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 2024. 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 what can seem like unlimited 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 1.8 million employees across the UK in 2022. 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 look at many of these within this 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 and volume' or 'extra contractual referral' basis. A key feature of this approach was the separation of the provision of hospital and community services from the purchasing or commissioning 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 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[2] (since superseded by the NHS Act 2006[3], the Health and Social Care Act 2012[4] and the Health and Care Act 2022[5]). The focus shifted away from the underlying competitive nature of the internal market to a more collaborative model, where NHS organisations worked together, and with local authorities, to re-focus healthcare on the patient. These 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. GP representation and engagement within the commissioning process was initially through health authority sub-committees. GPs would inform the commissioning process through these sub-committees, and as these arrangements became more established, GP groups were able to apply for trust status. This created bodies independent from the health authority and managing increasingly significant portions of former health authority budgets. Boundaries were encouraged to coincide where possible with local authority borders to simplify the integration of health and social care.

The 1999 Health Act established the Commission for Health Improvement. This was succeeded by the Commission for Healthcare Audit and Inspection, then by the Healthcare Commission and now the Care Quality Commission. The 1999 Health Act also established 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 the greater involvement of management at a local level.

The 'shared services initiative' was one element of this objective. The intention was to consolidate some administrative and back-office functions – for example, invoice processing or payroll services under a shared service partner. The sharing of services, rather than having many small local teams, would then lead to greater efficiencies, drive effectiveness, bring in greater consistency of reporting and lower costs in providing these management functions. In addition, the intention was to 'free-up'

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[1] UK Government, *The new NHS*, December 1997
[2] UK Government, Health Act 1999
[3] UK Government, National Health Service Act 2006
[4] UK Government, Health and Social Care Act 2012
[5] UK Government, Health and Care Act 2022

local teams to allow greater focus on areas such as financial advice and support, with less local management time spent on the transactional aspects (invoices, pay records) of financial services.

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). As the NHS structures have evolved, so have shared services and there are now several 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 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*[6] 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.

Further developments in 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*[7], 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 to the new SHAs, while commissioning functions were transferred to PCTs.

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[6] Department of Health, *The NHS plan: a plan for investment, a plan for reform*, July 2000
[7] Department of Health, *Shifting the balance of power*, July 2001

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 plan*[8] 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.

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 16 looks in more detail at 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[9], 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 those trusts deemed as having the highest level of performance ('three-star' trusts as assessed by the Commission for Health Improvement), 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 slowed as organisations struggled 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.

At the outset, the regulation regime for FTs was different to that of NHS trusts, and Monitor[10] was established in 2004, specifically to regulate NHS FTs. However, it has since been recognised that all NHS providers face similar challenges, and in practice, there is now little difference between the regulation and oversight of NHS trusts and NHS foundation trusts (further details are provided in chapters 9, 10 and 11).

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[8] Department of Health, *Delivering the NHS plan*, April 2002
[9] UK Government, Health and Social Care (Community Health and Standards) Act 2003
[10] Monitor, *About Monitor: an introduction to our role,* August 2013

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 several changes to the provision of healthcare services within the primary and secondary care sectors, including the development of 'polyclinics' where appropriate – a primary healthcare equivalent of the 'one-stop shop'. The final report – *High quality care for all*[11] – 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[12] 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 NHS structure 2012 to 2022

The structure introduced by the 2012 Act is shown in the diagram below and came into effect in April 2013. In April 2016, NHS Improvement (NHSI) was 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.

