HFMA introductory guide to NHS finance

Chapter 21: Health and Social Care in Northern Ireland

Chapter 21. Health and Social Care in Northern Ireland

Overview

This chapter describes the structure and governance of the Health and Social Care (HSC) service in Northern Ireland.

In addition, the chapter outlines the significant structural changes that are being introduced during 2022. The HSC is currently developing new arrangements and processes to deliver an integrated approach to health care delivery, one that empowers healthcare partners to work in partnership across organisational boundaries.

21.1 Introduction

The primary difference between the NHS in England and services in Northern Ireland is that in Northern Ireland health services and social care are fully integrated. The Department of Health (DoH) is one of the nine government departments that administers the responsibilities devolved to the Northern Ireland Assembly (NIA).

Currently, the specific elements of the health and care system for Northern Ireland consist of the Strategic Planning and Performance Group (SPPG) within the DoH, a multi-professional Public Health Agency (PHA), five local commissioning groups (LCGs) to cover the same geographical area as five health and social care trusts (HSC trusts) and seventeen integrated care partnerships (across the five local commissioning group (LCG) areas to ensure coverage of all GP practices).

The Northern Ireland Ambulance Service is the sixth trust in Northern Ireland and provides a regional emergency and non-emergency ambulance service. A regional Business Services Organisation (BSO) provides a range of business and administrative support functions for the health and social care service.

In recent years the DoH has published several documents and consultations as part of a long-term strategy to develop and enhance healthcare services across the region. In 2019, the DoH published *Quality 2020*[280] that set out a 10-year plan to protect and improve the quality of health and social care. The strategy identifies several design principles that should continue to inform planners and practitioners over the next 10 years. The strategy states that a high-quality service should:

- be holistic in nature
- focus on the needs of individuals, families and communities
- be accessible, responsive, integrated, flexible and innovative
- surmount real and perceived boundaries
- promote wellbeing and disease prevention and safeguard the vulnerable
- operate to high standards of safety, professionalism and accountability
- be informed by the active involvement of individuals, families and communities, HSC staff and voluntary and community sectors
- deliver value for money ensuring that all services are affordable, efficient and cost-effective.

---

[280] DoH, *Quality 2020,* October 2019

In 2021 the Health and Social Care Bill was introduced to address identified weaknesses in the system, particularly around complex and bureaucratic structures, and to provide greater clarity and transparency on accountability and decision-making. The bill became law in 2022 (*Health and Social Care Act (Northern Ireland)*[281] *2022* (the Act).

In 2022, the DoH also published a consultation entitled *Future Planning Model – Integrated Care System NI, Draft Framework*[282] (the framework). This identified the purpose of the integrated care system (ICS) as:

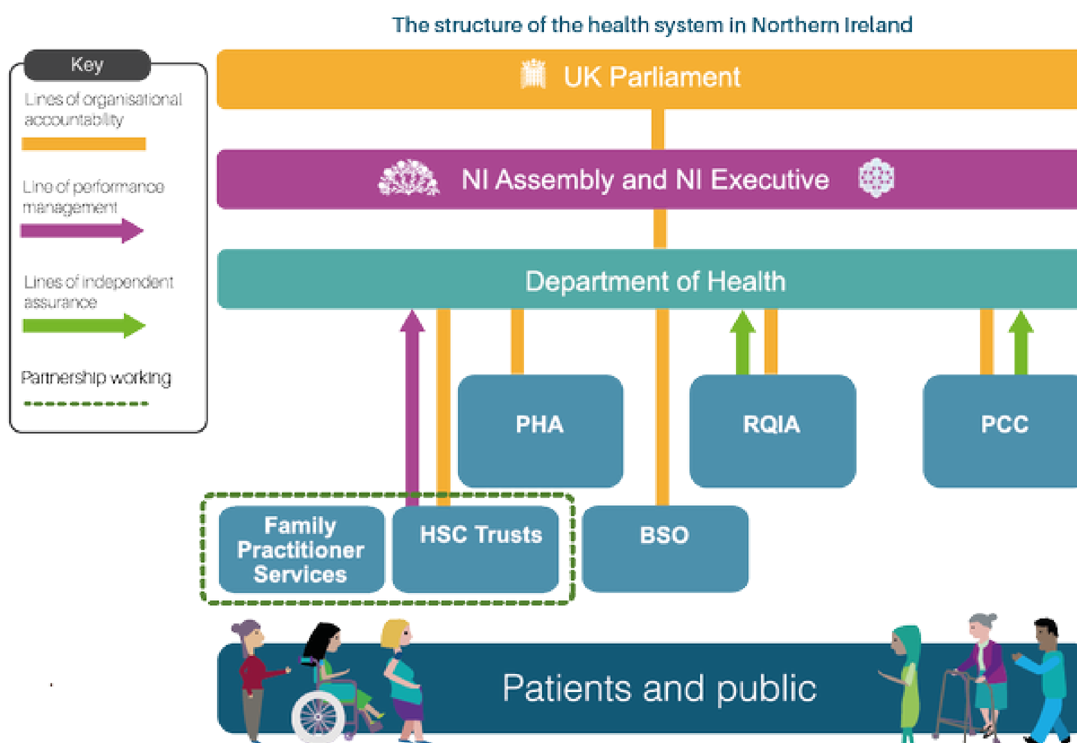
> 'A collaborative partnership between organisations and individuals with a responsibility for planning, managing, and delivering sustainable care, services and interventions to meet the health and wellbeing needs of the local population. Through taking collective action, partnerships will deliver improved outcomes for individuals and communities, and reduce inequalities.'

