CLINICAL FINANCE JOURNAL: VOLUME 2 ISSUE 1 2021
HTTP:// 10.47113/FFCFJ.V2I1.20

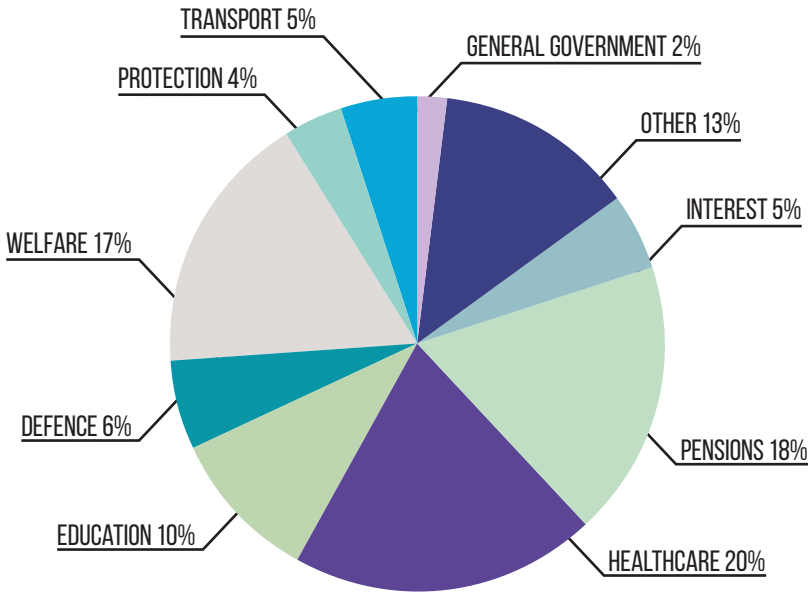
THE STRUCTURE OF THE NHS AND HOW MONEY FLOWS

S Rowe
Programme Manager
One NHS Finance

Healthcare receives the largest amount of pre-allocated public money; despite the large amounts of money given to the NHS, this is still a finite resource.

The NHS grapples with an ever-increasing expenditure commitment due to a combination of an ageing population with increasingly complex healthcare needs, advancing scientific understanding in medical sciences coupled with increasing pharmaceutical costs. As this increase in expenditure has not been met by the same rise in allocated funding, the NHS has undergone numerous reforms over the years (see figure 2) to meet this challenge.

The past year has been the most challenging in the history of the NHS. As recently as February 2021, the latest white paper 'Integration and Innovation: working together to improve health and social care for all' was outlined in Parliament, proposing significant changes to primary legislation.[1] This article sets out to explain the structure of the NHS, how this is changing and how the money flows through the system.



Source: https://www.ukpublicspending.co.uk/uk_budget_pie_chart

HEALTHCARE FUNDING

How public money is spent is determined by Parliament and, more specifically, the Chancellor of the Exchequer. Money allocated to healthcare is determined by the Spending Review, which would usually occur every 3 years and is amended annually by the Budget report. Due to the uncertainty caused by the coronavirus pandemic, it was decided that the latest Spending Review in November 2020 would cover April 2021 - March 2022.

The government department responsible for healthcare is the Department of Health and Social Care (DHSC) which has the largest amount of pre-allocated public money with an annual budget for 2021/22 of £169.1 billion (bn), including £22bn of COVID-19 funding[2]. The DHSC budget is divided into £147.1bn of revenue funding to cover day-to-day running costs such as staff salaries and medicines and £9.4bn of capital funding to pay for infrastructure and equipment and building maintenance costs. Out of the government's core capital funding are funding commitments of £3.7bn until 2024/25 to make progress on building 40 new hospitals, and £1.7bn until 2024/25 for over 70 hospital upgrades.[3]

In 2020, the UK was faced with the biggest health crisis in a generation, and the government promised that the NHS would have "whatever resources it needs" to deal with the outbreak.[4] For 2020/2021, there was approximately an additional £58bn of extra funding that was received to fund NHS Test and Trace (around £22bn), the procurement of personal protective equipment at approximately £15bn, £2.7bn for vaccines[5] and funding the independent sector to undertake some planned treatment of patients.