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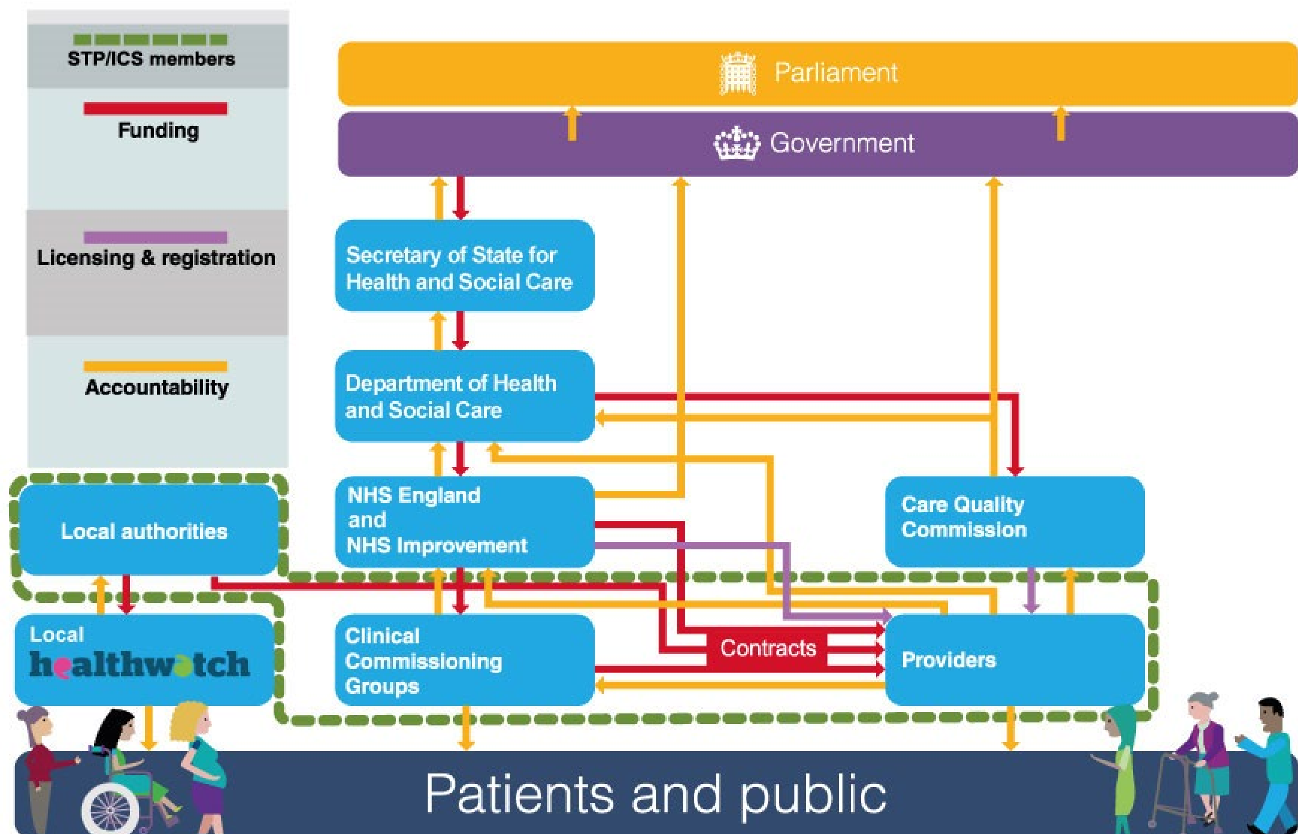
[11] Department of Health, *High quality care for all*, June 2008
[12] Department of Health, *The NHS Constitution for England*, March 2012, updated August 2023

NHS structure 2012 - 2022



The key changes introduced by the 2012 Act were:

- abolishing SHAs and PCTs from April 2013
- introducing NHS England to:
    - authorise clinical commissioning groups (CCGs)
    - allocate funding to them
    - commission some specialist services itself
- handing the majority of NHS commissioning to CCGs that were authorised by (and accountable to) NHS England
- extending Monitor's role to that of sector regulator 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, then, Department of Health to oversee NHS trusts
- 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. Public Health England has since been abolished, replaced

by the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities from 1 October 2021

- setting up 'health and wellbeing boards' in every upper tier local authority (at county council level) 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.

However, ways of working have evolved since 2012. The remainder of this chapter covers the subsequent key strategic developments and reforms, culminating in the Health and Care Act 2022[13].

