National Assembly for Wales
Public Accounts Committee

Health Finances 2012-2013 and beyond

March 2014

Cynulliad Cenedlaethol Cymru

National Assembly for Wales

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The Public Accounts Committee was established on 22 June 2011.

Powers

The Committee's powers are set out in the National Assembly for Wales' Standing Orders, with its specific functions of the Committee are set out in Standing Order 18 (available at **www.assemblywales.org)**. In particular, the Committee may consider reports prepared by the Auditor General for Wales on the accounts of the Welsh Government and other public bodies, and on the economy, efficiency and effectiveness with which resources were employed in the discharge of public functions.

The Committee also has specific statutory powers under the Government of Wales Act 2006 relating to the appointment of the Auditor General, his or her budget and the auditors of that office.

Current Committee membership

Darren Millar (Chair)
Welsh Conservatives
Clwyd West

Mohammad Asghar (Oscar)
Welsh Conservatives
South Wales East

Mike Hedges
Welsh Labour
Swansea East

Alun Ffred Jones
Plaid Cymru
Arfon

Sandy Mewies
Welsh Labour
Delyn

Julie Morgan
Welsh Labour
Cardiff North

Jenny Rathbone
Welsh Labour
Cardiff Central

Aled Roberts
Welsh Liberal Democrats
North Wales

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Chair's foreword / Summary

The funding of NHS Wales remains a huge challenge. Whilst significant efforts have been made by those working with the Welsh health service to make the immediate savings needed to breakeven, there is a still a great deal more which needs to be done to ensure that action taken is sustainable and does not store up even greater problems in the longer term.

The Auditor General for Wales, in his report Health Finances 2012-13 and beyond, raised a number of significant concerns regarding the finances of NHS Wales and as a Committee, we decided that these warranted further investigation, following on from our work published in 2013.

The Committee welcomes the action taken by the Government to introduce a more flexible system for financial planning for the Welsh NHS, indeed this is something we recommended in our report on 'A Picture of Public Services' published back in 2011. However, throughout the course of our inquiry it became apparent to us that there is a need for the Welsh Government to take further action to ensure that the system they intend to introduce is fit for purpose. We found little evidence to suggest that there was anything in place to assist Health Boards to develop their financial plans, or information about the criteria by which they will being assessed. It is for these reasons that we have made recommendations which should lead to a system which will allow for robust and disciplined financial planning.

During the course of the inquiry, we requested the up to date financial position for NHS Wales from the Welsh Government. We were very concerned at the two month delay in providing us with the information, by which time it became less relevant to our inquiry. It is important that such data is readily available to the Welsh Government to assist it in managing and responding to the financial challenges in NHS Wales and such delays give the impression that the Welsh Government does not have a sufficient handle on health finances.

This report is published against a backdrop of NHS Wales receiving two significant allocations of additional funding during 2013-14, initially one of £150 million and then a further £50 million. This continuation

of unplanned in year funding is not sustainable, and appears to do little to encourage NHS organisations to live within their means. We hope that the recommendations in this report will assist the Welsh Government to address the financial challenges faced by NHS Wales in the short, medium and longer term.

The Committee’s Recommendations

The Committee’s recommendations to the Welsh Government are listed below, in the order that they appear in this Report. Please refer to the relevant pages of the report to see the supporting evidence and conclusions:

Recommendation 1. The Committee recommends that the Welsh Government publishes a clear rationale for funding allocations of additional in year resources to NHS bodies. This would allow greater transparency and clarity in budgets and help to ensure that the resources are being allocated appropriately and value for money. (Page 14)

Recommendation 2. As recommended in the Committee’s previous report, we recommend that the Welsh Government hold senior management to account more rigorously, to ensure transparency for financial decisions. In particular, the Committee want to see a thorough process put in place to ensure accountability for any additional in year resources provided by the Welsh Government or other NHS bodies for specific purposes such as brokerage. (Page 16)

Recommendation 3. The Committee recommends, in order to enhance transparency and accountability, the Welsh Government publish, the monthly financial position of NHS Wales in a timely and accessible fashion. (Page 26)