Additional funding for 2021/22 of approximately £22bn for the costs of the pandemic has been planned, including £2.1bn for maintaining and distributing Personal Protective Equipment stocks, £15bn for Test and Trace and £163 million for COVID related medicines and therapeutics[6]. The £22bn includes the £3bn the NHS will receive to help clear the waiting lists for mental health and the elective backlog. As we continue to respond to the pandemic, additional funding will be needed; we cannot yet predict how much will be required and how long the pandemic will continue.

It is important to note here that the DHSC is not the main source of public funding for adult social care, though it may gain some strategic oversight in the new legislation likely to come into effect in 2022. Local Authorities fund social care via the Ministry of Housing, Communities and Local Government. [7]Through Clinical Commissioning Groups, the NHS does have pooled budgets with Local Authorities known as the Better Care Fund; this pooled funding arrangement in local areas supports NHS organisations and local government to plan and deliver services jointly. The Better Care Fund aims to help people manage 'their own health and wellbeing and live independently in their communities for as long as possible.'[8]

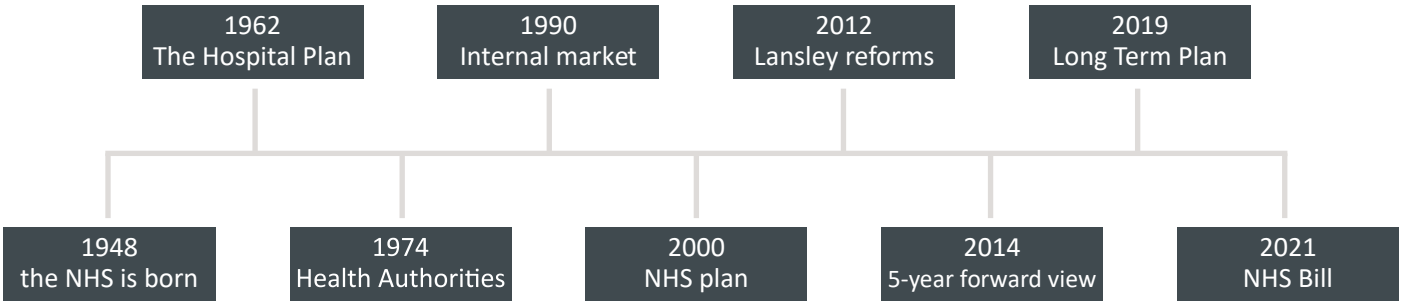
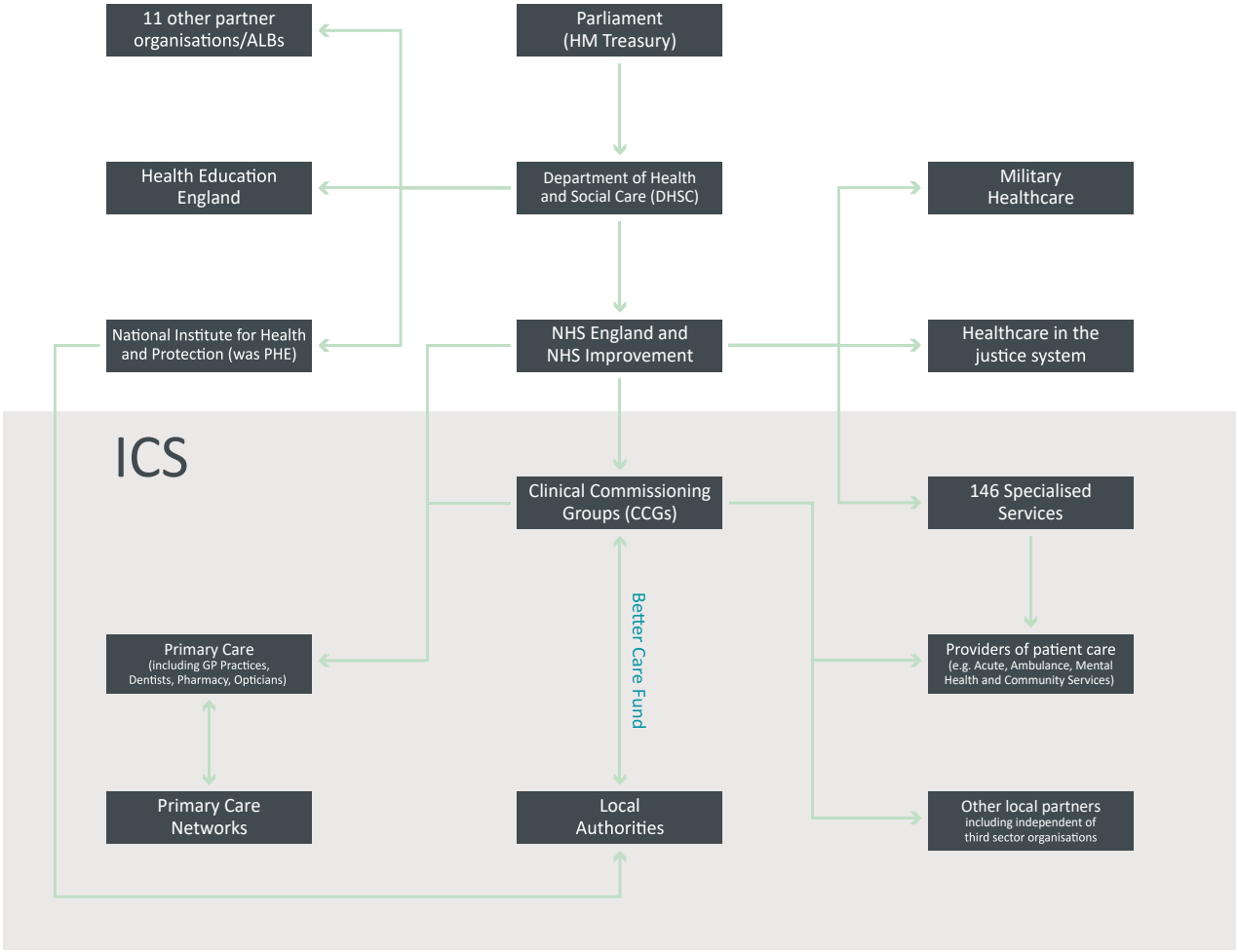


