HFMA introductory guide to NHS finance

Chapter 2: Background and context – how we got to where we are today

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Overview

This chapter looks back over the past few decades to chart the development of the NHS so that we can see how we have reached where we are in 2022. It also looks briefly at the origins of the NHS and its guiding principles.

2.1 The introduction of the NHS

The NHS was established by the NHS Act 1946. This Act specified that, it was `*the duty of the Minister ... to promote the establishment in England and Wales of a comprehensive Health Service designed to secure the improvement of the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness*'. The services provided to meet these aims were to be free of charge, based on clinical need, not the ability to pay. The NHS was launched, and the first patients treated on 5 July 1948.

Underpinning principles of the NHS

Although there have been many structural and policy developments since 1948, the underlying principles have not changed. These are that NHS services are:

- available to everyone
- free at the point of need (or use)
- based on clinical need, not the ability to pay.

All of the major political parties remain committed to these core principles.

Other enduring characteristics of the NHS are that:

- it is funded through taxation
- it manages within overall resource limits determined by the Government each year
- finite resources have to be matched with infinite demand for health services with tough choices over priorities needed as a result
- there is an expectation that 'efficiency savings' can be made, often as a result of structural or technical developments
- there is intense political, public and media interest in, and scrutiny of, the NHS.

The NHS is also Europe's largest employer with over 1.7 million employees across the UK in 2015. However, although it is usually referred to as if it were a single organisation, it actually comprises a wide range of different bodies with specific responsibilities – we will be looking at many of these later on in the guide.

2.2 Key policy developments that have shaped the NHS since the 1980s (and continue to have an impact)

The internal market, 1980s

In the late 1980s it was decided that the NHS should be reconfigured to operate a 'quasi-market', known as the internal market, with many treatments commissioned on a 'cost per case' or 'extra contractual referral' basis. A key feature of this approach was the separation of the provision of hospital and community services from the commissioning or purchasing function – the so-called 'purchaser/provider split'. Hospitals were encouraged to apply for self-governing trust status, creating organisations quite separate from the health authorities from which they were devolved. To achieve trust status, and formally separate from the health authorities, provider organisations had to follow an application process that assessed viability and robustness.

There was also an optional scheme to give general practitioners (GPs) the ability to hold budgets for the purchase of hospital services for their patients (known as GP fund holding). At the same time, trusts were encouraged to invest in and develop services and to compete with each other to win patient service contracts with purchasers.

The new NHS, 1997

In 1997, the white paper *The New NHS*[1] set out a programme for reform of the NHS. These proposals became law with the 1999 Health Act (since superseded by the NHS Act 2006 and the Health and Social Care Act 2012) and the focus shifted away from competition to a more collaborative model, where NHS organisations worked together and with local authorities to re-focus healthcare on the patient. By removing the competitive nature of the internal market, the changes in policy sought to ensure the seamless delivery of services.

Key changes were an end to GP fund holding and the introduction of new organisations for primary care. Primary care organisations (either 'groups' or 'trusts') were formed from groups of local GP practices. Boundaries were encouraged to coincide where possible with local authority borders to simplify the integration of health and social care. In their initial stages these groups were sub-committees of health authorities, used to inform the commissioning process. As they found their feet, they were able to apply for trust status, creating bodies independent from the health authority and managing increasingly significant portions of former health authority budgets.

The 1999 Health Act also established the Commission for Health Improvement (to be succeeded by the Commission for Healthcare Audit and Inspection, then by the Healthcare Commission and now the Care Quality Commission) and the National Institute for Health and Clinical Excellence or NICE – now the National Institute for Health and Care Excellence.

There was also a renewed emphasis on cutting management costs – a challenging objective given the increase in the number of NHS organisations, and greater involvement of management at a local level. The 'shared services initiative' was an attempt to mitigate the pressure on management costs by reducing the cost of providing support services (particularly 'back office' functions). National shared service centre pilots were established, run as a joint venture between the Department of Health and Steria known as NHS Shared Business Services (NHS SBS) and there are now a number of shared business services centres around the country.