Recommendation 4. The Committee recommends that the Welsh Government considers how it presents future budgets to ensure that it fully explains - in budget tables and the accompanying narrative report - the impact of any substantial changes following the supplementary budget on year-on-year comparisons. (Page 28)

Recommendation 5. The Committee recommends that local population needs, value for money and transparency are key considerations in the scope of the Review of the Allocation Basis and that no significant changes be made to the allocation formula without full consideration of the potential impact of redistribution on local health services. (Page 30)

Recommendation 6. The Committee recommends that the Welsh Government commission a piece of work to consider approaches to profiling potential pressures and how this can be used as an effective management tool within the NHS Wales. (Page 36)

Recommendation 7. The Committee recommends that the Welsh Government sets out the process for agreeing the three year budgets for health boards and how this differs from current processes, as well as how it intends to resolve any disputes that may arise during this process. (Page 39)

Recommendation 8. The Committee further recommends that given the risks of financial planning over 3 years, the Welsh Government should require:
a) Fully balanced plans over three years for each Health Board with supporting detail
b) Collective financial planning showing how budgets will balance across the whole NHS every year (so as to stay within DEL)
c) Detailed contingency plans setting out how Health Boards will respond if planned savings from up-front investment do not materialise and/ or there are additional cost pressures. These contingency plans should include an assessment of risks to patients/ services (Page 40)

Recommendation 9. The Committee recommends that the Welsh Government produce a clear set of guidelines for the utilising of external expertise for financial planning. This should include information on trigger points as part of the financial management process when Welsh NHS bodies would be required to use external support. (Page 42)

Recommendation 10. The Committee recommends that the Welsh Government works with Health Boards to develop mechanisms for sharing financial/service planning and management good practice across the NHS Wales at all levels. This could involve using the model of the Wales Audit Office Good Practice exchange. (Page 43)

Recommendation 11. The Committee recommends the Welsh Government examine whether the differences in terms and conditions between Wales and England have led to differences in cost-effectiveness and whether these are offset by benefits to recruitment and retention. The findings should inform discussions about the terms

and conditions to ensure Wales is able to attract the right calibre of staff while achieving optimum value for money. (Page 47)

Recommendation 12. In light of the move to disinvest in services, the Committee recommends that the Welsh Government provides the costs relating to pay protection in the NHS Wales. This will enable the cost and value of this policy to be determined. (Page 47)

1. Introduction

1. The Auditor General for Wales (Auditor General) published his report *'Health Finances 2012-13 and beyond'* on 16 July 2013. This report considers the financial position of NHS Wales[1] during 2012-13 and follows on from the previous Auditor General's report on *Health Finances*[2] published in July 2012, which the Public Accounts Committee (the Committee) considered in late 2012, and reported[3] on in February 2013.

2. The Auditor General's report sets out a detailed assessment of the financial position of the NHS bodies in 2012-13. It considers the performance in the delivery of services, particularly those areas which have been identified as a priority by the Department for Health and Social Services. The report also considers future financial and service challenges for the NHS over the short, medium and long term.

3. The report found that:

- The NHS bodies met their statutory financial targets in 2012-13, but that some of the actions taken to achieve breakeven are not sustainable in the long term.
- Although there have been some improvements in efficiency targets, with people spending less time in hospital, and quality of care such as with healthcare-associated infections and stroke services, there has been a deterioration in service performance on some key patient-focused areas such as waiting times for planned treatments, and emergency care.
- There are major service and financial challenges facing the Department and NHS bodies, and they are unlikely to be able to maintain the current levels of service and performance. In the medium to long term there needs to be significant change in terms of funding and transforming services through reconfiguration.