Figure 2: Timeline of the Major NHS Reforms

NHS STRUCTURE



WHO DOES WHAT?

EXECUTIVE AGENCIES	SPECIAL HEALTH AUTHORITIES	EXECUTIVE NON-DEPARTMENTAL PUBLIC BODIES
Part of Department of Health, but with greater independence than a section of the department	These are independent bodies but are still subject to ministerial direction.	These are established by primary legislation and have a statutory function. They operate at arm's length from ministers and are overseen by a board.
▪ Medicines and Healthcare Products Regulatory Agency (MHRA) ▪ Public Health England soon to be National Institute for Health Protection	▪ NHS Business Services Authority ▪ NHS Blood and Transplant ▪ NHS Resolution ▪ NHS Counter Fraud	▪ NHS England and NHS Improvement ▪ Care Quality Commission (CQC) ▪ National Institute of health and care excellence ▪ NHS Digital ▪ Health Education England (HEE) ▪ Health Research Authority ▪ NHS Digital ▪ Health Education England

The **Care Quality Commission** is an independent regulator who monitor, inspect, and regulate health and social care services to ensure that they meet with set quality and safety standards. The CQC set out the standards of care that are good and outstanding, and check that services are not falling below the fundamental standards of care that are expected. They publish findings from inspections and issue ratings to help patient's to choose their care. Where poor care is found, the CQC have powers to take action.

Health Education England is responsible for the education and training of the Healthcare Workforce. The Chancellor announced an additional £260 million for Health Education England to support training and retention of the NHS workforce.[9]

National Institute for Health Protection is replacing Public Health England. This new organisation will contain 'NHS Test and Trace' and the 'Joint Biosecurity Centre', alongside absorbing the current responsibilities of Public Health England, which include responding to threats from environmental hazards and infectious diseases, preventing poor health and reducing health inequalities. The pandemic has really highlighted the extent of health inequalities that need to be addressed in this country.

