HFMA introductory guide to NHS finance

Chapter 2: Structure and development of the NHS

Chapter 2. Structure and development of the NHS

Overview

This chapter looks at the current NHS structure and how this has developed over the last 50 years. It also provides a summary of 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[1]. 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.

The NHS is Europe's largest employer with 1.7 million employees across the UK[2]. However, although it is usually referred to as if it were a single organisation, in reality it comprises a wide range of different bodies with specific responsibilities. We will look at many of these throughout this guide.

2.2 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 the major political parties remain committed to these core principles.

Other enduring characteristics of the NHS are that:

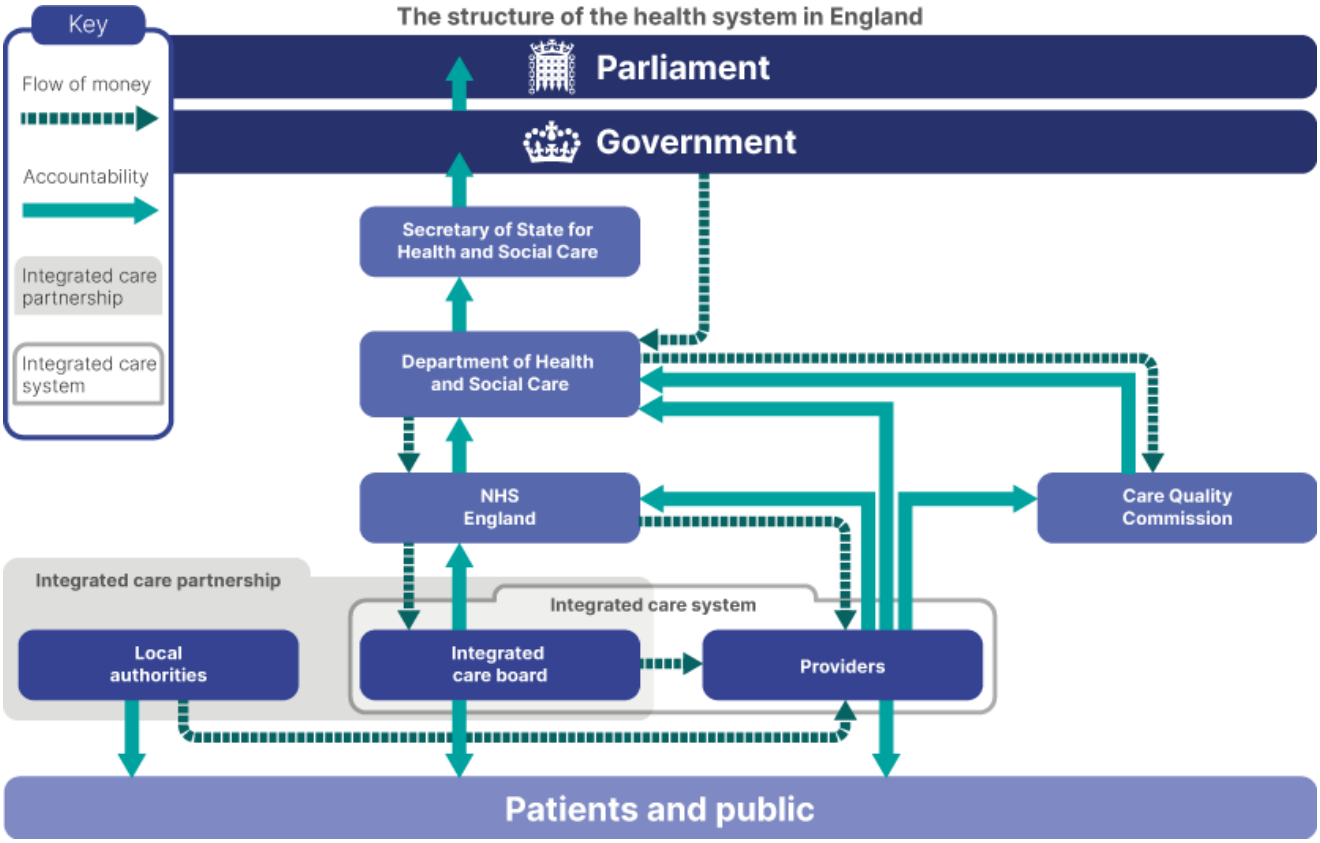
- it is funded through taxation
- it manages within overall resource limits determined by the government each year
- finite resources must be matched with what can seem like unlimited demand for health services with tough choices over priorities needed as a result
- there is an expectation that 'efficiency 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.

