to discharge

¹³ NHS England allocates funding to NHS Trusts and NHS Foundation Trusts and providers of primary care and other services as well as CCGs.

its functions in a particular way (but only when satisfied that a CCG has failed to discharge any of its functions).

2.3 Duties of CCGs and NHS England

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

- promoting the [NHS Constitution](#);
- securing continuous improvements in the quality of services commissioned;
- reducing inequalities;
- enabling choice and promoting patient involvement;
- securing integration; and
- promoting innovation and research.¹⁴

Further information about the commissioning of GP services by NHS England can be found in the Library briefing, *GP services in England*. Links to information on individual CCGs and contact details for NHS England can be found in the further information section at the end of this note.

¹⁴ A number of these duties are the result of amendments to the legislation made in response to recommendations of the NHS Future Forum made in June 2011.

3. Access to treatment

3.1 NICE

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

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

NICE has also published around 180 [Quality Standards](#), covering the main conditions and diseases, to provide a definition of what high-quality health and social care should look like. These standards play a key role in the development of the Commissioning Outcomes Framework, which measures the health outcomes and quality of care achieved by CCGs. The *Health and Social Act 2012* requires NHS England and CCGs to have due regard to these quality standards as they fulfil their duties.

Box 2: Patient rights, waiting times, choice and the NHS Constitution

The *NHS Constitution* sets out a number of patients' rights, including a right to a maximum 18-week waiting time from referral to consultant-led treatment. The 2010 Government introduced the first maximum waiting times for mental health treatment which apply from April 2015. There are plans to roll out access and waiting time standards to all mental health services by 2020.

Patients have a right to choose their provider and their consultant-led team care when they are referred for their first outpatient appointment with a service led by a consultant. These rights were for the first time extended to mental health services in April 2014, to embed parity of esteem and bring patients' rights in mental health in line with those for physical health.

To further strengthen patient choice, a legal right to have a personal health budget was introduced for adults receiving NHS Continuing Healthcare and children and young people receiving Continuing Care in October 2014. The *NHS Mandate* also provided for CCG's to further roll out personal health budgets to individuals who could benefit from April 2015.

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

3.2 The Cancer Drugs Fund

The [Cancer Drugs Fund](#) (CDF) was introduced in England in 2010 to enable patients to access drugs that would not usually be available on the NHS. In its first year (2010/11) the Department of Health allocated £50 million to the CDF, and subsequently it was provided with £200 million a year in 2011/12 and 2012/13.

The Government has announced funding for the CDF until 2015/16 and on 28 August 2014 it announced the Fund would receive an additional £80 million, making a total of £280 million in each of the two years 2014/15 and 2015/16.¹⁵

On 12 January 2015 NHS England announced that the NHS will increase the budget for the cancer drugs fund to £340 million in 2015/16.¹⁶

There is a single, national list of drugs and indications that the CDF will routinely fund and standard operating procedures for administration of the fund. The list of drugs and indications was compiled by NHS England Clinical Reference Group (CRG) for Chemotherapy and it continues to play a key role in the management of the CDF through the national CDF panel, a sub-group of the CRG. The chair makes recommendations to NHS England as to how the list should be developed and the group has adopted a formal process of horizon-scanning for new treatments which could have potential benefits for specific groups (cohorts) of patients.

In October 2014 NHS England carried out a four week [consultation](#) on proposed changes to the CDF. The proposed changes were [outlined on the consultation pages](#):

- Implementation of a re-evaluation process to assess the drugs on the current national list, and remove those which represent the lowest levels of clinical benefit;
- Inclusion into this re-evaluation system of a confidential element which assesses the average cost of a drug per patient in relation to the clinical benefit delivered; and
- Inclusion of an option which enables pharmaceutical companies to make adjustments to drug prices, in order to allow their drug/indication to remain on the CDF list.

NHS England has carried out a number of reviews of the drugs included in the Fund; as a result of these reviews, a number of drugs have been removed from the approved list. NHS has published [decision summaries](#) for the drugs that were reviewed.¹⁷

On 19 November 2015 NHS England and NICE launched a 12-week consultation on [proposals for a new CDF operating model, to be introduced from April 2016](#) (with a target to complete the full transition by the end of March 2017).