Health Research Authority protect and promote the interests of patients and the public in health and social care research.[10] The HRA regulate aspects of health and social care research ensuring that the research is ethically reviewed and approved, promoting transparency and providing independent recommendations re the process of patient identifiable data where it is not practical to gain consent.

National Institute for Health and Care Excellence provide national guidance and advice to improve health and social care.[11] NICE provide evidence based guidance and advice for practitioners, develops quality standards and performance metrics and provides information to improve outcomes for people using the NHS and other public health social care services.

NHS Digital are the national information and technology partner to the health and social care system using digital technology to transform the NHS and social care.[12] NHS Digital teams design, develop and operate the national IT and data services that support clinicians at work, help patients get the best care, and use data to improve health and care.

NHS Business Services Authority are responsible for providing platforms and delivering services that support the priorities of the NHS, government and local health economies. In so doing, they manage around £35 billion of NHS spend annually.[13] They are responsible for managing the NHS Pension Scheme and NHS Prescription Services.

NHS Blood and Transport manage NHS blood donation and transplant services in England and across the UK.[14] They collect and process donations of blood, care for blood transfusion patients, support and care for organ, tissue and stem cell donors and patients. They also provide research, diagnostic and therapeutic services in relation to blood transfusion, stem cell and organ donation.

Medicines and Healthcare Products Regulatory Agency regulates medicines, medical devices and blood components for transfusion in the UK.[15] The MHRA has two funding sources; the DHSC funds the regulation of medical devices, whilst the regulation of medicines is primarily financed through fees paid by the pharmaceutical industry. The agency ensures that medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy, that the supply chain is safe and secure, they educate the public and healthcare professionals about the risks and benefits of medicines, medical devices and blood components and support innovation and research and development that's beneficial to public health. The February White Paper outlined that the MHRA would be allowed to set up national medicines registries.

NHS Resolution manages negligence and other claims against the NHS in England on behalf of its members, manages concerns about practitioner performance, deal with Primary care appeals and supporting the NHS to better understand and learn from claims, concerns and disputes; to help providers of NHS care to target safety activity.[16]

Human Fertilisation and Embryology Authority are responsible for making sure fertility clinics, and research centres comply with the law.[17] By licensing, monitoring and inspecting fertility clinics, the authority ensures that everyone who steps into a fertility clinic, and everyone born as a result of treatment, receives high quality care.

Human Tissue Authority ensures that human tissue is used safely and ethically and with proper consent.[18] The authority regulates organisations that remove, store and use

human tissue for research, medical treatment, post-mortem examination, education and training, and display in public. They also give approval for organ and bone marrow donations from living people.

NHS Counter Fraud Authority leads the fight against fraud, bribery and corruption in the NHS.[19] They use information from a wide range of sources to build a better understanding of the fraud risks faced by the NHS and develop creative, innovative and proportionate solutions to tackle fraud. The authority also investigate the most serious, complex and high-profile cases of fraud, and work closely with the police and the Crown Prosecution Service to bring offenders to justice.

NHS England and NHS Improvement work together as a single operating model that has been designed to support the delivery of the NHS Long Term Plan. They support the NHS to deliver improved care for patients through 7 regional teams.

The new legislation will see NHS England and NHS Improvement officially merge and be designated as NHS England, which we expect to come into practice in 2022. There will be enhanced powers of direction for the government over NHS England. NHS England has been at arms-length since 2012 via annual mandate with limited powers of intervention from the Secretary of State for Health. The new legislation will give direct accountability of the NHS to the Secretary of State. There will be further measures to enable reforms to the NHS mandate to allow flexibility in timing, power to transfer functions between ALBs and removal of time limits on Special Health Authorities.