The purchaser/provider split created by the internal market was retained. Initially health authorities remained and continued to purchase healthcare using service and financial framework agreements. These health authorities were then abolished but the division between commissioning and provision

[1] UK Government, *The new NHS*, December 1997

continued with primary care trusts (PCTs) taking over responsibility for commissioning hospital services. At their inception, many PCTs also had a provider role in relation to community services.

The 1997 white paper also heralded a move towards longer planning time frames, promising the replacement of annual contract negotiations with three-year resource announcements.

The NHS was encouraged to form partnerships with both private and public sector partners, including local authority social services. The 1999 Health Act also broadened the scope for pooling of health and social services budgets. Partnership working with the private sector was formalised in a 'concordat' agreement, which highlighted scope for joint working in elective, critical and intermediate care. New independently run diagnosis and treatment centres or independent sector treatment centres (ISTCs) were established, extending the role of the private sector in providing services to the NHS.

The NHS plan: a plan for investment, a plan for reform, 2000

In July 2000 the NHS plan[2] was presented to Parliament. The plan consisted of a vision of the NHS first outlined in the 1997 white paper – modernised, structurally reformed, efficient and properly funded. Much of the document was dedicated to identifying new targets and milestones on wide ranging issues (from waiting lists to implementation of electronic patient records) and measures that needed to be taken to facilitate the achievement of those targets.

The *Health Act 2002*

In April 2002 a further tranche of changes came into effect. At the end of March 2002, the 95 health authorities in England were abolished and replaced by 28 strategic health authorities (SHAs). At the same time the eight regional offices were replaced by four directorates of health and social care which were themselves dissolved in 2003. The changes, first outlined in April 2001 in the policy paper *Shifting the balance of power*[3], were designed to transfer management resource and control closer to the locality, and hence to the patient.

The establishment of PCTs was also completed in 2002 – a key change here was the fact that PCTs were allowed to expand primary care services beyond those traditionally provided by GPs. This prompted a growth in 'GPs with special interests' and in services provided in the community by PCTs where previously they had been delivered in an acute hospital setting.

Many of the monitoring and planning processes were devolved from the old regional offices to the new SHAs, while commissioning functions were transferred to PCTs.

Payment by results

A key element of the Labour Government's modernisation plans involved reforming the financial framework and the way funding flowed around the NHS. The proposal for bringing about this change was set out in 2002 in *Delivering the NHS improvement plan*[4] and introduced a system of payment by results (PbR). This was designed to ensure that money flowed with patients.

The main driver behind this initiative was patient choice – by introducing nationally-set standard prices for treatments, the need for local negotiation on price was removed and instead the focus was shifted to quality and responsiveness, the things that are important to the patient. The combination of patient choice and PbR was expected to drive an increase in healthcare capacity and deliver shorter patient waiting times.

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[2] Department of Health, *The NHS plan: a plan for investment, a plan for reform*, July 2000
[3] Department of Health, *Shifting the balance of power*, July 2001
[4] Department of Health, *Delivering the NHS improvement plan*, April 2002

Both patient choice and PbR were phased in over a period of years. Key milestones in the development of patient choice included:

- providing patients waiting for elective surgery for over six months with the choice of an alternative provider (summer 2004)
- patients requiring a routine elective referral offered a choice of four or five providers (including one private sector provider) at the point of referral (usually at their GP) by the end of December 2005
- patients needing to see a specialist able to choose to go to any hospital in England, including many private and independent sector hospitals (from April 2008).

The first steps to introduce the PbR financial framework were taken in 2003/04. Chapter 19 looks in more detail at changes in the way that NHS services are reimbursed.

NHS foundation trusts

NHS foundation trusts (FTs) were created as new legal entities in the form of public benefit corporations by the *Health and Social Care (Community Health and Standards) Act 2003*, consolidated in the *NHS Act 2006*. They were introduced to help implement the Labour Government's 10-year NHS plan. By creating a new form of NHS trust that had greater freedoms and more extensive powers, it was hoped that services would improve more quickly.

Initially, applications for foundation status were restricted to a number of 'three-star' trusts with the first wave of FTs coming into being in April 2004. Since then, there has been a steady growth in the number of FTs although the pace has slowed as organisations struggle to demonstrate their long-term financial viability in the light of difficult economic circumstances, and increased expectations in relation to efficiency. The application process for FT status has also changed with an increased focus on clinical quality in the light of high-profile governance failures, such as that at Mid-Staffordshire NHS Foundation Trust. Monitor[5] was established in 2004 to regulate NHS foundation trusts.