Work will continue during 2022 to establish the associated organisational structures and working arrangements.

21.2 The structure of the HSC

The diagram below shows the current structure of health and social care in Northern Ireland.

Figure 10: Structure of the HSC



Each of these areas has specific responsibilities, outlined in the sections below. Where structural changes are planned as part of the development of an ICS system, these are identified.

---

[281] *Health and Social Care Act (Northern Ireland) 2022*

[282] DoH, *Future Planning Model – Integrated Care System NI, Draft Framework*, September 2021

Statutory bodies

UK Parliament

The funds for running all public services in the UK ultimately come from Parliament and the public sector in Northern Ireland is expected to operate within the broad framework established by HM Treasury.

Northern Ireland Assembly

The Northern Ireland Assembly (NIA) is the devolved legislature of Northern Ireland. It has power to legislate in a wide range of areas that are not explicitly reserved to the UK Parliament, and to appoint the Northern Ireland Executive. It consists of 90 democratically elected members of the legislative assembly (MLAs). There are five MLAs elected to each of the 18 constituencies across Northern Ireland.

Northern Ireland Executive

The Northern Ireland Executive is the executive arm of the NIA. It is answerable to the Assembly and consists of a First Minster, Deputy First Minister and ministers with individual portfolios and remits. Each minister is in charge of a department and is responsible for its policy and business.

Department of Health

In Northern Ireland, both health and social care are the responsibility of the Minister for Health. The Department of Health's (DoH) remit covers policy and legislation relating to:

- health and social care - this includes hospitals, family practitioner services, community health and personal social services
- public health - to promote and protect the health and wellbeing of the population of Northern Ireland
- public safety - this covers fire and rescue services.

The DoH's mission is to improve the health and social wellbeing of the people of Northern Ireland. It endeavours to do this by:

- leading a major programme of cross-government action to improve the health and wellbeing of the population and reduce health inequalities. This includes interventions involving health promotion and education to encourage people to adopt activities, behaviours and attitudes that lead to better health and wellbeing. The aim is a population that is much more engaged in ensuring its own health and wellbeing
- ensuring the provision of appropriate health and social care services, both in clinical settings such as hospitals and GP surgeries, and in the community through nursing, social work and other professional services.

The Permanent Secretary of the DoH is also chief executive of the HSC, as well as principal accounting officer the DoH.

Within the DoH, the key business groups are the:

- Strategic Planning and Performance Group (succeeding the Resources and Performance Management Group
- Healthcare Policy Group
- Social Services Policy Group

- Office of the Chief Medical Officer.

There are five professional groups within the department, each led by a chief professional officer. These are the:

- chief medical officer group
- office of social services
- nursing, midwifery and allied health professionals (AHP) directorate
- dental services
- pharmaceutical advice and services.