[1] UK Government, *The National Health Service Act 1946*
[2] Nuffield Trust, *The NHS workforce in numbers*, February 2024

2.3 The current NHS structure

The current NHS structure was established under the Health and Care Act 2022[3]. The details contained within the Act were first proposed in February 2021, in the *Integration and innovation: working together to improve health and social care for all* white paper[4]. These proposals were developed from the *NHS long term plan*[5] and the subsequent *NHS's recommendations to government and Parliament for an NHS bill*[6].

Figure 2.1 The current structure of the NHS in England



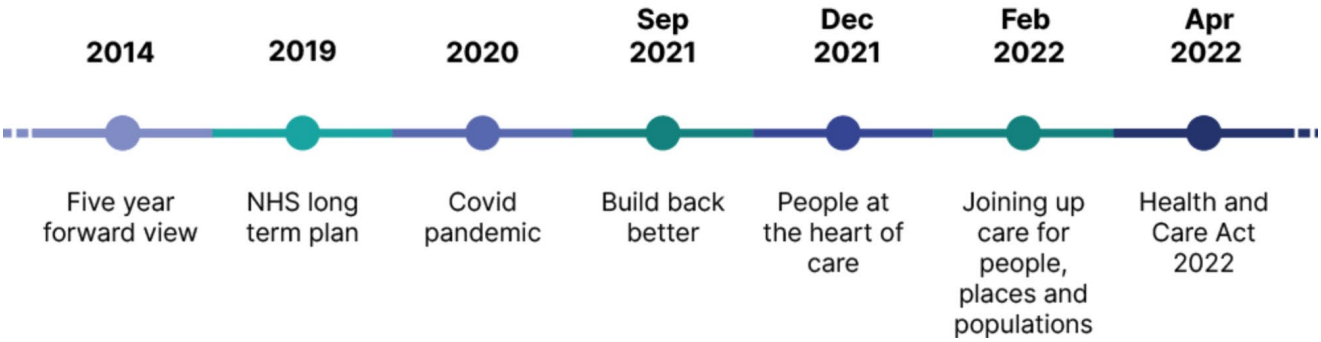
The current structure is built upon the principles of partnership working across healthcare bodies set out in the 2014 *Five year forward view*[7]. This is the starting point for looking at both legislation and policy developments.

2.4 Key legislative and policy arrangements for the current structure

The key principle that has underpinned recent developments and is a core feature of the current structure, is that of partnership working. This can be seen throughout the developments across the last ten years (figure 2.2), concluding with the Health and Care Act 2022.

[3] UK Government, Health and Care Act 2022
[4] Department of Health and Social Care, *Integration and innovation: working together to improve health and social care for all*, February 2021
[5] NHS, *The NHS long term plan*, January 2019
[6] NHS England and NHS Improvement, *The NHS's recommendations to government and Parliament for an NHS Bill*, September 2019
[7] NHS England, *The five year forward view*, October 2014

Figure 2.2 Developments from 2014



2.4.1 Five year forward view

The move to a greater focus on system and collaborative working can be traced to the 2014 *Five year forward view*. The developments that followed saw the beginning of the integrated care system - the foundation of the current structure. The forward view sets out the reasons for transformational change and the way that change may be achieved. The report stated that action was needed to:

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

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.

A significant step in December 2015 was the introduction of a single set of planning guidance across the NHS. *Delivering the forward view: NHS planning guidance 2016/17 – 2020/21*[8] also introduced the concept of geographically based sustainability and transformation plans (STPs). As well as issues concerning quality, workforce and finance, STPs needed to consider collaboration (including integration of services) and health and wellbeing at a local population level.

In early 2016, 44 STP areas or 'transformation footprints' were identified. 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 as not all services directly aligned across the same boundaries – for example, some community and mental health services.

With financial pressures continuing, it was recognised that the 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 2017 STPs became sustainability and transformation partnerships. As set out in the *Next steps on the NHS five year forward view*[9], it was intended that STPs would evolve into locally integrated care systems (ICSs).