Commissioning a patient-led NHS, 2005

Following a consultation process in 2005, a reconfiguration of SHAs, PCTs and ambulance trusts was launched by the Department of Health with a significant reduction in their overall numbers. The aim was to reduce management overheads and generate cost savings that could be re-invested in the provision of healthcare.

The reduction in PCT numbers was consistent with the simplification of the commissioning process inherent in the patient choice and PbR initiatives. Increasingly patients were able to select their preferred healthcare provider, thereby refocusing the commissioning role on assessing overall supply levels, negotiating provider standards and managing demand.

SHAs also reduced from 28 to 10 to reflect the geographical span of the government offices for the regions, and so make working with other public sector partners easier.

The merger of ambulance trusts was designed to achieve purchasing and management economies of scale and to allow them to develop greater resilience than was possible with smaller scale operations.

The Darzi review – *High quality care for all*, 2008

In July 2007, the Government asked the then health minister Lord Darzi to carry out a wide ranging review of the NHS. An interim report was issued in October 2007 and recommended a number of changes to the provision of healthcare services within the primary and secondary care sectors,

[5] Monitor, *About Monitor: an introduction to our role,* August 2013

including the development of 'poly-clinics' where appropriate – a primary healthcare equivalent of the 'one-stop shop'. The final report – *High Quality Care for All*[6] – was issued in June 2008 (in time for the 60th anniversary of the NHS on 5 July 2008) and set out a vision of an NHS that 'gives patients and the public more information and choice, works in partnership and has quality of care at its heart'.

The NHS constitution, 2010

In January 2010, the first ever NHS constitution[7] came into effect. All NHS bodies, along with private and third sector organisations that provide NHS services, are required by law to take account of the Constitution in their decisions and actions.

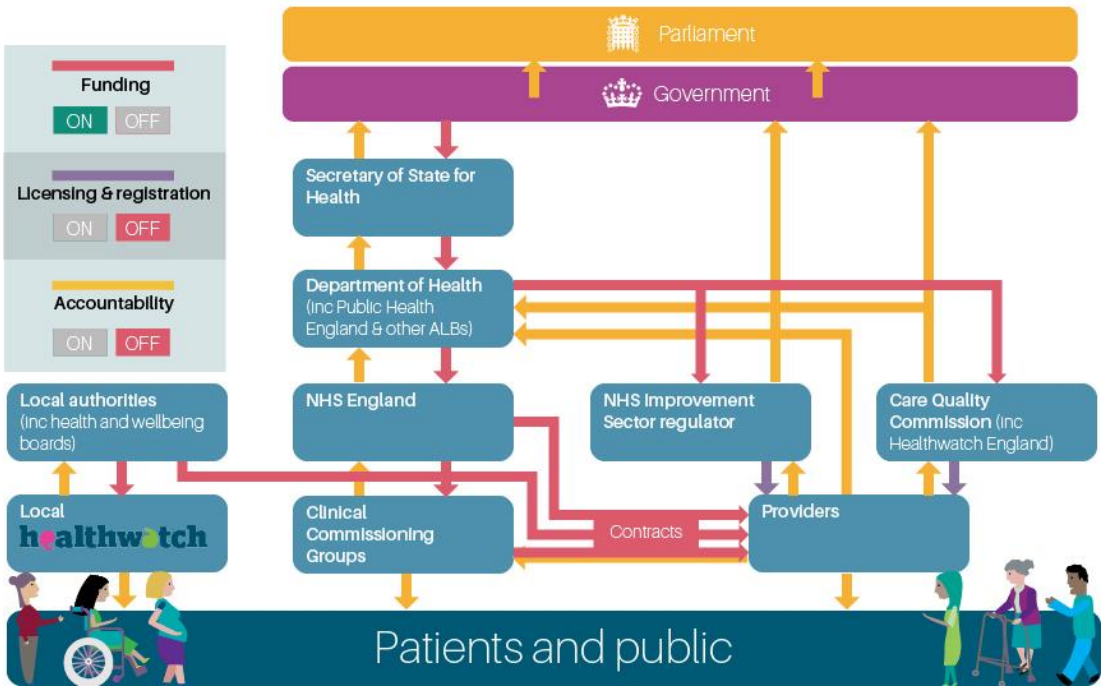
Equity and excellence: liberating the NHS, 2010 and the Health and Social Care Act 2012

