Northern Ireland Assembly

Research and Information Service Briefing Note

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Programmes of Care – Update

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1 Context

This briefing note updates briefing paper NIAR 132-2020 regarding Programmes of Care in the NI HSC and other neighbouring jurisdictions.

As highlighted in that briefing paper the current nine 'Programmes of Care' within the Northern Ireland (NI) HSC are divisions of healthcare, into which activity and finance data are assigned, to provide a common management framework.

In addition, as stated in that paper, the Northern Ireland Capitation Formula is used by the Health and Social Care Board (HSCB) to determine the 'target fair shares' of resources for hospital and community services, for the population of each Local Commissioning Group (LCG). The current capitation formula is based on the Programme of Care (PoC) approach.

In terms of understanding the origins of the current PoC and the potential to instigate a new PoC, RaISe posed a number of questions via email to the Department of Health as follows:

- When and how were the current nine PoC established?
- Are the PoC set out in legislation anywhere or are they an administrative construct? and
- If there were to be a new PoC – what would the process be for its establishment?

RaISe also posed a number of questions via email to neighbouring jurisdictions, referring to the PoC in NI:

- Is there a similar system in use within the jurisdiction?
- If not, what is the system used to assign finance to areas of healthcare?
- If there are such PoC in use – in which one does Autism Services sit or belong?

To date, further information has been received for NI, Scotland, Wales and Republic of Ireland.

2. History of Data Collection in the NHS – The Körner Review

Edith Körner[1] was an influential figure in the development of the information and statistics system used by the NHS. She became Chair of the South Western Regional

[1] Edith Körner was born in Czechoslovakia, the daughter of a corn miller, she arrived in the UK as a schoolgirl in 1939, alone, and never again saw her parents or 40 other relatives who perished in the Nazi extermination camps. She spoke no English but was fluent in Russian, German, Italian and French. These skills, allied with her intelligence and determination, enabled her to earn a living monitoring enemy military and civilian radio traffic; at the same time she obtained, in two years, an honours degree in economics at the London School of Economics. During the war, she met her husband Stephan, also from Czechoslovakia, who was doing a PhD in philosophy at Cambridge University. When the war ended,

Health Authority in England in 1976, where she established a national reputation for clear thinking and innovation. In 1980 she was chosen to chair a full-scale review of health service information. The Körner Committee sat for four years and produced six reports. It was the first major examination of the way the NHS collected and used its data and set the way forward for a comprehensive computerisation of the health system.[2]

The aim was to devise a series of sets of basic statistics that every health authority should have to manage its health services properly and that could be collected economically, quickly, and accurately and led to the 'Korner definitions' for data collecting within the NHS.[3]

3. How did the Körner Review Impact on NI?

In terms of NI, the Data Administration Branch of the then DHSSPS led a review, guided by the 'Korner definitions' to produce guidance in 1992 to allow the **capture of data by PoC**.[4]

The review was conducted with significant input from service and professional leads, including Social Services to ensure the required data definitions, data collation and reporting structures were reflected in the guidance. The data standards were designed to support the consistent capture and use of data across health and social care organisations. This was to allow both a consistent basis for management reporting information flows and it was considered that this would facilitate more accessible /understandable reporting to the public and users of the service.

Following the issue of the first version of the guidance in 1992, the then DHSSPS designed some of their formal finance reports such as Trust Financial Returns TFRs around these established categories. **Whilst there has been some refinement to these reports over the years, they still largely follow a PoC structure.**

The Department of Health noted that versions two and three were published in 1994 and 1996 respectively and provided a pdf version of the 1996 guidance. To illustrate the history of the PoC approach in NI, the following information is taken from that 1996 version, which states that the guidance provides a set of rules to enable all areas of the HPSS to adopt a consistent approach:

she went with him to Bristol, where he had obtained a chair at the university. There, they brought up their two children and she began her involvement in public life. https://www.theguardian.com/news/2000/aug/30/guardianobituaries.nhs

[2] Edith Körner, Obituary, The Guardian, 30th August 2000, https://www.theguardian.com/news/2000/aug/30/guardianobituaries.nhs

[3] Körner group urges changes in NHSA statistics, British Medical Journal, 27th November 1982, vol 285, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1500526/pdf/bmjcred00634-0075a.pdf

[4] Personal Email Communication from Department of Health to RaISe on 1st July 2020.

- All activity and direct costs concerned with service delivery within the then NI HPSS should be allocated to a PoC;
- Expenditure not directly associated with service delivery such as Board HQ costs and training should be excluded from PoC;
- All overheads, such as staff and all support services, all allocated to a PoC based on the activity to which they relate;
- Resources allocated to voluntary organisations for provision of direct patient/client care should be allocated to a PoC; and
- It may at times be necessary to allocate activity and costs to a PoC based on local information, available data or experience.