The CDF currently funds cancer drugs in England that are not approved by NICE and the consultation document outlines a new system that would instead be integrated into the NICE appraisal process. Under the proposed model, the CDF would become a transitional fund that would only pay for new drugs in advance of NICE carrying out a full assessment of whether the drugs should be recommended for routine commissioning. NHS England considers that this would provide time for further 'real world' evidence to be collected to support the NICE

¹⁵ [DH press release, 28 August 2014](#)

¹⁶ NHS England, [NHS increases budget for cancer drugs fund from £280 million in 2014/15 to an expected £340 million in 2015/16](#), 12 January 2015

¹⁷ See also [Cuts to cancer treatments announced](#), BBC, 12 January 2015

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appraisal process. The consultation document provides the following summary:

The proposal is that the CDF should become a 'managed access' fund for new cancer drugs, with clear entry and exit criteria. It would be used to enable access to those drugs which appear promising but where NICE indicates that there is insufficient evidence to support a recommendation for routine commissioning. These drugs would be given a conditional recommendation by NICE and their use enabled by the CDF for a pre-determined period whilst further evidence is collected. At the end of this period the drug would go through a short NICE appraisal, using this additional evidence. It would attract either a NICE positive recommendation, at which point it would move out of the CDF into routine commissioning, or a NICE negative recommendation, at which point it would move out of the CDF and become available only on the basis of individual patient funding requests. This approach will enable the money in the CDF to be more effectively managed, as well as providing a new pathway for innovative drugs to be assessed and made available to patients.¹⁸

NHS England note that its proposals are in line with the recommendation of the independent Cancer Taskforce report, which proposed that the new CDF should operate with NHS England and NICE.¹⁹

An independent review of access to innovative treatments (the [Accelerated Access Review](#) or AAR) is also currently underway. The aim of this review is to identify options for speeding up access to transformative innovative drugs, devices and diagnostics for NHS patients. NHS England note that its proposals for the new CDF are consistent with the emerging conclusions of the AAR.

¹⁸ NHS England, NICE, [Consultation on proposals for a new Cancer Drugs Fund Operating Model from 1 April 2016](#), (November 2015)

¹⁹ Independent Cancer Taskforce, [Achieving world-class cancer outcomes – a strategy for England 2015–2020](#) (July 2015)

4. Regulation and accountability

4.1 Monitor

Monitor, previously the independent regulator of Foundation Trusts, is the new sector regulator for health services in England. Monitor has the power to set and enforce a framework of rules for providers and commissioners; implemented in part through licences issued to NHS-funded providers. Monitor works alongside the quality and safety regulator, the Care Quality Commission (CQC), to take remedial action when CQC reports that a hospital trust is failing to provide good quality care.²⁰

Monitor is also responsible for setting prices for NHS-funded services alongside NHS England, tackling anti-competitive practices, helping commissioners ensure that essential local services continue if providers get into financial difficulty, and enabling better integration of care.

Monitor is also continuing its initial role ensuring NHS foundation trusts are well-led and financially sustainable.

The [Monitor website](#) provides more detailed information on its responsibilities.

Box 3: Foundation Trusts

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

4.1 The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator for quality in health and social care in England (including private providers). It registers and inspects hospitals, care homes, GP surgeries, dental practices and other healthcare services. It publishes ratings of each trust and its core services. If services are not meeting fundamental standards of quality and safety, CQC has powers to issue warnings, restrict services, issue a fixed penalty notice, suspend or cancel registration, or prosecute the provider.

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

4.2 The NHS Trust Development Authority

The role of the NHS Trust Development Authority is to oversee the performance of NHS trusts. The key functions include:

²⁰ Monitor, [About Monitor: an introduction to our role](#), 28 August 2013

- Assurance of clinical quality, governance and risk in NHS Trusts
- Supporting the transition of NHS Trusts to Foundation Trust status
- Appointments to NHS Trusts of chairs and non-executive members where the Secretary of State has a power to appoint.

Box 6: How the regulators work together to address serious failures in care

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

CQC, Monitor and the NHS Trust Development Authority (TDA) also work together to take regulatory action where NHS trusts and foundation trusts have serious failures in quality of care. A number of hospital trusts have since been placed into special measures by Monitor and the NHS TDA, following advice from the CQC.

In July 2015 the Government announced that Monitor and the TDA will operate under the name 'NHS Improvement' with a single chief executive, who is expected to be in place by the end of September 2015.

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

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

In addition, Monitor and the NHS TDA review the leadership of trusts in special measures and, if necessary, use their powers to ensure trusts have the right leadership in place.