In July 2010, following the formation of the Coalition Government, the then Secretary of State for Health issued a series of consultation papers that signalled far-reaching changes for the NHS in England. These proposals (amended in places) were enacted in the Health and Social Care Act 2012 resulting in a new structure and approach for the NHS from April 2013.

2.3 The current NHS

The structure introduced by the 2012 Act is shown in the diagram below and came into effect in April 2013. Since April 2016, NHS Improvement (NHSI) has been established as an integrated management structure enabling Monitor and the NHS Trust Development Authority (NHS TDA) to work together closely, particularly in supporting all NHS healthcare providers (foundation and non-foundation NHS trusts). In 2019, NHS England and NHS Improvement came together to form a single management organisation but remained legally separate.

Figure 1: Current NHS structure



[6] Department of Health, *High quality care for all*, June 2008
[7] Department of Health, *The NHS Constitution for England*, March 2012 (updated January 2021)

The key changes introduced by the 2012 Act are listed below.

- abolishing SHAs and PCTs from April 2013
- introducing NHS England to authorise clinical commissioning groups (CCGs), allocate funding to them and commission some specialist services itself
- handing the majority of NHS commissioning to CCGs that are authorised by (and accountable to) NHS England
- extending Monitor's role to that of sector regulator (now operating as part of NHS Improvement) for the health and social care sectors with responsibility for licensing healthcare providers, setting and regulating prices and (with NHS England) ensuring continuity of services
- strengthening the role of the Care Quality Commission (CQC)
- setting up the NHS Trust Development Authority within the Department of Health to oversee NHS trusts (now operating as part of NHS Improvement)
- allowing commissioners to pay quality increments and impose contractual penalties
- giving FTs greater freedom on income, governance, and mergers
- handing responsibility for public health to local authorities with Public Health England set up within the Department of Health
- setting up 'health and wellbeing boards' in every upper tier local authority to 'join up commissioning across the NHS, social care, public health and other services … directly related to health and wellbeing'
- developing local HealthWatch organisations from existing local involvement networks to ensure that the views of patients, carers and the public are considered
- setting up HealthWatch England as an independent committee within the CQC to support and lead local HealthWatch bodies.

The structure laid out in the 2012 Act remains in place in 2022, although Public Health England has been abolished and was replaced by the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities from 1 October 2021.

However, ways of working have evolved since 2012. The remainder of this chapter covers the key strategic changes, culminating in the publication of a white paper in February 2021 to reform the NHS.

Five year forward view

In October 2014, the *Five year forward view*[8] was published. This set out the transformational changes needed by the NHS in order to meet the anticipated £30bn funding gap by 2020/21 arising from the difference between existing funding and that needed to meet expected demand. It set out the reasons for transformational change and the way that change may be achieved. The report stated that action was needed on four fronts:

- tackling the root causes of ill health, including obesity and drinking too much alcohol
- giving patients more control over their care
- breaking down barriers between GPs and hospitals, health and social care and physical and mental health
- introducing new models of care as well as investing in workforce, innovation, and technology.

[8] NHS England, *The five year forward view*, October 2014

The new models of care (in addition to those already operating in the NHS) outlined in the *Five year forward view* drew on international experiences and included:

- multispecialty community providers (MCPs)
- primary and acute care systems (PACs)
- urgent and emergency care networks
- viable smaller hospitals
- specialised care
- modern maternity services
- enhanced health in care homes.

The new care models were expected to provide better networks of care with increased out of hospital care and services better integrated around the patient. In January 2015, NHS England invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme. During that year, 50 vanguard sites were chosen to develop the various models, with the intention that they could be replicated elsewhere.