---

[8] NHS England, *Delivering the forward view: NHS shared planning guidance 2016/17 – 2020/21*, December 2015
[9] NHS, *Next steps on the NHS five year forward view,* March 2017

Refreshing NHS plans for 2018/19[10] identified the ICSs framework as the one through which commissioners and NHS providers, working with GP networks, local authorities and other partners, agreed 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'.

The five-year forward view for general practice.

The *General Practice forward view*[11] was published in 2016 and NHS England committed an extra £2.4 billion a year to support general practice services by 2020/21. The plan focussed on five areas: investment, workforce, workload, practice infrastructure and care redesign.

The five-year forward view in mental health

The *Five year forward view for mental health*[12, 13] set out a view of the state of mental health services in England. It gave a long-term view of improvements needed along with a series of recommendations across NHS, 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) requires commissioners to increase spending on mental health in line with their overall increase in allocation each year.

2.4.2 NHS long term plan

Published in January 2019, the *NHS long term plan*[14] 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 NHS plan can be considered as the definitive long-term strategy for the NHS and brings together the previous visions. It 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. It provides a framework for local systems to develop plans, based on principles of collaboration and co-design.

In June 2019, the *NHS long term plan implementation framework*[15] set out the requirements on STPs/ ICSs when creating their five-year strategic plans. System plans were to be aggregated into a national implementation plan, and systems must ensure that local plans align with the following principles:

- clinically led
- locally owned
- workforce planning should be realistic
- are financially balanced
- long-term plan commitments must be delivered, and national access standards must be met

---

[10] NHS, *Refreshing NHS plans for 2018/19,* February 2018
[11] NHSE, *General practice forward view, April 2016*
[12] Mental Health Taskforce, *The five year forward view for mental health*, February 2016
[13] NHS, *Implementing the five year forward view in mental health,* July 2016
[14] NHS, *The NHS long term plan*, January 2019
[15] NHS, *NHS long-term plan implementation framework*, June 2019

- timeframes for implementation of NHS plan priorities should be phased, based on local need
- health inequalities and unwarranted variation must be reduced
- a focus on prevention, just not on treatment
- engagement with local authorities
- drive innovation.

2.4.3 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 face-to-face contact.

Managing the pandemic required significant changes in how healthcare was delivered, across clinical, corporate and administrative functions. With the removal of many traditional barriers, the pandemic demonstrated how organisations could work together to address a common challenge, with many areas reporting improved relationships across health and social care.

The pandemic shone a light on the importance of partnership working, effective business rules and financial governance – accelerating the NHS towards the goals set out in the *NHS long term plan*. The following section looks at the statutory framework that built on this collaborative working to support recovery from the demands of the pandemic.

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. Having to make such significant changes to the financial payment and contracting regime highlighted the requirement for a detailed review of arrangements. This is discussed in further detail in chapter 18.

2.4.4 Build back better

With NHS services focused upon the Covid-19 pandemic, routine treatments were adversely affected resulting in large increases in waiting lists and times as well as a noticeable drop in cancer care.

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*[16] focused on three main aspects: tackling the elective backlog, putting the NHS on a sustainable footing, and focusing on prevention.

The plan also set out the intention to support and enable integration between health and social care, to ensure that people experience well-coordinated care.

2.4.5 People at the heart of care

People at the heart of care: adult social care reform[17] 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.

---

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

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

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.

The vision 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 the 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.

2.4.6 Joining up care for people, places and populations

Joining up care for people, places and populations[18] sets out a vision to join up planning, commissioning, and delivery across health and adult social care. 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'[19] 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'. It also identifies that clear accountability is required at a place level so that all partners know where delivery and financial responsibility lies.

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 *6.6 Local strategic partnerships*.

2.4.7 The Health and Care Act 2022

The Health and Care Act 2022 builds on the *NHS long term plan* and subsequent developments, with the intention of advancing the collaborative working that evolved during the pandemic. The Act has three core themes[20]:

- removing barriers that stop systems being truly integrated
- reducing bureaucracy
- effective accountability arrangements

The key feature within the Act is the establishment of integrated care boards (ICBs). There is significant emphasis on collaboration, with the ICB as 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 Act also established integrated care partnerships (ICPs); see chapter 4 for more details. These partnerships bring together health, social care and public health as well as other bodies as

---

[18] Department of Health and Social Care, *Joining up care for people, places and populations*, February 2022
[19] Place: a geographic area that is defined locally, but often covers 250,000-500,000 people - for example, at borough or county level.
[20] DHSC, *Health and care act 2022: Impact assessment summary document and analysis of additional measures*, November 2022

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 for local authorities.