CQC, Monitor and the TDA have published further details in [A guide to special measures.](#)'

4.3 The Secretary of State for Health

One of the aims of the 2010 Government's health reforms was to end political interference in the NHS. Under the 2012 Act the Secretary of State sets the strategic direction for the NHS in England through the [Mandate to NHS England](#) and the [NHS Outcomes Framework](#).²¹

The Secretary of State also sets the overall budget for NHS England, which does the same for CCGs.²² NHS England holds CCGs to account for their financial management. The Chief Executive of NHS England, as Accounting Officer, is accountable both to the Department of Health and to Parliament. In the last resort, the Secretary of State also has powers to intervene where he considers that NHS England or any other NHS body is failing to discharge its functions.

²¹ DH, [NHS Outcomes Framework](#), December 2014

²² The Secretary of State also sets an overall limit on the amount that can be spent on administrative costs in the system.

4.4 The Health Select Committee

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

5. Competition and non-NHS providers

Part 3 of the *Health and Social Care Act 2012* creates a framework for choice and competition in the provision of NHS services. In particular, the 2012 Act allows the DH to set regulations giving Monitor, as the new economic regulator for the NHS, the power to investigate and remedy anti-competitive behaviour by clinical commissioning groups or NHS England. Regulations on competition and procurement have been introduced under Section 75 of the 2012 Act (and sometimes known as section 75 regulations).

The Government has said clinical commissioning groups will decide when to use competitive tendering as a means of improving NHS services. However, there have been concerns that commissioners are unclear about when to put services out to competitive tender and that more NHS contracts are being awarded to private companies now than was previously the case.²³ In particular, it has been alleged that the *Health and Social Care Act 2012* has extended competition law to the NHS and led to greater private sector involvement.²⁴ The 2010 Government responded that their reforms do not extend pre-existing competition and procurement rules but rather create a framework within which competition can operate on the basis of quality, not price.²⁵ See the further information section at the end of this note for links to reports analysing the impact of NHS competition and choice policies.

Box 4: Background to competition law in the NHS

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

There had been some contracting out of support services, such as cleaning and catering, during the 1980s but the first major reforms to introduce competition to the NHS came in 1991 with the first internal market reforms and the introduction of NHS trusts and the “purchaser-provider split” (the term commissioner is now preferred to purchaser). From 2002, a number of policies were introduced to strengthen the role of competition and patient choice within the NHS and NHS spending on non NHS providers in England grew steadily from around 3% in 2002/03 to 9% in 2014/15.²⁶

²³ “NHS contracts 'going to private firms'”, *Health Service Journal*, 16 January 2014; “Is the great NHS sell-off under way?”, *BMJ*, 29 April 2014

²⁴ “Labour calls for freeze on NHS contracts with the private sector until after general election”, *BMJ*, 30 July 2014

²⁵ The key provisions of the 2012 Act are set out in a Department of Health factsheet on [choice and competition](#).

²⁶ [Source: DH Annual Report 2014/15](#). Around £10 billion of the total NHS budget in England is spent on care from non-NHS providers, around 9% of total NHS expenditure. See DH Accounts 2002/03 onwards and DH data presented in Nuffield Trust, *Into the red – The state of NHS finances* (2014). The DH figure for spending on independent providers as a percentage of total NHS revenue is 6.3% in 2014/15, up from 4.4% in 2009/10. This refers only to NHS spending on independent/private

6. Public health services

6.1 Public health and local government

The *Health and Social Care Act 2012* transferred responsibility for the provision of a range of public health services from the NHS to local authorities; the first time councils have had a statutory role in the provision of healthcare since 1973.²⁷

The Government said in its 2010 White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, that tackling health inequalities and improving health and wellbeing would be driven by local government and local communities.²⁸ The White Paper was responding to the *Marmot Review* of health inequalities, commissioned in 2008 by the previous Labour Government.²⁹

From 1 April 2013 upper-tier and unitary authorities have new responsibilities to improve the health of their populations, backed by a ring-fenced grant.³⁰

Local authorities' public health duties are carried out by local Directors of Public Health. A list of current Directors of Public Health by area is maintained on the [Government website](#).