The DoH reviews any guidance issued by the National Institute for Health and Care Excellence (NICE) and decides if it is relevant for Northern Ireland. If guidance is not considered relevant, or if the DoH decides that it is only partly relevant, it advises on any changes that need to be made. The DoH is likely to approve most NICE guidance and usually decides shortly after NICE has made its decision.

Established under the 2022 Act, the Strategic Planning and Performance Group (SPPG) is part of the DoH and replaces the Health and Social Care Board (HSCB).

Together with local commissioning groups and integrated care partnership committees (see below), it is accountable to the Minister for Health. Its role is to translate the vision for health and social care into a range of services that deliver effective outcomes for users, good value for the taxpayer and compliance with statutory obligations.

To achieve this, the SPPG plans and oversees the delivery of health and social care services for the population of Northern Ireland and takes responsibility for planning, improving and overseeing the delivery of effective, high quality, safe health and social care services within available resources.

One of its key tasks is to ensure effective commissioning of a full range of health and social care services. In addition, the SPPG performance manages HSC bodies against agreed objectives and targets, including the effective use of resources.

Existing local arrangements

Local commissioning groups (LCGs)

There are currently five local commissioning groups (LCGs). Each LCG is a subcommittee of the SPPG and is co-terminus with its respective HSC trust area. The five LCGs are:

- Belfast
- Northern
- Southern
- South Eastern
- Western.

LCGs are responsible for assessing health and social care needs; planning health and social care to meet current and emerging needs; and securing the delivery of health and social care to meet those needs.

Under the new ICS arrangements, LCGs will be replaced with area integrated partnership boards (AIPBs). Their key responsibilities cover the strategic planning for their areas, and the local delivery of services that meet local population needs.

Integrated care partnerships (ICPs)

Within LCG areas there are also integrated care partnerships (ICPs) that were established in May 2013. There are 17 ICPs across the five LCG areas. Each ICP is based around natural geographies of approximately 100,000 people and 25 – 30 practices. ICPs bring together a range of providers from across the health and social care system to review how care is being provided and to consider how services could be improved and better coordinated. ICPs focus on services for frail elderly people and those with some long-term conditions: respiratory conditions, diabetes and stroke. They support the overall vision of making home and the community the hub of care.

The new ICS framework looks to further enhance local and community partnership working. It is expected that local level structures will be based around existing GP federations and integrated care partnership areas and will align and integrate with local council structures (community planning partnerships) and boundaries. The aim is to involve individuals and community leaders, and to ensure there is access and engagement in the provision of services.

Health and social care trusts

The five HSC trusts provide the full range of local acute, mental health and community services. Regional and specialist services may also be provided by individual trusts. As integrated organisations, trusts also provide social care services including nursing home and domiciliary care, learning disability and children's community services. Trusts fulfil the role of 'corporate parent' to children in care, the majority in foster care.

HSC trusts, as corporate entities, are responsible in law for the discharge of statutory social care functions delegated to them by virtue of authorisations made under the *Health and Personal Social Services (Northern Ireland) Order 1994*. Trusts are accountable for the discharge of such functions and are obliged to establish sound organisational and related assurance arrangements to ensure their effective discharge.

New local arrangements

Developing an integrated care system (ICS)

The future planning framework identifies the rationale behind the development of an ICS across Northern Ireland. It identifies the overarching roles and responsibilities of the bodies that will support this arrangement. The new approach is described on page 8 of the framework as:

- the way we design and deliver services must be focused on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration
- local providers and communities must be empowered to work in partnership, including Health and Social Care (HSC) Trusts, independent practitioners, and the voluntary and community sectors.

This partnership structure is shown in the diagram below:

Figure 11: Proposed partnership structure

Although the exact responsibilities and structural arrangements are to be finalised, the framework lays out the intentions as:

- regional: oversight, co-ordination and support across the economy including overall responsibility for governance and accountability across the system, and for coordinating the planning and delivery of region wide and specialist services
- area: strategic area planning and local delivery. Five AIPBs, one per trust area, will have responsibility for ensuring local populations' needs are met, while guided by the region wide strategy
- locality: operating at GP Federation and ICP areas. Local Groups will be working to deliver programmes and interventions, agreed by the AIPBs, at that locality level. Alignment will be developed with other key locality partners, for instance, local councils
- community: a focus on individual towns/communities. Engagement in the provision of healthcare needs at that local community level, so linking to GP practices, community pharmacies and other community partnerships. The exact nature has not been determined as this will be determined on a community-by-community basis.