In December 2015, the financial position of the NHS had deteriorated and *Delivering the forward view: NHS planning guidance 2016/17 – 2020/21*[9] was published. This introduced the concept of sustainability and transformation plans (STPs) which were geographically based, five-year strategic plans. This was the first time that a single set of planning guidance was made available to the whole NHS. It was produced by all the Department's ALBs, (NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission, Health Education England, National Institute for Health and Care Excellence and Public Health England).

In early 2016, all NHS bodies (working with local authorities and the third sector) identified 44 STP areas which covered the whole of England. Initially, these areas were called 'transformation footprints' but they are generally referred to as STPs. These footprints were determined locally based on natural communities, patient flows and existing working relationships. Some NHS bodies and local authorities are members of more than one STP. The rest of 2016 was spent working together to develop STPs which included the aim to bring the NHS back into financial balance by looking at better ways of working together to provide the best quality health and social care in the best place.

In March 2017, the *Next steps on the NHS five year forward view*[10] was published and STPs became sustainability and transformation partnerships. The proposal was that STPs would evolve into accountable care systems (ACS) which would work as a locally integrated health system.

In February 2018, *Refreshing NHS plans for 2018/19*[11] replaced the term ACS with integrated care system (ICS) in which commissioners and NHS providers, working with GP networks, local authorities and other partners, agree to take shared responsibility for how they operate their collective resources for the benefit of their local populations. This document also set out the ambition that all GP practices should be part of a primary care network (PCN) to achieve 'complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19'.

[9] NHS England, *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21*, December 2015
[10] NHS, *Next steps on the NHS five year forward view,* March 2017
[11] NHS, *Refreshing NHS plans for 2018/19,* February 2018

Implementing the five year forward view in mental health[12]

Following the publication of the *Five year forward view*, the chief executive of NHS England commissioned an independent review of mental health services. Led by the chief executive of MIND, the Mental Health Taskforce published its final report in February 2016[13]. It set out a view of the state of mental health services in England, a long-term view of improvements needed along with a series of recommendations for NHS organisations, the Department's arm's length bodies (ALBs), the government and other partners involved in the commissioning and provision of mental health services. The report concluded that £1 billion of additional investment in mental health services was needed by 2020/21. As a consequence, the mental health investment standard (MHIS) was established which required CCGs to increase spending on mental health in line with their overall increase in allocation each year.

NHS long term plan

In July 2018, the NHS celebrated its 70th birthday. To coincide with this, the then prime minister announced a long-term funding settlement for the NHS, outside of the normal spending review cycle. An additional £20bn was committed by 2023. However, this funding came with the condition that the NHS must develop a 10-year plan to improve efficiency and address five key areas: putting the patient at the heart of how care is organised; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention, not just cure; and true parity of care between mental and physical health.

In January 2019, the *NHS long term plan*[14] was published. The plan aims to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers' investment. The plan sets out a range of aims – making sure everyone gets the best start in life, delivering world class care for major health problems and supporting people to age well. The plan provides a framework for local systems to develop plans, based on principles of collaboration and co-design with the objective of ICSs covering the whole country by April 2021. Typically, it is expected that there will be one CCG for each ICS.

In June 2019, the *NHS long term plan implementation framework*[15] was published, setting out the requirements on STPs and ICSs in creating their five-year strategic plans. System plans will be aggregated into a national implementation plan and are expected to adhere to the following principles:

- the implementation of commitments in the NHS long-term plan that have clinical implications, should be clinically led
- local communities should have meaningful input into the local plan
- workforce planning should be realistic
- plans need to include how local systems and organisations will meet the five financial tests set out in the NHS long-term plan, including setting out capital investment priorities
- all commitments in the NHS long-term plan must be delivered and national access standards must be met
- implementation of the NHS long-term plan should be phased, based on local need
- health inequalities and unwarranted variation must be reduced

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[12] NHS, *Implementing the five year forward view in mental health,* July 2016
[13] Mental Health Taskforce, *The five year forward view for mental health*, February 2016
[14] NHS, *The NHS long term plan*, January 2019
[15] NHS, *NHS long-term plan implementation framework*, June 2019

- local systems should consider how to prevent ill health as well as treat it
- plans should be developed in conjunction with local authorities.