COMMISSIONING

NHS England and NHS Improvement receives the majority of the Department of Health budget with funding for 2021/22 of £139.1bn, including the £3bn of additional COVID-19 funding mentioned above. In 2018, then Prime Minister Teresa May announced a £20.5bn 5-year settlement for the NHS. The NHS Long Term Plan that was published in January 2019 sets out the key ambitions for the NHS over the next ten years and the priorities for the additional funding. The plan builds on the policy platform laid out in the NHS Five Year Forward View, which expressed the need to integrate care to meet the needs of a changing population.20

According to NHS England, "Commissioning is the process of planning, agreeing, and monitoring services". Commissioning aims to improve health outcomes, reduce health inequalities, improve quality and increase productivity. NHS England and NHS Improvement directly commission many services, including, Dentistry, Community Pharmacy, Primary ophthalmic services, military healthcare, health services in the justice system (for healthcare for children, young people and adults across secure and detained settings) and specialised services.

There are 146 directly commissioned specialised services with a budget of roughly £20.1 billion. They are grouped into six national programmes of care, NPoC, who oversee the commissioning of specialised and highly specialised services.21

The role of the NPoC is to provide leadership and oversight of the development and delivery of a comprehensive work programme that achieves demonstrable improvements in the quality, equity, value and outcomes of commissioned specialised services. There are six national programmes of care, each including a Board and then a number of Clinical Reference Groups (CRGs), which are groups of clinicians, commissioners, public health experts, patients and carers.

The majority of NHS England and NHS Improvements budget, around £85 billion, is allocated to Clinical Commissioning Groups (CCGs). There are currently 106 CCGs in England as of April 2021, a number that is decreasing in the move towards Integrated Care Systems; there were 192 at the beginning of 2019/20.

These groups are clinically led and comprise mainly of GPs, but also include representatives from nursing, the public and hospital doctors. CCGs plan and commission services for their patients, including planned hospital care, rehabilitative care, urgent and emergency care, community health services, mental health, and learning disability services.

Since April 2015, Primary care or GP services are co-commissioned by NHS England and NHS Improvement and CCGs. Primary care co-commissioning was introduced to support the development of integrated out-of-hospital services based on local people's needs.22 The Budget for Primary care is around £8.8bn.

NATIONAL PROGRAMME OF CARE	SERVICES COVERED
Internal Medicine	Covers defined specialised and highly specialised services related to digestion (colorectal), renal (kidney), hepatobiliary (liver and pancreas) and the circulatory system (heart, lungs and vascular). As well as specialised medical services in skin, endocrinology and rheumatology, Internal Medicine also includes the majority of the solid organ transplant services. The Internal Medicine NPoC consists of a Board and nine Clinical Reference Groups (CRGs) that provide clinical advice and leadership on the specialised services in Internal Medicine.
Cancer Care	Includes complex cancer surgery, radiotherapy and chemotherapy. The role of the Cancer NPoC is to support the commissioning of specialised and highly specialised cancer services. This involves the development of national commissioning products, such as service specifications and clinical policy, as well as the provision of expert clinical and commissioning advice to support service improvement and innovation. The Cancer NPoC team works directly with four cancer specific CRGs and a National Specialty Advisor for PET-CT and is supported by a Steering Group.
Trauma	Covers specialised services in traumatic injury, orthopaedics, head and neck and rehabilitation. It consists of an NPoC Board and seven CRGs.
Women and Children	Covers services in women and children, congenital and inherited diseases. It consists of an NPoC Board and ten CRGs which includes specialised surgery in children, neonatal critical care and specialised women's services.
Blood and Infection Services	Covers specialised services in infection, immunity and haematology. It consists of an NPoC Board and six CRGs.
Mental Health	Encompasses perinatal and child mental health as well as specialised mental health and forensic psychiatric services.

SOURCES OF INCOME FOR CCGS

CCGs receive their funding allocations from NHS England based on weighted capitation formulas, where the population size is adjusted based on health needs and reflect regional cost variations.23 The formula used for allocations means that deprived areas or areas with an older population receive more money than they would if it was based on population alone. Once CCGs have received their allocations, it is up to them to plan and buy services for their population based on local needs. CCGs also have a responsibility to monitor the quality of care they have commissioned from hospitals for their population.