NHS England continues to set financial allocations and other financial objectives at a system level. All NHS bodies must meet the system financial objectives and deliver financial balance. NHS providers within the ICS retained their current structures, governance, and organisational financial statutory duties and are compelled to have regard to the system financial objectives.

The 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.

2.4.8 Subsequent key plans issued since 2022

The Health and Care Act 2022 not only built on the *NHS long term plan* but was also designed to accelerate the positive changes in the health and care system that came about through the pandemic. However, legislation is just one part of the change and much relies on having the right workforce, good leadership and the right incentives and financial flows.

A plan for digital health and social care

In June 2022 the government published *A plan for digital health and social care*[21]. 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.[22]

Workforce plan

In June 2023 NHS England published the *NHS long term workforce plan*[23]. This is the first comprehensive long-term strategy for NHS workforce planning and identifies three priority areas:

- train – growing the workforce through increases in education and development, considering what roles are needed to best meet patient needs, and looking at the routes available into NHS professional groups.
- retain – staff retention through improving support and enhancing flexibilities, together with improvements in culture and leadership.
- reform – improvements in productivity through better ways of working and training, building teams and ensuring that staff/ teams with the right skills are deployed effectively and efficiently to meet patient needs.

[21] DHSC, *A plan for digital health and social care*, June 2022
[22] NHS England, *Digital transformation*, February 2024
[23] NHS England, *NHS long term workforce plan,* updated January 2024

Payment systems

In April 2023 NHS England amended the payment mechanism that is used by commissioners to reimburse providers of NHS healthcare in England. The mechanism known as the national tariff was replaced by the NHS payment scheme (NHSPS)[24].

The NHSPS sets out four payment approaches[25]:

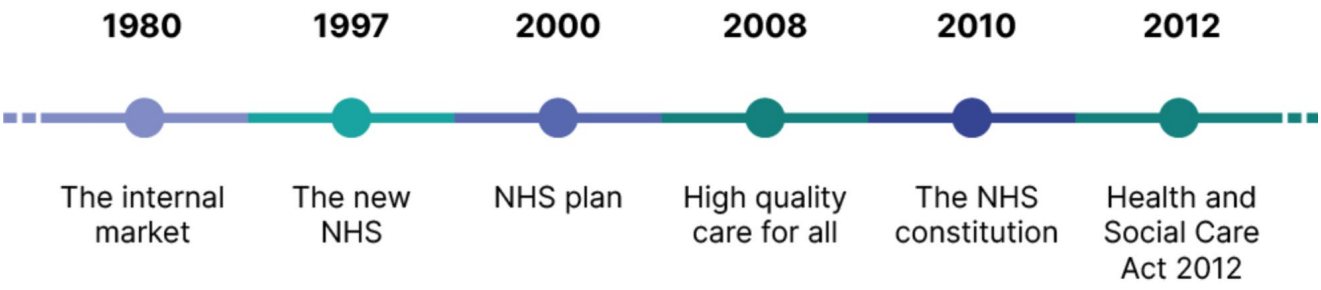
- contracts with NHS providers over £0.5m per annum use a form of blended payment – the fixed element funds an agreed level of activity with a variable element based on levels of activity.
- contracts with NHS providers under £0.5m per annum use a block payment approach with a nationally set value.
- contracts with non-NHS providers are based on activity with a nationally set price.
- a local payment approach can be used if none of the above approaches apply.

Further details can be found in chapter 16.

2.5 Developments from the 1980s that continue to have an impact

The period from the 1980s through to 2012 saw significant changes across the NHS, many of which are still a significant element of today's NHS. Knowledge of these changes is important in understanding how we got to where we are today.

Figure 2.3 Developments from the 1980s through to the Health and Social Care Act 2012



2.5.1 The internal market, 1980s

In the late 1980s it was decided that the NHS should be reconfigured to operate as a 'quasi-market', known as the internal market. 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, provider organisations had to follow an application process that assessed viability and robustness. Trusts were encouraged to invest and develop services, and also to compete to win patient service contracts.

In addition, an optional scheme (known as GP fund holding) gave general practitioners (GPs) the ability to hold budgets for the purchase of hospital services for their patients.