4. Since the publication of the Auditor General's report, the NHS Finance (Wales) Bill was passed by the Assembly and has now become

[1] NHS Wales comprises of the Welsh Government Department of Health and Social Services and the ten NHS bodies across Wales
[2] Health Finances, July 2012
[3] Health Finances Report, February 2013

an Act.[4] This legislation provides for NHS bodies to budget on a three year cycle. This will allow more flexibility for NHS bodies, and should move the focus away from the short term year end, as the requirement to break even will be over a three year period, instead of annually. The Bill was scrutinised by the Finance Committee, and therefore to avoid duplication the Committee agreed not to consider issues material to the Bill. In our February 2013 report on *Health Finances*, we indicated our support for the Welsh Government's intention to explore options for greater flexibility which we had previously recommended in our report on *'A Picture of Public Services'.*[5]

5. The Committee received a briefing on the report findings from the Auditor General at its meeting on 24 September 2013. Following this session, the Committee agreed to undertake an inquiry looking at:

- Quality of 3 year plans and the risk of potential 'frontloading' in year 1;
- Difficulties in achieving savings;
- The deterioration of performance in some services areas;
- Service reforms and the link to reducing costs;
- Increase in negligence claims;
- How Tier 1 priorities are determined.

6. The Committee took evidence from Welsh Government, Cardiff and the Vale University Health Board and the Wales NHS Confederation. We have made a number of recommendations arising from this work, which can be found in this report.

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[4] NHS Finance (Wales) Act 2014 (Royal Assent was given 27 January 2014)
[5] A Picture of Public Services, April 2012

2. NHS Financial Position and Service Performance 2012-13

7. The Auditor General's report shows that all NHS bodies in Wales met their statutory requirement to break even in 2012-13. However, the report raises some important questions about how sustainable the actions taken to break even have been. The report also shows a mixed bag in terms of service performance. While performance in some areas has improved, elective waiting times and unscheduled care have deteriorated significantly.

The Financial Position of the NHS across 2012-13

8. The Auditor General's report shows that all NHS bodies in Wales met their statutory requirement to break even in 2012-13. The report comments that:

> "It is commendable that all NHS bodies achieved break-even in 2012-13 given the significant ongoing financial pressures"[6]

9. The report found that the NHS bodies were only able to break even through a mix of savings, postponements in planned patient procedures, and additional funding from the Welsh Government. A full breakdown of each NHS body can be found in the Auditor General's report.

Additional funding

10. Following a Government led 'mid-year review' of NHS Wales' finances, in September 2012, an additional £82 million was allocated to NHS Wales bodies. As part of their financial planning each NHS body forecast their projected year-end deficit. However, the amount allocated to each NHS body did not correlate directly with their forecast deficit. The Auditor General's report outlined that:

> "The Department's risk assessment went wider than the financial risk; it also included risks to delivery against other performance targets and priorities. Consequently, three local health boards received more funding than was required to cover their reported likely deficits."[7]

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[6] Health Finances 2012-13 and beyond, paragraph 1.15
[7] Health finances 2012-13 and beyond, paragraph 1.9

11. The Committee questioned the Director General for Health and Social Services/Chief Executive, NHS Wales (Director General) about the reasoning behind the allocation of the additional funding. With regards to Aneurin Bevan University Health Board, he told the Committee that:

> "When we got below the surface of that [their forecast break even] , it was actually carrying equally significant risks within the health board, but it was in a position where it was telling us that it was going to try to manage the risks, rather than putting them into its forecasted out-turn. So, our assessment was that it had the same level of unscheduled care pressures within the system."[8]

12. The Auditor General's report concluded that the process for allocating the additional funding was an overall improvement on that adopted previously, where most NHS bodies received the same amount regardless of their financial position.

13. The Committee understands the approach taken by the Welsh Government in allocating this funding aimed to mitigate against potential risks, and welcomes the more considered approach to the allocation of funds, rather than just a blanket allocation of money to each NHS body.

14. However, the Committee does not feel that the approach taken by the Welsh Government was clearly set out. As a result, it is difficult to assess whether the Welsh Government applied its criteria consistently to each NHS body. The Committee agrees with the Auditor General's finding that the Department and NHS bodies need to forecast on a consistent basis and the Department should be more explicit about the criteria against which it assesses and balances risks, which would allow NHS bodies to have a clearer idea of the underpinning rationale.

15. Furthermore, greater clarity would aid those wanting to hold such spending to account and understand the allocation of money. The initial outline information presented does not provide an explanation as to why a Health Board which is forecasting break even is being allocated additional funds. It is confusing and should be more transparent. As a Committee, we found it hard to assess whether value

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[8] RoP, Public Accounts Committee, 5 November 2013, paragraph 54

for money was achieved, as the background for this decision was unclear.