4. How would a new PoC be developed in NI?

The Department of Health have advised RaISe that the process for either the introduction of a new PoC or material changes to the data definitions within an existing PoC would need to be initiated by a directive coming from the Department to the DoH Strategic Information Group (SIG). Policy direction would be required from the DoH and input needed from across the HSC including Service and Professional leads, Information, Data and Finance expertise.[5]

5. Scotland

As stated above RaISe approached the Scottish NHS with the following query:

- Is there a similar PoC system in use within the jurisdiction?
- If not, what is the system used to assign finance to areas of healthcare?
- If there are such PoC in use – in which one does Autism Services sit or belong?

The following response was received from the Scottish Government Directorate for Health Finance, Corporate Governance and Value and does not refer to a PoC system. RaISe has since emailed two of the individual Health Boards to pursue this query further to see if PoC are used at the Health Board level. This information will be forwarded on when received by RaISe.

The NHS Scotland Resource Allocation Committee (NRAC) formula is the method used to ensure the fair and equitable allocation of funds between Health Boards, taking

[5] Personal Email Communication from Department of Health to RaISe on 1st July 2020.

into account key determinants in the variation of healthcare need in populations. The latest 'target shares' are available through this web link:

https://www.isdscotland.org/Health-Topics/Finance/Resource-Allocation-Formula/resource-allocationlatest.asp

The majority of funding is provided as baseline budget and the 14 **NHS Boards have the discretion to direct this funding to local priorities although there are separate performance outcomes, which must be achieved**. NHS Scotland's performance is measured against Local Delivery Plan (LDP) Standards, which comprise the priorities that are set and agreed between the Scottish Government and NHS Boards. Performance data is published by the Scottish Government.

A small proportion of funding flows through specific Directorates within Scottish Government and is allocated to NHS Boards in line with policy commitments. This funding is directly outcomes-based.

The policy area responsible for strategy and delivery of Autism services sits within the Directorate for Mental Health, which is part of the wider Health and Social Care Directorates.

The Scottish Government has set out its commitment to autistic people and their families through the ten year *Scottish Strategy for Autism*. Launched in 2011, the strategy's focus is very much on outcomes intended to ensure autistic people live healthier lives, enjoy choice and control over the services they use, and are supported to be independent and active citizens. Funding was agreed and announced at the start of the strategy and has been a consistent allocation to specific work streams of the strategy.

Scotland refreshed its priorities for the strategy's next phase following an engagement exercise with autistic people and their families and professionals in 2018 and committed to evaluating the Strategy at the end of its ten years. The Strategy's priorities are monitored by the Autism Strategy Group, which is made up of the funded work streams, autism organisations and autistic individuals.

The Strategy is also independently monitored by the Scottish Parliament's Cross Party Group on Autism.

6. Wales

The Knowledge and Analytical Services centre of the Welsh Government provided RaISe with the NHS expenditure programme budgets, which presents NHS

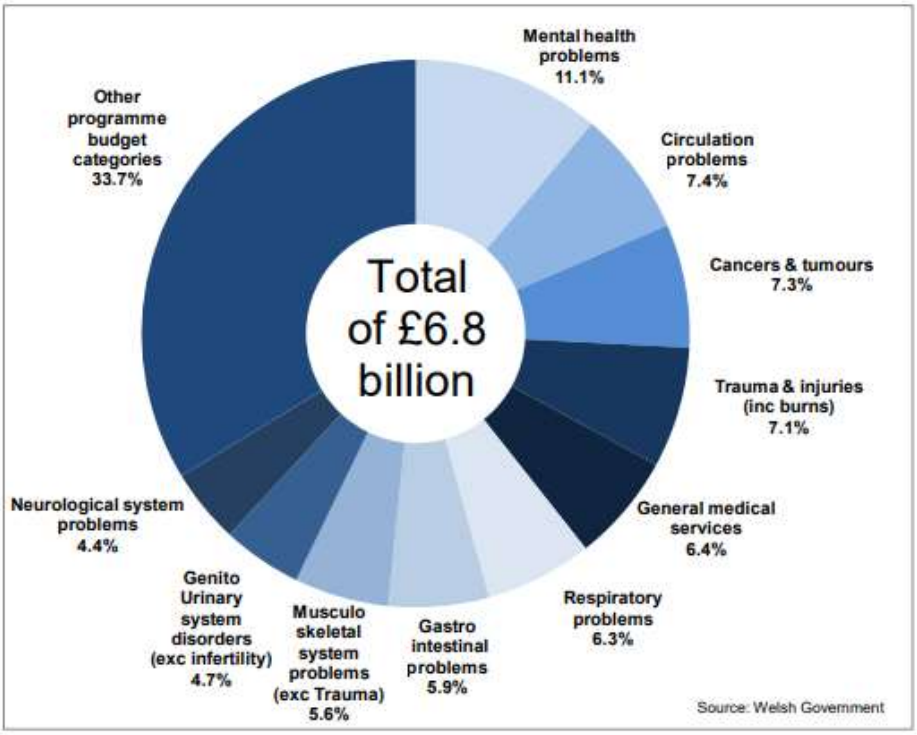
expenditure by **programme of care (PoC)**, allocated based on the medical condition to which the expenditure relates. In this context, each category represents a **PoC** focused on the recipient, rather than the provider of care.