Commissioning support units (CSUs)

Initially the Health and Social Care Act 2012 gave all clinical commissioning groups (CCGs) the option to obtain business support services – notably payroll, HR, finance, IT and communications services, from commissioning support units (CSUs) hosted by NHS England. Service level agreements (SLAs) set out what each party to the agreement expected and/ or required. Initial SLAs were in place until October 2014. NHS England subsequently ran a national procurement process to make commissioning support services available to CCGs and other commissioners of health and social care. This resulted in the lead provider framework (LPF).

In 2018, the LPF was replaced by the health systems support framework (HSSF)[14] to support the development of population health management and integrated systems. This framework is available for use by any public sector body engaged in the management or support of the health, care, or wellbeing of the population across the United Kingdom.

Five year forward view

In October 2014, the *Five year forward view*[15] was published. This set out the transformational changes needed by the NHS 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.

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 (UEC) networks
- viable smaller hospitals

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[13] UK Government, Health and Care Act 2022
[14] NHS, *Health systems support framework*
[15] NHS England, *The five year forward view*, October 2014

- 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 integration 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*[16] was published. This introduced the concept of sustainability and transformation plans (STPs) - 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 arm's length bodies (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 that 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 were members of more than one STP; not all services directly aligned across the same boundaries – for example, some community and mental health services.

The rest of 2016 was spent working together to develop plans that addressed the STP key themes: collaboration (including integration of services), population health and wellbeing, quality, sustainability, workforce, facilities (IT and estates), and financial health.

As plans progressed, the requirement to close the gap in NHS finances and reduce deficits became more prominent. The STP model recognised that effective management of finances requires a system wide approach, one that looks at better ways of working together to provide the best quality health and social care in the most appropriate place, and within the resources available.

In March 2017, the *Next steps on the NHS five year forward view*[17] 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 locally integrated health systems.

In February 2018, *Refreshing NHS plans for 2018/19*[18] 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 operating 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'.

Implementing the five-year forward view in mental health[19]

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,

[16] NHS England, *Delivering the forward view: NHS shared planning guidance 2016/17 – 2020/21*, December 2015
[17] NHS, *Next steps on the NHS five year forward view,* March 2017
[18] NHS, *Refreshing NHS plans for 2018/19,* February 2018
[19] NHS, *Implementing the five year forward view in mental health,* July 2016

the Mental Health Taskforce published its final report in February 2016[20]. 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 £1bn of additional investment in mental health services was needed by 2020/21. Consequently, the mental health investment standard (MHIS) was established that 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[21]. An additional £20.5bn 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
- true parity of care between mental and physical health.

In January 2019, the *NHS long term plan*[22] was published. The plan aimed 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 set 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 provided 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. At that time, it was expected that there would be one CCG for each ICS.

In June 2019, the *NHS long term plan implementation framework*[23] was published, setting out the requirements on STPs and ICSs when creating their five-year strategic plans. System plans were to be aggregated into a national implementation plan and were 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 should include how local systems and organisations would 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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[20] Mental Health Taskforce, *The five year forward view for mental health*, February 2016
[21] UK government, *Prime Minister sets out 5-year NHS funding plan,* June 2018
[22] NHS, *The NHS long term plan*, January 2019
[23] 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 (WHO) 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 monies were made available to purchase equipment and repurpose wards and other facilities to treat Covid-19 patients. During the first wave of the pandemic capital spending was approved retrospectively to allow changes to be made at speed.

Managing the pandemic required significant changes in how healthcare was delivered, both as regards clinical practices, and for corporate and administrative functions.

Prior to the pandemic, there had already been a focus on some key aspects of healthcare – for example, system working and digital healthcare.

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. In addition, having to make such significant changes to the financial payment and contracting regime highlighted the requirement for a detailed review of arrangements. This will be discussed in further detail in chapter 16.

With NHS services being focused upon the Covid-19 pandemic itself, there has been an adverse impact on routine treatments with a large increase in waiting lists and times as well as a noticeable drop-in cancer care.

Current plans and developments look to recover the backlogs that have arisen and focus again on delivery of the NHS long term plan. The NHS is also looking to continue development in those areas that were seen to provide a greater efficacy and quality in healthcare provision, particularly as regards integrated working and digital solutions.