The Committee recommends that the Welsh Government publishes a clear rationale for funding allocations of additional in year resources to NHS bodies. This would allow greater transparency and clarity in budgets and help to ensure that the resources are being allocated appropriately and value for money.

Brokerage

16. Two NHS bodies – Powys Teaching Health Board and Hywel Dda University Health Board required 'brokerage', from surpluses generated by other NHS bodies, in order to break even at the end of 2012-13. Powys Teaching Health Board required an additional £4.2 million and Hywel Dda University Health Board a further £2.3 million. The Committee raised concerns about how robustly these bodies were held to account during this process and what was in place to stop other Health Boards adopting a similar approach.

17. The Committee questioned the Director General about how health boards requiring brokerage were held to account, and what safeguards were in place to prevent other health boards from following the same route. He told the Committee that:

> "So, we have particularly encouraged those health boards where we feel there are particular challenges, for example, with the two health boards that required some brokerage from health boards at the end of last year, we felt it was particularly important that their plans were subject to some external quality assurance, testing and scrutiny."[9]

18. The Director General explained that clinicians are held to account for the expenditure in their areas through clinical directorate structures which are present in nearly all NHS organisations. Likewise, managers at all levels work within a context of managerial responsibility and accountability. He argued that this meant that there is rigour and discipline in the budget and that therefore:

> "The notion that there is some lack of observance of budgets is wrong. That is certainly not my experience. The whole system

[9] RoP, Public Accounts Committee, 5 November 2013, paragraph 32

> would be all over the place, to be honest, and that clearly is not the case in terms of our performance."[10]

19. The Committee asked the Chief Executive of Cwm Taf University Health Board, whether some health boards receiving brokerage was a disincentive for other health boards to break even. She assured the Committee that this was not the case as:

> "The statutory responsibility has always been something that has weighed very clearly and very heavily on the shoulders of the board. So, there is no doubt that the responsibility for quality, safety and the appropriate use of resources is very clear with boards."[11]

20. The Committee previously raised concerns about accountability of senior managers within the NHS. In our *Picture of Public Services* report, we recommended that:

> "… in line with the views of the National Assembly for Wales's Finance Committee, the Welsh Government holds senior management within Local Health Boards to account for their statutory financial management responsibilities, following the end of the 2011-2012 financial year. In subsequent years thereafter, we recommend that the Welsh Government set out a financial accountability framework for Local Health Boards, to promote effective financial planning and delivery of services in accordance with statutory responsibilities. This should include information on incentives and sanctions for senior managers as appropriate."[12]

21. In response to this recommendation, the Welsh Government stated that the then Minister for Health and Social Services had written to NHS bodies to reinforce the message that senior managers would be held to account for failing to deliver statutory duty. Furthermore, in our previous Health Finances report, we concluded that:

> "…. we consider that the Welsh Government should consider how NHS organisations can be more accountable for any failures to achieve financial targets. This could include examining whether there is the potential to include clauses

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[10] RoP, Public Accounts Committee, 5 November 2013, paragraph 71
[11] RoP, Public Accounts Committee, 12 November 2013, paragraph 39
[12] A Picture of Public Services, recommendation three, page 17

> around achieving targets in incoming Chief Executives contracts of employment, or otherwise examining whether radical or innovative approaches can be employed to challenge non-delivery."[13]

22. However, despite these two reports, and the evidence gathered as part of this inquiry, we still have not been provided with a clear response on how the NHS bodies that required brokerage have been held to account. From the evidence we received it appears that accountability has been limited to receiving support from external consultants. Given the financial pressures currently on the NHS, the Committee believes the Government needs to provide a better, more proactive steer to Health Boards than a letter from the Minister. We want to see a strong leadership role taken by the Welsh Government, to ensure that accountability for budgets is clear, in particular in a situation where brokerage is required. Furthermore, it is vital for the Welsh Government to be able to ensure accountability for any additional in year resources they may provide.

As recommended in the Committee's previous report, we recommend that the Welsh Government hold senior management to account more rigorously, to ensure transparency for financial decisions. In particular, the Committee want to see a thorough process put in place to ensure accountability for any additional in year resources provided by the Welsh Government or other NHS bodies for specific purposes such as brokerage.