In Wales, Programme Budgeting in the health service is an appraisal of resource allocation. It collects financial information that allocates all NHS expenditure, including primary care services, to **PoCs** based on medical conditions. Financial figures are collected from all Welsh NHS Trusts and local health boards (LHBs) in Wales together with the Welsh Health Specialised Services Committee (WHSSC). The 2018-19 latest published release is the second based on data collected from NHS organisations in partnership with a new all Wales costing system software supplier.[6]

The data covers all Local Health Board expenditure and the expenditure of the Public Health Wales NHS Trust analysed by **PoC**, including expenditure on primary care services, such as GPs and dentists, as well as secondary care services, such as hospitals. Most programme budget categories reflect 'ICD 10' chapter headings, e.g. cancer, coronary heart disease, problems of the skin, etc. The chart below is taken from the 2018-19 release and shows ten named PoC:

This annual release presents NHS expenditure by programme of care allocated based on the medical condition (ICD10) the expenditure relates to.

Chart 1: Percentage of NHS expenditure by programme budget category, 2018-19



[6] NHS Expenditure Programme Budgets, 2018-19, Welsh Government, Statistical First Release, 28th April 2020, https://gov.wales/sites/default/files/statistics-and-research/2020-04/nhs-expenditure-programme-budgets-april-2018-march-2019-371.pdf

In some cases, it was not possible to assign activity by medical condition, preventative activity or social care need. In such instances, expenditure is allocated to a category of 'other programme expenditure', which accounted for 14.5 per cent of the total in 2018-19. 44.2 per cent of the other programme expenditure was expenditure on general medical services provided by GPs.

In addition to the expenditure that can be categorised by medical diagnosis, there are two specific groups for 'Healthy Individuals' and 'Social Care Needs'. These capture the costs of prevention programmes and services that support individuals with social rather than health care needs. Together they amounted to 3.0 per cent of total expenditure in 2018-19.

The statistical releases can be found here: https://gov.wales/nhs-expenditure-programme-budgets

With further detailed data is available at StatsWales:

https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Health-Finance/NHS-Programme-Budget

With regard to **Autism Services**, the Welsh Government advised Wales that **Autism Services** are generally part of the 'Learning Disability Problems' and 'Mental Health Problems' programme budgeting categories. Mental Health and Learning Disability specialty services in Wales are categorised to a programme budgeting category based on a specialty basis, but **autism services are not a specialty on their own and is an area where multiple diagnoses are common.** Expenditure on autism services falls primarily into the 'Learning Disability Problems' programme budget category and into the 'Child & Adolescent Mental Health Services' and 'General Mental Illness' programme budget sub-categories of 'Mental Health Problems', but there is also the possibility of services related to autism being included in the remaining two 'Mental Health Problems' sub-categories as there are often cross-over diagnoses.[7]

In March 2016, as part of the refreshed Welsh *Autistic Spectrum Disorder Strategic Action Plan* (ASD SAP), the Welsh Government announced that it would be funding a new national Integrated Autism Service (IAS). The refreshed ASD SAP also outlined planned improvements to children's assessment and diagnosis, education, social care and employment support and information, advice and training.

An evaluation of the ASD SAP and accompanying Delivery Plan was published in March 2019.[8]

[7] Personal email to Raise from Health, Social Services and Population Statistics, Knowledge and Analytical Services, Welsh Government, 15th July 2020

[8] Evaluation of the Integrated Autism Service and the Autism Spectrum Disorder Strategic Action Plan Final report, Welsh Government 28th March 2020, https://gov.wales/sites/default/files/statistics-and-research/2019-04/evaluation-of-the-integrated-autism-service-and-the-autism-spectrum-disorder-strategic-action-plan-final.pdf

7. Republic of Ireland

The Planning and Performance Office of the Health Service Executive National Finance Division directed RaISe to Table 6.2 of the Health in Ireland – Key Trends 2019 document.[9]

They indicated that autism services are funded under the Care for Persons with Disabilities Programme.[10]

Table 6.2 lists the non-capital expenditure as being assigned to one of nine separate programmes - care of older people, care of people with disabilities, mental health, primary care and community health, multi care group services, palliative care and chronic illness, social inclusion, health and wellbeing and acute division.