2.4 Developments due to the Covid-19 pandemic

On 11 March 2020, the World Health Organisation declared that Covid-19 was a pandemic, meaning that it had spread worldwide. The NHS rapidly responded to the anticipated demand for Covid-19 care and increased intensive care beds by suspending all elective care and moving to telephone and digital consultations to limit contact. For NHS finance, the normal payment and contracting regime was paused and all providers received monthly block payments, based upon income received between April and December 2019, the most up to date information available at that time. Capital was made available to purchase equipment and repurpose wards and other facilities to treat Covid-19 patients. During the first wave of the pandemic these capital costs were approved retrospectively to allow changes to be made at speed.

The pandemic caused significant transformation in the delivery of healthcare with one of the most significant changes being the rapid uptake of telephone and digital consultations. This has meant that one of the key ambitions of the NHS long term plan is being met sooner than anticipated. However, there has been an adverse impact on routine treatments with a large increase in waiting lists and a noticeable drop in cancer care. The improvements set out for these areas in the NHS long term plan now need to address the change in starting point for many organisations.

Covid-19 demonstrated how organisations could work together to address a common goal when traditional financial barriers were removed, with many areas reporting improved relationships across health and social care. As Covid-19 cases reduce with the vaccination programme, the NHS intends to build upon the positive changes that the pandemic has created.

Health inequalities

The NHS has been legally required to tackle health inequalities since the introduction of the *Health and Social Care Act 2012* but, since the Covid-19 pandemic, the focus on health inequalities has dramatically increased. The unequal impact of the pandemic across different sectors of society has highlighted existing inequalities and potentially created new ones. This was recognised in the 2021/22 planning guidance which required NHS bodies to specifically address health inequalities in elective recovery plans and accelerate preventative programmes for groups at the greatest risk of poor health outcomes. This is an ongoing requirement for the NHS.

2.5 Health and Care Act 2022

The *Health and Care Act 2022*[16] received Royal Assent on 28 April 2022. The Act builds on DHSC's legislative proposals for the NHS published on 11 February 2021, in the *Integration and innovation: working together to improve health and social care for all* white paper[17]. The proposals were developed from the *NHS long term plan* and the subsequent *NHS's recommendations to Government and Parliament for an NHS bill*[18].

The Act will establish integrated care boards (ICBs) and abolish clinical commissioning groups (CCGs). The functions, staff, assets and liabilities of CCGs will be transferred to ICBs. However, there will be a greater emphasis on collaboration, with the ICB becoming the statutory commissioning body within an ICS.

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[16] UK Parliament, *Health and Care Bill*, July 2021 – the Act was not available to reference at time of publication
[17] Department of Health and Social Care, *Integration and innovation: working together to improve health and social care for all*, February 2021
[18] NHS, The NHS's recommendations to Government and Parliament for an NHS Bill, September 2019

The ICS, as a partnership of NHS bodies within the local system, will be responsible for:

- developing a plan to meet the health needs of their population
- developing a capital plan for NHS providers within their geography
- securing the provision of health services to meet the needs of the system population.

The creation of ICBs will also allow NHS England to set financial allocations and other financial objectives at a system level. There will be a statutory duty to meet the system financial objectives and deliver financial balance. NHS providers within the ICS will retain their current structures, governance, and organisational financial statutory duties but there will be a new duty to compel providers to have regard to the system financial objectives.

The *Health and Care Act 2022* will also establish integrated care partnerships (ICPs). This partnership will bring together health, social care and public health as well as other bodies as appropriate, to develop a plan to address the wider health and care needs of the system. This plan will inform decision making by the NHS organisations within an ICS and local authorities.

The white paper states that the proposed legislation is not intended to address all the challenges faced by the health and social care system, and that there are further reforms to be undertaken. These broader changes include proposals to reform social care, the future design of the public health system and modernising the *Mental Health Act*.

The legislative changes not only build on the NHS long term plan but are also designed to accelerate the positive changes in the health and care system that have come about through the pandemic. The white paper highlights that legislation is just one part of the change and much relies on having the right workforce, good leadership and getting the incentives and financial flows right. A supporting implementation programme will be developed for these areas, and it is expected that the reforms outlined in the white paper will begin to be implemented in 2022.