In the move to Integrated Care Systems, funding is increasingly being allocated at the system level as a system envelope, allowing for strategic commissioning focussing on population health outcomes and for the ICS to delegate budgets to the place level, with decisions being made closest to the communities that the resources serve. From 2021/22, both capital and revenue resources will be allocated at ICS level.

SOURCES OF INCOME FOR GPS

GP practices are funded through several different income streams. Around half of its income comes from the global sum payment which includes out of hours and additional services. The payment is based on an estimate of a practice's workload and certain 'unavoidable costs' the additional costs of serving a rural or remote area or the effect of geography on staff markets and pay, rather than on the actual activity that is carried out.24

The average practice list size is 9,085, and the list is weighted based on the Carr-Hill formula (which accounts for factors such as age and gender). The value per patient rate for 2021/22 is £97.28, which is paid monthly. The payment is reviewed quarterly to account for changes to the practice population.

Other funding streams for GP practices include:

Quality Outcomes Framework (QOF) – a point based incentive scheme for GP practices that is voluntary for practices to opt into. Payments are made for good performance against indicators that include common chronic conditions, public health concerns and preventative services.

Local / Designated Enhanced Services – services agreed nationally (DES) or locally (LES) that supplement core services, this is also voluntary. They cover such things as Learning Disability Health Check, minor surgery and de-registered patients.

Premises Funding – practices are reimbursed by the CCG for water rates, clinical waste and rent if the property is leased or mortgage payments if owned.

Primary Care Networks – member practices receive a participation payment.

SOURCES OF INCOME FOR PROVIDERS

The majority of a trust's income comes from commissioning, mainly from CCGs/ICSs but also partly from NHS England via Specialist Service Commissioning. Other sources of income include private patients, leasing of property, car parking charges, retail and catering facilities and education, training and research.

Once a commissioner agrees to a contract with a provider, the contract determines the payment mechanism by which the services are paid. There are many different payment systems for providers, some of which are outlined in figure 3.

During the pandemic, providers received payment on a block basis to provide financial certainty during the crisis. This will continue into the first 6 months of 2021/22 (H1) for providers

Block	A "lump-sum" payment to cover a specific or range of services, with no dependency on the quantity of demand or supply. **Example: Community services**
Capitation	A "lump-sum" payment linked to size and "complexity" of population served by a provider. **Example: GP services**
Pathway of care	A single payment to cover activity related to aspects of a specific pathway of care. **Example: Hospital maternity services**
Pay for performance	Payment linked to the delivery of specific performance targets. **Example: GP Quality for Outcomes (QOF) - Commissioning for Quality and Innovation (CQUIN) in Acute, Community and Mental Health Services**
Per diem	A "lump-sum" payment per patient per day of care. **Example: Excess bed days in the acute sector**
Care based	Activity based reimbursement based prospectively on complexity of diagnosis/ treatment/patient characteristics. **Example: National tariff based payments in acute and mental health services**
Pass through	Cost of service delivery paid by commissioning body. **Example: High cost chemotherapy drugs**

Drawn from Appleby et al., (2012)- Figure 3 outlines some of the traditional payment systems used in the NHS

along with any Covid-19 allocations. Acute providers may also receive funding through the Elective Recovery Framework for any elective activity that is carried out above the threshold value of activity and acute, mental health and community providers may receive service delivery funding to enable delivery of Long Term Plan priorities.

The block payments include CQUIN payments, and commissioners are not currently withholding payment for non-achievement of CQUIN. Payments for patients visiting from another commissioner area (NCAs) are also included within the system envelope and therefore charging NCAs is also suspended during H1 of 2021/22.

As we move to the system working, there will be a change in payment systems and a shift towards whole system contracts. NHS England and NHS Improvement have been developing a new payment system for the future, which is anticipated to be a blended payment model.

For more information on NHS Payment Systems, please read 'Payment Systems in the NHS', which can be found in issue one of this journal.25

MOVING TO INTEGRATED CARE AND SYSTEM WORKING

In 2015, England was divided geographically into 44 areas, each with an average population of 1.2 million, though it ranges from 300,000 to 2.8 million. NHS organisations and local councils were asked to collaborate and develop plans on how they would meet their populations' health and social care needs. These groups are known as Sustainability and transformation partnerships or STPs.