[24] NHS England, *NHS payment scheme*, 2023
[25] NHS England, *2023-25 NHS payment scheme,* updated December 2023

2.5.2 The new NHS, 1997

In 1997, the white paper *The New NHS*[26] set out a programme for reform of the NHS. These proposals became law with the 1999 Health Act[27]. 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 focus shifted away from the underlying competitive nature of the internal market to a more collaborative model. These changes in policy sought to ensure the seamless delivery of services.

Commissioning and the purchaser/ provider split

The purchaser/ provider split created by the internal market was retained, however GP fund holding was abolished and new organisations for primary care were introduced.

GP representation and engagement within the commissioning process was initially through health authority sub-committees. As these arrangements became more established, GP groups were able to apply for trust status. These new Primary Care Trusts (PCTs) were independent from the health authority and took on responsibility for managing increasingly significant allocations from the health authorities. Eventually health authorities were abolished and PCTs took over responsibility for commissioning the majority of hospital services.

Regulation

The 1999 Health Act established the Commission for Health Improvement (CHI). CHI's statutory functions were to:

- provide national leadership to develop and disseminate clinical governance issues
- independently scrutinise local clinical governance through a rolling programme of reviews of clinical governance arrangements
- review and monitor local and national guidelines
- help the NHS identify and tackle serious service failures.

CHI has since been replaced by the Care Quality Commission.

The 1999 Health Act also established the National Institute for Health and Clinical Excellence or NICE. The body was established to create consistent guidelines across the NHS and is now the National Institute for Health and Care Excellence.

Management costs

Emphasis was renewed on reducing 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 used to help deliver this objective through the consolidation of some administrative and back-office functions. For example, invoice processing or payroll services could be brought under a shared service partner, accessing economies of scale and freeing up local teams to be able to have a greater focus on financial advice and support.

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).

---

[26] UK Government, *The new NHS*, December 1997
[27] UK Government, Health Act 1999

Collaboration

The NHS was encouraged to form partnerships with both private and public sector partners, including local authority social services. The 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, that 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.

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

The 2000 *NHS plan*[28] 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.

In the following years, various developments in both structure and ways of working, were introduced.

Organisational developments in 2002

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. The changes (*Shifting the balance of power*[29]*)* 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 community services provided by PCTs.

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

Payment by results, 2003

Payment by results (PbR) was designed as a payment system that ensured that money and patient flows were aligned, and was set out in 2002 in *Delivering the NHS plan*[30] .

This was essential for patient choice – by introducing nationally-set standard prices for treatments, the need for local negotiation on price was removed and the focus shifted to quality and responsiveness. The combination of patient choice and PbR was expected to drive an increase in healthcare capacity and deliver shorter patient waiting times.

The first steps to introduce the PbR financial framework were taken in 2003/04. Chapter 18 looks in more detail at the way that NHS services are reimbursed.

NHS foundation trusts, 2004

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[31]. By

---

[28] Department of Health, *The NHS plan: a plan for investment, a plan for reform*, July 2000
[29] Department of Health, *Shifting the balance of power*, July 2001
[30] Department of Health, *Delivering the NHS plan*, April 2002
[31] UK Government, Health and Social Care (Community Health and Standards) Act 2003

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, the number of FTs grew steadily 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.

Further organisational developments, 2005

SHAs, PCTs and ambulance trusts were subject to a significant re-organisation in 2005. The aim was to reduce management overheads and generate cost savings that could be re-invested in the provision of healthcare.

PCT numbers reduced from 303 to 152 – reflecting the simplification of the commissioning process inherent in the patient choice and PbR initiatives.

SHAs reduced from 28 to 10 – the new SHA boundaries were aligned with the geographical span of the government offices for the regions.

Ambulance trusts reduced from 31 to 13 - designed to achieve purchasing and management economies of scale and to facilitate greater resilience through larger scale operations.

2.5.4 High quality care for all, 2008 (the Darzi review)

In July 2007, the government asked the then health minister Lord Darzi to carry out a wide-ranging review of the NHS. The final report – *High quality care for all*[32], 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'.

2.5.5 The NHS constitution, 2010

In January 2010, the first ever *NHS constitution*[33] 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. The constitution identifies seven key principles for the NHS:

- a comprehensive service, available to all
- access based on clinical need, not on ability to pay
- aspiration to the highest standards of excellence and professionalism
- the patient at the heart of everything
- working across organisational boundaries
- provides best value for money
- accountability to the public, communities and patients.