Funding under the ICS model

No changes to the current funding model are currently proposed; arrangements are, and would be, complex, and it is expected that it would take some time to develop new arrangements. The framework document does lay down the overarching principles that are expected to apply in the future, although no timescale has currently been set.

The intention is that local areas will control central resources, and they will be responsible for allocating and managing funds, to ensure cost effective delivery of healthcare for their local population. The AIPBs will be responsible for agreeing how resources should be utilised (working with all ICS partners), and there would be no presumptions as to how funding is allocated; funding would not automatically lie with any specific organisation or service.

Other healthcare agencies

Public Health Agency

The Public Health Agency (PHA) has four primary functions:

- improvement in health and social wellbeing – working with partners across different sectors and communities to make the best use of collective resources; focusing on giving children the best start in life, ensuring a decent standard of living for all and making healthy choices easier
- health protection – protecting the population from infection and environmental hazards
- public health support to commissioning and policy development
- HSC research and development – promoting research and development into initiatives designed to improve the health and wellbeing of the population of Northern Ireland.

Regulation and Quality Improvement Authority (RQIA)

The Regulation and Quality Improvement Authority (RQIA) is an independent health and social care regulatory body. Its functions include promoting quality through disseminating best practice; regulating a wide range of health and social care services through registration; monitoring and inspection; reviewing and reporting on clinical and social care governance in health and social care and keeping the DoH informed about the provision, availability and quality of health and social care services.

Its role is to ensure that health and social care services in Northern Ireland are accessible, well managed and meet the required standards. The RQIA works to ensure that there is openness, clarity and accountability in the management and delivery of all these services.

Patient and Client Council (PCC)

The Patient and Client Council (PCC) is a regional body supported by five local offices operating within the same geographical areas as the five regional HSC trusts. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers and communities on health and social care issues.

Business Services Organisation (BSO)

The Business Services Organisation (BSO) provides a range of business and administrative support and specialist professional services to health and social care bodies - for example, financial services; human resources; legal services; information technology and procurement of goods and services.

BSO hosts the HSC shared services department that delivers accounts payable; accounts receivable; payroll and recruitment services for all HSC bodies.

The regional procurement and logistics service (PALS) is part of BSO and is the sole provider of professional supplies services (logistics and procurement) to all public health and social care organisations in Northern Ireland. It is a recognised centre of procurement expertise established under the Northern Ireland Public Procurement Policy as approved by the Northern Ireland Assembly.

Other HSC agencies and non-departmental public bodies (NDPBs)

A variety of specialist functions are carried out by organisations on a Northern Ireland-wide basis. These include:

- Northern Ireland Blood Transfusion Service
- Northern Ireland Guardian Ad Litem Agency
- Northern Ireland Practice and Education Council
- Northern Ireland Medical and Dental Training Agency
- Northern Ireland Social Care Council
- Northern Ireland Fire Rescue Service.

21.3 How health and social care is financed

Overall public sector funding for Northern Ireland is provided via the Northern Ireland block vote, as part of the national spending reviews. It is based on a population driven mathematical formula known as the Barnett Formula that has been in use since 1979. Changes to the total provision for Northern Ireland are largely determined through the principle of comparability, whereby HM Treasury adjusts the Northern Ireland block vote in line with comparable programmes in England.

The NIA has the discretion to allocate devolved resources within the Northern Ireland block across all departmental spending programmes. The DoH sets its proposed allocations in the context of the Minister's overall priorities and objectives for the DoH's public expenditure programme. Spending on health and social care equates to approximately 46% of the total public expenditure (revenue and capital) within the control of the NIA (2022/25 Draft Budget[283]).

Revenue allocation

The DoH makes direct revenue allocations to the SPPG, PHA, RQIA and PCC in the form of a revenue resource limit (RRL). This is to cover hospital, community health and social care services and equates to approximately 50% of total public expenditure.