STPs have now evolved into Integrated Care Systems or ICSs, which are alliances of providers such as hospitals, community services, mental health services, GPs and may even include independent or third sector organisations that decide to work together to deliver care rather than compete. ICSs will not improve population health or the health inequalities that have been highlighted in the pandemic without involving local government. The goal is to facilitate 'joined up care for everyone in England', ensuring all parts of the NHS, public health and social care system connect and collaborate.26

It is likely that funding will increasingly be distributed at the ICS level with commissioning on a more strategic basis. The impact of COVID-19 has accelerated many of the changes needed to work effectively as a system and delayed some timelines as attention remains on COVID support and managing our exit from the pandemic.

Another key aspect of the Long Term Plan was the creation of Primary Care Networks or PCNs. PCNs are made up of neighbouring general practices covering a population of between 30,000-50,000 people. PCNs' build on existing primary care services and enable a greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home.'27 £1.8bn of the £2.8bn promised over five years in The NHS long term plan will come through the network contract rather than directly to individual practices.

SUMMARY

In summary, £1 in every £5 of government spending is spent on healthcare. The money flows from Parliament via the Department of Health and Social Care and NHS England and NHS Improvement and in the most part Clinical Commissioning Groups to the organisations that provide patient care.

However, there are many organisational changes coming with a shift to system working with integrated care becoming the default as outlined in the White Paper setting out legislative proposals for a Health and Care Bill.

Integrated care is based on the concept of population health, where ICSs are responsible not just for the treatment of their population but also to keep them healthy in the first place. The legislative changes that we expect to come into place in 2022 will be the biggest changes to the health service since the 2012 Lansley Reforms.

There will still be a role for commissioners in the world of integrated care, but it will look different and 2021/22 will be a key year to start to see what these changes look like – and how COVID affects this.

KEY WORDS

NHS, Cost improvement plans, Error, Harm, Opportunity Costs,

REFERENCES:

1. https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all
2. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/966868/BUDGET_2021_-_web.pdf p.32
3. November 2020 Spending Review, NHS Providers, https://nhsproviders.org/media/690572/november-2020-spending-review-final.pdf
4. https://www.bbc.co.uk/news/av/uk-politics-51791165
5. November 2020 Spending Review, NHS Providers, https://nhsproviders.org/media/690572/november-2020-spending-review-final.pdf
6. https://www.gov.uk/government/publications/spending-review-2020-documents/spending-review-2020#departmental-settlements
7. https://www.nuffieldtrust.org.uk/news-item/who-organises-and-funds-social-care#england
8. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/about-the-better-care-fund/
9. November 2020 Spending Review, NHS Providers, https://nhsproviders.org/media/690572/november-2020-spending-review-final.pdf
10. https://www.hra.nhs.uk/about-us/what-we-do/
11. https://www.nice.org.uk/about
12. https://digital.nhs.uk/
13. https://www.nhsbsa.nhs.uk/what-we-do
14. https://www.nhsbt.nhs.uk/
15. https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency
16. https://resolution.nhs.uk/
17. https://www.hfea.gov.uk/
18. https://www.hta.gov.uk/
19. https://cfa.nhs.uk/
20. The NHS Long Term Plan Explained, The Kings Fund https://www.kingsfund.org.uk/publications/nhs-long-term-plan-explained
21. https://www.england.nhs.uk/commissioning/spec-services/npc-crg/
22. About Primary Care co-commissioning, https://www.england.nhs.uk/commissioning/pc-co-comms/pc-comms/
23. NHS Funding Allocations:Clinical Commissioning Groups, House of Commons Library Briefing Paper September 2019, Rachel Harker
24. https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained
25. http://www.clinicalfinancejournal.co.uk/index.php/home/article/view/13
26. Integration and Innovation: working together to improve health and social care for all by the Secretary of State for Health and Social Care, February 2021, p.7
27. https://www.england.nhs.uk/primary-care/primary-care-networks/