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

Further information on the new statutory responsibilities for public health services are set out in Library note [Local authorities' public health responsibilities \(England\)](#) (SN06844). In March 2013 the Communities and Local Government Select Committee published a report on [The role of local authorities in health issues](#), (HC 694, Eighth Report of Session 2012-13).

sector providers, whereas the 9% figure encompasses all non-NHS providers of care; including those from the independent sector, voluntary sector and local authorities.

²⁷ *The National Health Service Reorganisation Act 1973* transferred responsibility for community services (with the exception of environmental health) from local authorities to the NHS. The *Local Government Act 2000* gave local authorities a statutory responsibility to improve the economic, social and environmental circumstances in their area; the *Health Act 2001* also gave councils health scrutiny powers.

²⁸ HM Government, *Healthy Lives, Healthy People: Our Strategy for Public Health in England*, CM7985, November 2010, p4

²⁹ The Marmot Review, *Fair Society Healthy Lives: Strategic Review of Health Inequalities in England post 2010*, February 2010 and DH, [The new public health role of local authorities](#), October 2012

³⁰ The Department of Health has allocated a ring-fenced public health budget to local authorities of £2.7 billion and £2.8 billion for 2013-14 and 2014-15.

6.2 Public Health England and directly commissioned services

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

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

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

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

- tackling obesity particularly among children
- reducing smoking and stopping children starting
- reducing harmful drinking and alcohol-related hospital admissions
- ensuring every child has the best start in life
- reducing the risk of dementia, its incidence and prevalence in 65 to 75 year olds
- tackling the growth in antimicrobial resistance
- achieving a year-on-year decline in tuberculosis incidence

In March 2015 the Public Accounts Committee (PAC) published a report on PHE's grant to local authorities. The Report states that PHE has made a good start in its efforts to protect and improve public health.³¹ However, the PAC had a number of concerns about the slow progress in tackling health inequalities:

There are still unacceptable health inequalities across the country, for example healthy life expectancy for men ranges from 52.5 years to 70 years depending on where they live. These inequalities make PHE's support at a local level particularly important but we

³¹ PAC, [*Public Health England's grant to local authorities*](#) (HC 893, 6 March 2015)

are concerned that PHE does not have strong enough ways of influencing local authorities to ensure progress against all of its top public health priorities. Finally, given how important it is to tackle the many wider causes of poor public health, PHE needs to influence departments more effectively and translate its own passion into action across Whitehall.”³²

In July 2013 NHS England published [*The NHS belongs to the people: a call to action*](#), which set out the challenges facing the NHS, including a growing elderly population with more complex conditions, increasing costs and rising expectations of the quality of care. It called for the creation of a true health service rather than just an “illness service”.

In February 2014 the Health Committee published a report on [*Public Health England*](#) (HC 840, Eighth Report of Session 2013-14).

³² *Ibid*, summary

7. Health and Wellbeing boards and Healthwatch

7.1 Health and Wellbeing Boards

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

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

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

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

7.2 Healthwatch England and local Healthwatch

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

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

Healthwatch also works at the local level through local Healthwatch organisations (set up by local authorities) which have taken over the role of Local Involvement Networks (LINKs).³³

³³ LINKs were set up in 2008 in each local authority area to involve local people in decisions about how local services are run.

Local Healthwatch organisations:

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

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

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

A [Library briefing](#) provides further information on Health and Wellbeing Boards and Healthwatch.

8. The future

The Conservative Party's 2015 General Election Manifesto's health policy commitments included the following promises of extra funding and improved access to services seven days a week:

- "spend at least an additional £8 billion by 2020 over and above inflation to fund and support the NHS's own action plan for the next five years."
- "ensure you can see a GP and receive the hospital care you need, 7 days a week by 2020, with a guarantee that everyone over 75 will get a same-day appointment if they need one."

The Prime Minister had previously committed to continue real-terms increases in funding in the 2015 Parliament (1 October 2014) and the Health Secretary had also promised the NHS in England would train and retain 5,000 extra GPs between now and 2020.³⁴

On 18 May 2015, the Prime Minister further outlined the Government's intentions to deliver a "seven day NHS", as part of the plan developed by the Chief Executive of NHS England, Simon Stevens.³⁵

Cabinet Office briefing notes for the [Queen's Speech 2015](#) reiterated that the Government's "vision is for a modern, efficient and sustainable NHS that provides high quality care for patients seven days a week". And that it "will increase investment into the NHS by £8 billion a year by 2020 to support the transformation of services across the country, including an increase in the number of GPs, faster access to new drugs and treatments and a greater focus on mental health and healthy living."