Table 6.2 as reproduced from Health in Ireland – Key Trends 2019

Table 6.2

HSE Non-Capital Vote Allocation in Millions of Euro, 2012-2018

	2012	2013	2014 A	2015 A	2016	2017	2018	% change 2017-2018
Care of Older People	1,366	1,366	1,468	1,569	1,620	1,693	1,774	4.8
Care for Persons with Disabilities	1,554	1,535	1,554	1,654	1,773	1,858	2,004	7.8
Mental Health	711	737	754	780	804	860	913	6.1
Primary Care & Community Health*	3,129	3,352	3,462	3,506	3,892	4,009	4,203	4.8
Multi Care Group Services^	482	113	-	-	-			
Palliative Care & Chronic Illness^	73	72	75	78	-			
Social Inclusion^	115	-	-	129	-			
Health and Wellbeing	-	228	214	185	191	211	112	-46.9
Other^	81	-	-	-	-			
Primary, Community and Continuing Care Total	7,510	7,403	7,527	7,901	8,280	8,633	9,006	4.3
Acute Division	3,978	4,286	4,496	4,701	4,929	5,243	5,589	6.6
Long Term Charges Repayment Scheme	2	8	8	4	2	2	2	0.0
Statutory Pensions #	737	678	597	626	670	686	728	6.1
Other#	850	647	628	667	708	812	992	22.1
HSE Gross Non-Capital Total	13,077	13,022	13,256	13,899	14,589	15,376	16,316	6.1
Total Appropriations-in-Aid	1,485	1,354	1,043	1,075	1,061	1,054	1,085	3.0
HSE Net Non-Capital Total	11,592	11,668	12,213	12,824	13,528	14,322	15,231	6.3

Source: Revised Estimates for Public Services (2012 - 2019); HSE National Service Plans (2012 - 2017); and HSE Performance Reports (2014-2018).

8. England

To recap on the information provided in the previous paper (NIAR 132-2020) - NHS England and its partners set the overall commissioning strategy and clinical priorities. NHS England commissions: primary medical services (for GPs this is mostly devolved to Clinical Commissioning Groups (CCGs); 'specialised' services (such as treatments for rare conditions and secure mental health care); military and veteran health services; health care in prisons and also some public health services.[11]

[9] Health in Ireland, Key Trends 2019, Government of Ireland, Table 6.2, https://www.gov.ie/en/publication/f1bb64-health-in-ireland-key-trends-2019/

[10] Personal email from Planning and Performance, National Finance Division, HSE, 9th July 2020.

[11] NHS Commissioning, https://www.england.nhs.uk/commissioning/who-commissions-nhs-services/nhs-england/

However, the 'specialised' national services are grouped into six **National Programmes of Care** (NPoC). Each has an NPoC Board, which coordinates and prioritises work across the services in that programme of care. The six NPoC's are – Internal Medicine; Cancer; Mental Health; Trauma; Women and Children; and Blood and Infection.[12]

The CCGs are groups of general practices (GPs) in each area to commission services for their patients and population. CCGs commission most secondary care services, and play a part in the commissioning of GP services. CCGs commission: planned hospital care; rehabilitative care; urgent and emergency care; community health services; learning disability and/or autism services; and mental health services.[13]

NHS England and a number of Clinical Commissioning Groups have been contacted to gain further information on the use of PoC and this will be forwarded when it is received by RaISe.

A Health Policy Specialist in the House of Commons Library advised RaISe that the practical division of national and locally commissioned services in England is complicated, with many areas of shared commissioning between NHS England and CCGs with very broad responsibilities set out under the Health and Social Care Act 2012.[14]

In overview, under the 2012 Act responsibility for commissioning has largely been divided between NHS England and CCGs as follows:

- The majority of healthcare commissioning is the statutory responsibility of local CCGs. Their commissioning responsibilities include urgent and emergency care, such as A&E, elective hospital care, and community health services;
- NHS England is responsible for commissioning some services centrally, including primary care and specialised services.

In addition to CCGs' and NHS England's commissioning roles, local authorities also have statutory commissioning responsibilities for some public health services, and for social care.

In England, the majority of health services for people with autism are commissioned by CCGs, although NHS England has a role in commissioning some specialised inpatient care. There is also a role for local authorities in meeting the social care needs for people with autism.

[12] National Programmes of Care and Clinical Reference Groups, NHS England, https://www.england.nhs.uk/commissioning/spec-services/npc-crg/
[13] NHS England, CCGs, https://www.england.nhs.uk/commissioning/who-commissions-nhs-services/ccgs/
[14] Personal Email to RaISe from Health Policy Specialist, House of Commons Library, 23rd July 2020.