The pandemic shone a light on the importance of partnership working, on effective business rules and financial governance. The following section looks at the statutory framework that aims to build on the collaborative working through Covid-19 and support recovery to meet the NHS long term plan.

2.5 Health and Care Act 2022

The Health and Care Act 2022[24] received Royal Assent on 28 April 2022. The Act built on the 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[25]. The proposals were developed from the *NHS long term plan* and the subsequent *NHS's recommendations to government and Parliament for an NHS bill*[26].

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[24] UK Government, Health and Care Act 2022

[25] Department of Health and Social Care, *Integration and innovation: working together to improve health and social care for all*, February 2021

[26] NHS England and NHS Improvement, *The NHS's recommendations to government and Parliament for an NHS Bill*, September 2019

Key provisions in the Act came into force from 1 July 2022. From this date, integrated care boards (ICBs) were established, and clinical commissioning groups (CCGs) abolished. The functions, staff, assets and liabilities of CCGs transferred to ICBs. There is a greater emphasis on collaboration, with the ICB becoming the statutory commissioning body within an ICS.

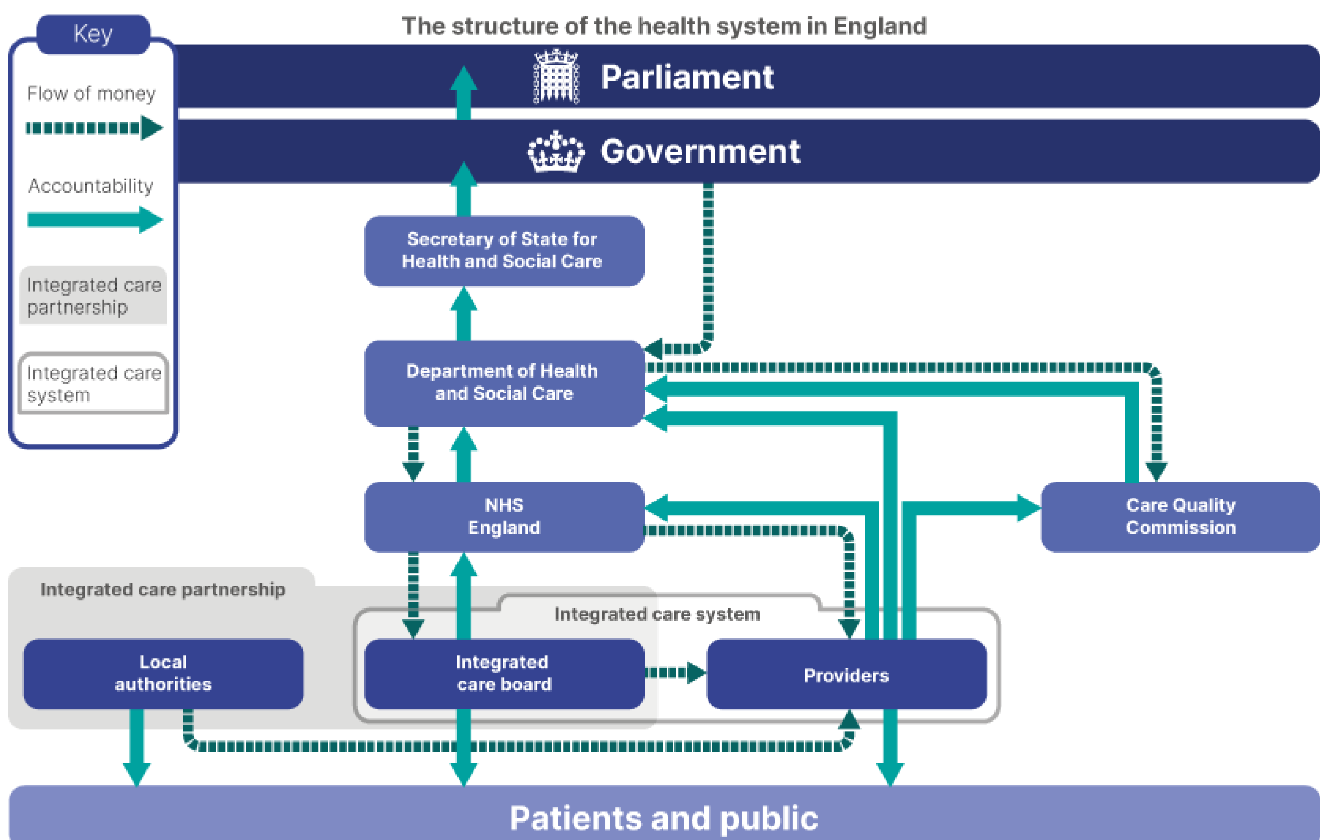
The ICB is responsible for:

- 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 allows NHS England to set financial allocations and other financial objectives at a system level. There is a statutory duty for all NHS bodies to meet the system financial objectives and deliver financial balance. NHS providers within the ICS retain their current structures, governance, and organisational financial statutory duties but there is a new duty to compel providers to have regard to the system financial objectives.

The Health and Care Act 2022 also established integrated care partnerships (ICPs). This partnership brings 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 new structure (simplified) is set out in the diagram below.

The current NHS structure



Since 2019, NHS England and NHS Improvement (made up of Monitor and the NHS Trust Development Authority (NHS TDA)) worked as a single organisation. However, the underlying statute did not allow them to fully collaborate. The Act transferred the powers of Monitor and NHS TDA to NHS England and abolished the previous organisations.

The white paper stated that the new legislation was not intended to address all the challenges faced by the health and social care system, and that further reforms would be needed. These broader changes include proposals to reform social care, the future design of the public health system and modernising the Mental Health Act.

The Health and Care Act 2022 not only built on the NHS long term plan but is also designed to accelerate the positive changes in the health and care system that have come about through the pandemic. However, 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.

2.6 Other plans and white papers

Build back better

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*[27] 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.

Additional funding through a health and social care levy was initially introduced from April 2022 as a 1.25 percentage point increase on national insurance contributions, but this approach was reversed in the September 2022 mini-budget. However, HM Treasury confirmed that the additional funding requirement arising from the *Build back better* plan would still be met.

People at the heart of care

People at the heart of care: adult social care reform[28] 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

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[27] UK Government, *Build back better: our plan for health and social care*, September 2021, updated March 2022

[28] Department of Health and Social Care, *People at the heart of care: adult social care reform*, December 2021, updated March 2022

than reactive intervention, helping people to retain or regain their skills and independence and preventing needs from developing.

The white paper sets out several '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 processes for direct payments, 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

Joining up care for people, places and populations[29] 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 several 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 level'[30] 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 were 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
- 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. Further detail on pooled and aligned budgets are included in *8.6 Local strategic partnerships*, but in summary:

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[29] Department of Health and Social Care, *Joining up care for people, places and populations*, February 2022
[30] Place: a geographic area that is defined locally, but often covers 250,000-500,000 people - for example, at borough or county level.

Pooled budgets -The pooling of budgets involves partner organisations formally combining funds into a single budget, to be spent on agreed projects for designated services.

Aligned budgets - Aligned budgets can be either an informal or formal arrangement whereby partners align resources to meet agreed aims but have separate accountability for the respective funding streams.

It is expected that the use of pooled and aligned budgets will increase, although existing mechanisms such as the better care fund[31] will be kept under review as progress accelerates.

A plan for digital health and social care

In June 2022 the government published *A plan for digital health and social care*[32]. This policy document noted that digital transformation will provide the foundations for long term sustainability of health and social care. Four digital goals were identified:

- equipping the system digitally for better care
- supporting independent healthy lifestyles
- accelerating adoption of proven technologies
- aligning oversight with accelerating digital transformation.

With the merger of NHS Digital into NHS England in February 2023, NHS England has responsibility for the design and operation of digital systems, and the national data infrastructure.[33]

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.
- 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. This is now enshrined in legislation.
- The Health and Care Act 2022 puts integrated care systems onto a legal footing.

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 online learning courses that are available. The directory of resources can be found here.

[31] NHS England, *Better Care Fund*, August 2022
[32] DHSC, *A plan for digital health and social care*, June 2022
[33] NHS England, *Digital transformation*