The SPPG and PHA use a weighted capitation revenue allocation formula to determine target allocations for hospital, community health and personal social services on a programme of care basis. The formula determines how much each of the five LCGs receives to purchase services for its residents from trusts.

Allocations are also made to the SPPG to commission the four family practitioner services – general medical, pharmacy, dental and ophthalmic services.

[283] Department of Finance, *2022-2025 Draft Budget*, February 2022

Budgets are set for each LCG area based on a weighted capitation formula. Performance against budget for each LCG area is closely monitored particularly in those areas of high expenditure - for example, prescribing.

As well as commissioning income, HSC trusts may also receive income from:

- other government bodies or charitable organisations in the form of grants
- the Northern Ireland Medical and Dental Training Agency (NIMDTA)
- the DoH to fund specific initiatives - for example, funding for professional training and research and development
- contributions from clients in nursing or residential care provided through trusts where clients have been assessed as being able to pay
- charges to staff, visitors or patients - for example, catering, parking or private patient facilities
- recovering the costs incurred if a person treated after being involved in a road traffic collision subsequently makes a successful claim for personal injury compensation
- charitable donations for the benefit of and expenditure on patients and clients. These charitable funds are accounted for separately from the funds that trusts are allocated for providing healthcare to patients and running their organisations
- commercial research activities.

Capital allocation

The DoH also receives a capital allocation from the NIA – in 2022/23 this amounts to approximately 18% of the total public sector capital budget. Capital allocations are made directly to the PHA, trusts and smaller non-departmental bodies in the form of a capital resource limit (CRL).

Strategic capital planning is the responsibility of the DoH. Individual HSC organisations submit business cases for capital requirements that must be supported by the commissioner (SPPG) and submitted to the DoH for formal approval. Trusts are allocated funding for non-specific capital expenditure (general capital) used for replacement equipment, maintenance and minor capital works. The utilisation of this funding is also supported by business cases, samples of which are checked for compliance by the DoH.

The DoH is informed by, and contributes to, the overall 10-year Investment Strategy for Northern Ireland prepared by the Northern Ireland Executive.

21.4 How HSC organisations demonstrate financial accountability

HSC bodies have two statutory duties – to break even and to stay within their revenue and capital resource limits.

The HSC trusts prepare annual accounts in formats prescribed by the DoH. Accounts are produced based on guidance in HM Treasury's Financial Reporting Manual[284] (FReM) following international financial reporting standards (IFRS).

The DoH issues a detailed manual of accounts for all health and social care bodies that is updated annually as required to reflect changes in reporting requirements. Where these differ for a DoH body, the manual sets out the procedures that the body must follow.

The accounts must be formally adopted by the DoH, in time to meet the NIA summer recess deadlines (normally June following the financial year-end on 31 March). Following this the accounts must be published on the websites of the HSC bodies and made available to members of the public.

---

[284] HM Treasury, *The Government Financial Reporting Manual: 2021/22*, December 2021

The director of finance is responsible for preparing the accounts.

The annual accounts are audited by the Northern Ireland Audit Office (NIAO), either by its own staff or by contracting out to private sector firms of accountants and auditors. Each set of accounts is then formally laid before the NIA. The Assembly has a Public Accounts Committee (PAC) with a similar role to the committee of the House of Commons of the same name.

HSC bodies are required to have in place suitable internal audit arrangements. At present, this service is provided by BSO Internal Audit Unit. Internal audit must comply with Public Sector Internal Audit Standards (PSIAS). The adequacy of the internal audit arrangements is reviewed and reported on each year by the NIAO as part of their report to those charged with the governance of each body.

21.5 How HSC organisations are regulated

The key regulatory body in Northern Ireland is the Regulation and Quality Improvement Authority (RQIA), as described earlier.

21.6 How HSC organisations are structured and run

The governance regime for HSC bodies is like that in place throughout the NHS in the rest of the UK making use of codes of conduct and accountability, internal audit, external audit, board reports, annual accounts, annual report and public board meetings.

As with the NHS in England, the board of each HSC body is the pre-eminent governing body. There are also two mandatory committees of the board – audit and remuneration.

Chief executives of HSC organisations are designated accounting officers. They are accountable to the DoH (and ultimately to the NIA) for the appropriate stewardship of public money and assets and for the organisation's performance. Chief executives are also accountable to their board for meeting its objectives and the day-to-day running of the organisation.