NHS England and NHS Improvement (made up of Monitor and the NHS Trust Development Authority (NHS TDA)) have been working as a single organisation since 2019. However current legislation does not allow them to fully collaborate. The Act also sets out the intention to transfer the powers of Monitor and NHS TDA to NHS England and abolish the previous organisations.

It is anticipated that the provisions in the Act will come into force from 1 July 2022.

2.6 Other plans and white papers

On 7 September 2021, the Prime Minister announced a new plan for health and care, with an additional £36bn to be spent over the next three years. *Build back better: our plan for health and social care*[19] set out intentions for healthcare and adult social care, supported by a new health and social care levy to raise the necessary funds through taxation.

The plan for healthcare focused on three main aspects: tackling the elective backlog, putting the NHS on a sustainable footing, and focusing on prevention. £5.4bn will be invested in adult social care over the next three years to fund social care payment reforms. From October 2023, a new £86,000 cap will be introduced to limit the amount that anyone in England will need to pay for personal care over their lifetime.

The plan also set out the intention to develop integration further than that set out in the *Health and Care Act 2022*. A national plan will support and enable integration between health and social care, to ensure that people experience well-coordinated care.

[19] UK Government, *Build back better: our plan for health and social care*, September 2021

The levy will be introduced from April 2022 as a 1.25 percentage point increase on national insurance contributions. From April 2023, the levy will be separated from national insurance contributions and will show as a separate deduction line on employee payslips. The levy is a hypothecated tax, which means that the funds raised from it will be ring fenced for use in health and social care.

Two further white papers have since been published to set out more details on the ambitions of the plan for health and social care.

People at the heart of care: adult social care reform[20] sets out a 10-year vision for adult social care describing how previously announced funding will be used to reform adult social care, including developing the workforce, supporting digital transformation, and improving integration with housing.

The 10-year vision builds on the principles of personalised care, to drive user-led social care and give people choice, control, and independence. The vision applies this principle to those who draw on care and support, and their families and unpaid carers. It is recognised that early support is better than reactive intervention, helping people to retain or regain their skills and independence and preventing needs from developing.

The white paper sets out a number of 'I' statements to describe what adult social care should allow and enable, from the perspective of the person in receipt of services, or their family. It is expected that, to deliver this, the government, NHS, local authorities, care providers, voluntary and community groups and wider public sector, will work closely together to provide a range of support. This support will include home adaptations, better direct payments' processes, use of technology, improved co-design of care, promoting participation in work, and promotion of healthier choices and interventions.

To support improvements in the quality of care delivered, the 10-year vision aims to put social care on a par with the NHS, in terms of public perception of value and quality. The importance of data is acknowledged with an aim to give easy access to timely digitised information.

Fairness and accessibility also feature within the vision, building on recent announcements around capping the cost of care and ensuring that self-funders pay the same rates for care as local authorities. Improved information, advice and transparency is expected to make it easier to navigate the care system.

Joining up care for people, places and populations[21] sets out a vision to join up planning, commissioning, and delivery across health and adult social care. Children's social care is excluded from the paper. The white paper sets out a number of areas where improvements can be made, building on existing policies and plans in many cases. There is a strong focus on integrated working at a place[22] level as it is thought that that is the scale at which joint action is most effective. It states that *'the truly radical possibilities in this agenda are much more likely to be identified and realised by local organisations than through central prescription.'*

The white paper states that clear accountability is required at a place level so that all partners know where delivery and financial responsibility lies. An illustrative place board model is described, and, by spring 2023, all places are expected to adopt an equivalent model. It is expected that this governance model will provide:

- clarity of decision making around service reconfigurations
- risk management
- agreement of outcomes

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[20] Department of Health and Social Care, *People at the heart of care: adult social care reform*, December 2021
[21] Department of Health and Social Care, *Joining up care for people, places and populations*, February 2022
[22] Place: a geographic area that is defined locally, but often covers 250,000-500,000 people, for example at borough or county level.

- resolution of disagreements between partners
- identify a single person who is accountable for the delivery of the shared plan.