Further information on attempts to extend hours and weekend access to GP services can be found in Library briefing, [General Practice in England](#).

A House of Lords Library briefing, prepared for the Queen's Speech Debate on Health and Social Care provides reaction to the Government's health policy proposals ([LBP- 2015-4, 21 May 2015](#)).³⁶

The NHS *Five Year Forward View*, [published on 23 October 2014](#) identified three key drivers for change across the NHS: health and wellbeing, care and quality, and funding and efficiency. Some background on these three key areas is provided below.

The House of Commons Library's Key Issues for the 2015 Parliament also contains sections on [NHS funding and productivity](#) and on [integrating health and social care](#).

Safety of care

³⁴ *GP Magazine Online*, '[Conservatives pledge to maintain NHS funding ring-fence](#)', 1 October 2015

³⁵ Gov.uk, '[PM on Plans for a 7 Day NHS](#)', 18 May 2015
The Daily Telegraph, '[Cameron: New GPs to Transform the NHS](#)', 18 May 2015

³⁶ See also: "[NHS lacks money and staff for seven-day operation, David Cameron told](#)", *The Guardian*, 18 May 2015

A major driver of change in the last Parliament was Sir Robert Francis QC's Report into the failings at Mid Staffordshire NHS Foundation Trust, which was published in 2013.

The health related provisions in the [Care Act 2014](#) largely address specific recommendations from the Francis Report – specifically about transparency and care standards.³⁷ Provisions in the 2014 Act also respond to wider concerns about how regulatory systems are co-ordinated to ensure patient safety, raised by Francis and the subsequent [Keogh](#) and [Berwick](#) reviews. Specifically Part 2 of the *Care Act 2014* allows for the introduction of an “Ofsted-style” rating system for hospitals and care homes, creates a single regime to deal with financial and care failures at NHS hospitals, introduces a duty of candour for health and social care providers and makes it a criminal offence for care providers to give false and misleading information about their performance. On 11 February 2015 DH published [Culture change in the NHS](#), setting out the progress made in applying the lessons learned from the failings at Mid Staffordshire (the [supporting annex](#) to the report set out action on each of the 290 specific recommendations).

Box 5: learning from clinical incidents in the NHS

On 16 July 2015 the Governments published its response to three inquiries into patient safety: the Morecambe Bay Investigation, Robert Francis' report into whistleblowing (*Freedom to Speak Up*) and the Public Administration Select Committee report on clinical incidents. In particular, the Government response, [Learning not blaming](#), set out plans for an Independent Patient Safety Investigation Service to be established and in place from 1 April 2016. Launching this report, on 16 July 2015, the Secretary of State also gave a [speech](#) setting out his ambition for the NHS to become the world's largest learning organisation.

Future funding

The NHS, like many international healthcare systems, is facing rising demands and costs. Increasing costs of providing healthcare, and a population that is growing in number, in age and with more long-term conditions, mean that there is projected to be a “funding gap” (a potential mismatch between resources and patient needs) of £30 billion by 2020/21.³⁸ The NHS [Five Year Forward View](#) suggests this could be met with £8 billion of additional funding and £22 billion of efficiencies by 2020/21 – implying productivity improvements averaging 2.4% per year.

Integration of services

Efforts have been made to integrate health and social care services across the UK, and the NHS [Five Year Forward View](#) proposed a new central-local partnership to support and stimulate the creation of a number of new care models. Plans for devolution in Greater Manchester include the pooling of its £6bn health and social care

³⁷ The Library briefing [The Francis Report \(Report of the Mid-Staffordshire NHS Foundation Trust public inquiry\) and the Government's response](#) provides background to the public inquiry led by Robert Francis QC, and the Government's response.

³⁸ Technical annex to NHS England's [A Call to Action](#) (2013)

budget and there are a number of “integrated care pioneers” across England. NHS England is also backing plans to integrate primary, community and acute care in 29 “vanguard” areas across England.

Further information on recent local developments to integrate care in [Manchester](#) and in 29 “vanguard” areas can be found on the [NHS England website](#).

Box 6: Better Care Fund

The Better Care Fund (BCF) was announced in the June 2013 Spending Round, to support transformation and integration of health and social care services to ensure local people receive better care, and will be introduced in 2015/16. The BCF is a pooled budget of £3.8 billion that is intended to shift resources into social care and community services for the benefit of the NHS and local government.