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

2.5.6 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.

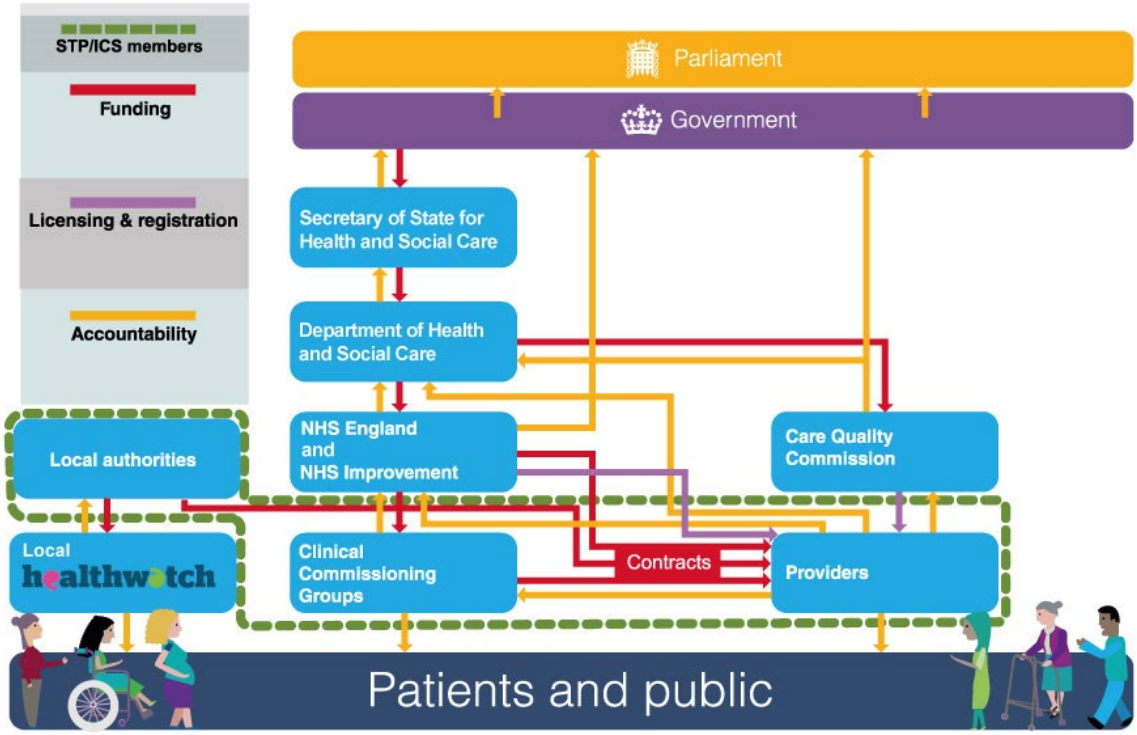
2.5.7 The NHS structure 2012 to 2022

The 2012 structure could be considered as the foundation of the current NHS structure and is shown in the diagram below. The key changes introduced by the 2012 Act were:

- abolishing SHAs and PCTs from April 2013 and establishing clinical commissioning groups (CCGs).
- CCGs had responsibility for the majority of NHS commissioning and were authorised by (and accountable to) NHS England
- established NHS England (NHSE). At this time, NHSE did not have responsibility for the provider sector. Responsibilities included the management of CCGs and funding allocations. NHSE also had a responsibly for commissioning some specialist services
- setting up the NHS Trust Development Authority within the Department of Health to oversee NHS trusts
- handing responsibility for public health to local authorities, establishing Public Health England within the Department of Health.

The structure is shown in the diagram below and came into effect in April 2013.

Figure 2.4: NHS structure 2012 - 2022



Other developments included:

- setting up health and wellbeing boards (HWBs) 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.

The Act also changed the powers of FTs, and Monitor was given role of sector regulator for the health and social care sectors, with responsibility for licensing healthcare providers, setting and regulating prices (with NHS England) and ensuring continuity of services.

The role of the CQC was strengthen including setting up HealthWatch England as an independent committee within the CQC to support and lead local HealthWatch bodies.

Subsequent amendments

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 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.

Key learning points

- Collaboration and integration have been drivers for change in the NHS since 2014, although you can see this coming to the fore during the 1990s and 2000s.
- 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.
- 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 with integrated care boards as the NHS statutory body of each ICS.

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.