It is expected that any arrangements will build upon existing structures and processes such as health and wellbeing boards and better care fund arrangements. A place board will not be required where an integrated care system (ICS) is made up of a single place.

The white paper recognises that a good financial framework can support integrated approaches to delivering health and care. It cites two main mechanisms for doing this – pooled and aligned budgets, where pooled budgets represent a formal agreement to align and share resources. It is expected that the use of pooled and aligned budgets will increase, although existing mechanisms such as the better care fund will be kept under review as progress accelerates.

2.7 Comprehensive spending reviews and budgets

In terms of overall funding levels, the Labour Government made a commitment in 1997 to increase NHS funding to a level that would bring the UK's health spending in line with the average for the rest of Europe. The first step toward this target was taken in the 2000 budget, with a further significant increase in 2001. However, it was the 2002 budget that gave the first indication of the substantial and long-term increases required if that promise was to be delivered. Funding for these increases was achieved by the introduction of employer and employee national insurance surcharges at a rate of 1%, and from the release of funds from other sources, enabled by the Government's comprehensive spending review (CSR). The CSR process is designed to assess critically the spending of government departments in the light of changing priorities.

Successive budgets maintained the commitment to longer-term funding increases. However, the 2007 CSR process led to more modest increases for the three-year period from 2008/09 compared with the preceding period, averaging 3.9% growth in real terms, compared with 7.5% for the previous CSR period.

The impact of the economic downturn following the banking crisis in 2008 led to warnings about the future funding of the NHS.

In preparation for tighter times ahead, efficiency savings targets steadily moved upwards. To help achieve these targets and in line with a renewed emphasis on quality, the Department of Health expected NHS organisations to meet the 'quality, innovation, productivity and prevention (QIPP) challenge'. In practice, this meant organisations had to follow 'lean management principles' of avoiding duplication, preventing errors that then need to be corrected, and stopping ineffective practices. Inevitably this involved a focus on reducing back-office functions and (from a finance perspective) re-ignited the debate about the relative advantages and disadvantages of shared services.

The spending review in November 2015 focused on the need to reduce the public sector borrowing requirement whilst investing in key services notably the NHS in order to support the delivery of the Five Year Forward View. The health budget was increased by £10 billion per annum by 2020 over and above that for 2014/15, taking the projected NHS budget to £119.6 billion (see chapter 10 for more about the financing of the NHS).

In 2018, the then prime minister announced a long-term funding settlement for the NHS, outside of the normal spending review cycle. An additional £20bn was committed by 2023.

The 2020 spending review only set out plans for the 12 months from April 2021, due to the disruption caused by Covid-19 to public spending and the uncertainty in long term planning. However, the review set out that the NHS in England would get an extra £6.3bn to help meet the government's commitment to get the NHS budget to £148.5bn by 2023-24. The devolved nations received a corresponding uplift to funding based upon the Barnett formula[23] which determines how money is allocated across the United Kingdom.

The autumn budget and spending review in 2021[24] established a three-year budget for the Department of Health and Social Care, representing a 4.1% increase over the 2022 – 2025 period for the department. Within this, NHS England and NHS Improvement will receive a 3.8% real terms increase over the next three years, with its current £136.1bn budget rising to £151.8bn in 2022/23, £157.4bn in 2023/24, and £162.6bn in 2024/25. The spending review also set out capital funding for the next three years.

Key learning points

- Despite continual policy and legislative change, the underpinning principles of the NHS remain as they were in 1948 - NHS services are available to everyone; free at the point of need (or use); and based on clinical need, not the ability to pay.
- The current NHS structure was defined in the *Health and Social Care Act 2012*.
- NHS funding decisions usually form part of the wider comprehensive spending review process.
- Since the publication of the *Five year forward view* in 2014, the NHS has been working towards a more collaborative, integrated structure.
- Proposed legislation is expected to put integrated care systems onto a legal footing in 2022.

Additional HFMA resources

The HFMA maintains a directory of resources which provides links to other HFMA outputs such as briefings and webinars across a range of subjects. It also highlights e-learning courses that are available. The directory of resources can be found here.

[23] House of Commons Library, *The Barnett formula*, January 2020
[24] HM Treasury, *Autumn budget and spending review 2021,* October 2021