21.7 Commissioning

The SPPG develops an annual commissioning plan in close partnership with the Public Health Agency through a ‘commissioning cycle’ that covers:

- assessing needs
- strategic planning across the HSC and all programmes of care
- priority setting
- securing resources to address needs
- agreeing with providers the delivery of appropriate services (and subsequent monitoring of that delivery)
- assuring that the safety and quality of services commissioned are improving, that recommendations from the RQIA and other reviews have been implemented and that as a minimum, services meet DoH and other recognised standards
- evaluating the impact of that assessment and feeding learning back into the new baseline position in terms of how needs have changed.

For the most part the SPPG/ PHA commissioning plan reflects the decisions and recommendations of the LCGs as they have devolved responsibility for assessing and ultimately addressing the needs of their local populations, working within regional policy and strategy frameworks, available resources and performance targets.

The geographical basis of LCGs better reflects the needs of natural communities and the organisation of local health and social care economies, including hospitals, community networks and geographically based partners. On the other hand, commissioning around 'communities of interest' or client-groups, or 'programmes of care' can ensure that the needs of service users and carers are addressed holistically, and services are planned in a coordinated way to meet identified needs.

Both approaches operate within the health and social care commissioning landscape in Northern Ireland. While the establishment of LCGs gives prominence to geography, this is balanced by 'programme of care' based planning within LCGs. These teams link across LCG boundaries where necessary, to form regional strategic planning networks relevant to client or 'community of interest' groups. Commissioning of services from independent family practitioner contractors is managed centrally. These arrangements recognise regional priorities, including service framework standards.

21.8 Costing

The five HSC trusts submit annual reference cost returns that capture the cost of services across a prescribed list of health and social care activities. Health resource group (HRGs) based reference costs are calculated for most hospital acute inpatients and day cases, and community and personal social services indicators are calculated for a range of community and social care services.

Organisations use these reference costs to compare their costs with those of similar organisations. This comparison establishes a benchmark that enables organisations to identify areas where they may be able to reduce costs or increase productivity by understanding and implementing best practice methodologies used in other provider organisations. The unit costs are also used to inform the revenue business case process and respond to assembly questions and external information requests.

Further details regarding NHS Costing are provided in chapter 17 of the Introductory Guide to NHS Finance.

21.9 Charitable funds

Charitable funds accounts are held by HSC trusts in Northern Ireland and are largely comprised of donations by individuals or legacies.

As in England and Wales these funds are used for the purpose for which the original donation was intended, or the bequest was made (where that is known) otherwise the uses to which the funds can be put may be unrestricted. Charitable funds are held and managed by HSC trusts and boards as corporate trustees.

Where a DoH body controls a charitable fund, as well as preparing separate annual accounts for its charitable funds, the body is also required to consolidate these accounts into its annual accounts (as per the DoH Manual of Accounts).

The Charity Commission for Northern Ireland was established on 27 March 2009 and regulates charities, including HSC charitable funds.

Further details regarding Charitable Funds in the NHS are provided in chapter 20 of the Introductory Guide to NHS Finance.

Key learning points

- The primary difference between the NHS in England and services in Northern Ireland is that in Northern Ireland health services and social care are fully integrated.
- The HSC is introducing revised arrangements to develop an effective integrated care service.
- The new arrangements bring together all partner bodies to deliver an effective healthcare service that addresses, and is responsive to, the needs of the individual, while working within a regional wide healthcare strategy.
- Further developments are taking place during 2022 to establish structures and operational arrangements to support and ensure delivery of effective partnership working under the framework.
- Overall public sector funding for Northern Ireland is provided via the Northern Ireland block vote, as part of the national spending reviews. It is based on a population driven mathematical formula known as the Barnett Formula that has been in use since 1979.
- Accounts are produced based on guidance in HM Treasury's Financial Reporting Manual (FReM) following international financial reporting standards (IFRS).
- HSC organisations follow governance arrangements like NHS England bodies, with leadership of the organisations being through a board.

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, including a section dedicated to NHS charitable funds. It also highlights online learning courses that are available. The directory of resources can be found here.