£3.8 billion is the minimum amount to be pooled for the Better Care Fund for 2015/16 and local areas can choose to pool more than their Fund allocations. Plans submitted in September 2014 indicate that local areas actually plan to pool £5.3bn in total. Further information can be found on the [NHS England website](#).

In November 2014 the NAO published a report [Planning for the Better Care Fund](#), which found that plans forecast £314m of savings for the NHS rather than the £1 billion in early planning assumptions.

9. Health services in Scotland, Wales and Northern Ireland

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

Scotland

NHS Scotland consists of:

- Fourteen regional NHS Boards that are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services.
- Seven Special NHS Boards and one public health body that support the regional NHS Boards by providing a range of specialist and national services.

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

Regional NHS Boards are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services. Special NHS Boards support the regional NHS Boards by providing a range of important specialist and national services.³⁹

Box 7: The integration of health and social care in Scotland

The *Public Bodies (Joint Working) (Scotland) Act 2014* is an Act of the Scottish Parliament that puts in place a requirement on NHS Boards and Local Authorities to integrate health and social care.

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

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

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

Wales

In Wales, seven Local Health Boards are responsible for planning and delivering healthcare services, and aim to integrate specialist, secondary, community and primary care and health improvements. There are three all-Wales NHS Trusts: the Welsh Ambulance Service, Velindre NHS Trust

³⁹ See www.show.scot.nhs.uk for further information.

(provides specialist services in cancer and other national support) and Public Health Wales.⁴⁰

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

Northern Ireland

The healthcare service in Northern Ireland provides both health and social care and is administered by the Department of Health, Social Services and Public Safety.

The Health and Social Care Board holds overall responsibility for commissioning services through five Local Commissioning Groups, which are committees of the Health and Social Care Board.

Five Health and Social Care Trusts have responsibility for providing integrated health and social care in their regions. The Northern Ireland Ambulance Service is designated as a sixth region-wide trust

A separate Public Health Agency has responsibility for improving health and wellbeing and health protection.⁴¹

⁴⁰ See www.wales.nhs.uk for further information.

⁴¹ See <http://www.dhsspsni.gov.uk/> for further information. The further information section at the end of this note provides further information on differences between the health systems in the different parts of the UK.

10. Further information

Health service reform in England

The NHS [Five Year Forward View](#) (October 2014) is the key document setting out the future of the reform; the following links provide further information on recent changes:

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

The Library briefing [The reformed health service, and commissioning arrangements in England](#) provides an overview of the key funding, commissioning and accountability structures under the old and new systems, and focuses on new health service commissioning arrangements and the formal powers and duties of NHS England and CCGs under the 2012 Act.⁴²

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

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

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

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

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

- [Labour's Record on Health 1997-2010](#) (2013)
- [The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015](#) (2015)⁴³

⁴² Further information about the way in which health commissioning operated prior to the changes enacted by the *Health and Social Care Act 2012* can be found in this Library Standard Note [SN05607](#) on *NHS Commissioning*.

⁴³ Vizard and Obolenskaya, [Labour's Record on Health 1997-2010](#), LSE (2013); and [The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015](#), LSE (2015).

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

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

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

Health services across the UK

A useful overview of the health systems in the different parts of the UK can be found in two reports: from the Nuffield Trust/Health Foundation in 2014 and the National Audit Office in 2012.

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

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

In the last decade there has been notable divergence in policy and performance management between the nations, particularly in the use of competition between healthcare providers. Since devolution, the commissioners and providers of health services have been reintegrated in Scotland and Wales, thus removing the internal market. In contrast, the internal market remains in Northern Ireland and the role of competition has increased in England.⁴⁴

Contacting NHS England and Clinical Commissioning Groups

Website addresses and contact details for individual CCGs, including names of clinical leads and accountable officers, are available here:

⁴⁴ NAO, [Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland](#), June 2012, p8 para 12

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

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

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

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

NHS England
PO Box 16738
Redditch
B97 9PT

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

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

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

Professor Sir Malcolm Grant
Chair

NHS England
4W20 Quarry House
Leeds LS2 7UE

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

Simon Stevens
Chief Executive
NHS England
4W12 Quarry House
Leeds LS2 7UE

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

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

Raising concerns

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

Further information can be found in the Library briefings [NHS complaints procedures in England](#), and [NHS whistleblowing policies in England](#).

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