Savings

23. In order to achieve their break even target the Welsh Government had to make a number of cuts in important areas of the health budget, such as training for NHS staff. The report details the following key areas which were subject to a reduction in spending:

- £4.5 million from training the NHS workforce (2.4 per cent of budget);
- £1.9 million from health protection and immunisation (16 per cent of budget);
- £2.0 million from health promotion (31 per cent of budget);

[13] Health Finances Report page 5

- £1.2 million from emergency preparedness (20 per cent of budget);
- £3.9 million from health research and development (8.9 per cent of budget); and
- £0.5 million from hospice support (7.1 per cent of budget).[14]

24. The Auditor General's report details a breakdown of the areas and types of savings made by NHS bodies. These include savings in workforce modernisation and medicine management. The report raises a number of questions about the nature and robustness of some of the reported savings, particularly workforce savings. Furthermore, the Auditor General's report shows that NHS bodies collectively fell some way short of their target for savings.

25. The Auditor General's report found significant year-on-year reductions in the amount of savings that the NHS reported. The level of reported savings fell by £100 million between 2011-12 and 2012-13. The Director General confirmed this, although he suggested that savings in excess of 4-5% were not sustainable:

> "On the pattern of savings, we have done some analysis that shows that, over the last four years, the level of savings in percentage terms in 2010-11 was 4.6%, in 2011-12 it was 5.2%, in 2012-13 it was 3.4% and this year it is 3.5%. So, you are right—there was a drop in the last year. Our take in looking forward is that it would be unwise to plan on the generation of savings to a level in excess of 4% or 5%; we think that it is more appropriate to plan on the level of something like 3% to 4%—where we are at the moment."[15]

26. Witnesses told us about the increasing difficulty in finding further financial savings in the usual areas. This was also referred to within the Auditor General's report, which questioned where the reported workforce savings have come from. When the Committee asked the Director General about this, his response was still not entirely clear, other than pointing to reductions in locum and agency costs which are welcome .[16]

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[14] Health Finances 2012-13 beyond, paragraph 1.10
[15] RoP, Public Accounts Committee, 5 November 2013, paragraph 81
[16] RoP, Public Accounts Committee, 5 November 2013, paragraph 84

27. The Committee agrees with the concerns in the Auditor General's report about the potential long term costs implications of some of these short term reductions, particularly in areas of prevention and training. We are also concerned about the sustainability of these savings and the reliance on workforce savings which are consistently not being delivered.

Financial management at NHS bodies during 2012-13

28. The Auditor General's report found that most of the NHS bodies started 2012-13 without agreed plans to deliver a balanced budget. The report states that:

> "Many NHS bodies did not present their 2012-13 savings plans for their Board approval before 1 April 2012 and some plans were presented well into the financial year."[17]

29. It goes on to say that:

> "…some budget holders in the NHS bodies refuse to sign up to their delegated budgets and/or savings plans. Budget holders often view elements of their budgets/savings plans to be outside their control and/or unrealistic, and so do not see why they should be held accountable."[18]

30. When questioned about the accountability for budgets, the Director General made it clear that this was a matter for Health Boards:

> "It is clearly the case that the allocations that are provided by the Welsh Government translate into systems that have a robust, resilient, efficient and effective budgetary framework. In a sense, it is a decision to be taken at a health board or trust level in terms of the way that it is delegated and devolved to particular parts of the organisations, and there is not any sense of a perpetual process of negotiation about it; there is a point at which the particular sub-units of the organisation have to accept the reality of the situation."[19]

31. The Committee received reassurances from the Chief Executives of both Cardiff and the Vale and Cwm Taf University Health Board that

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[17] Health Finances 2012-13 and Beyond, paragraph 1.29
[18] Health Finances 2012-13 and beyond, paragraph 1.32
[19] RoP, Public Accounts Committee, 5 November 2013, paragraph 13

their budgets had been signed off fully by all the relevant board members.

32. The Committee raised concerns about the practice of budget holders not accepting budgets in its report on *the Governance Arrangements at Betsi Cadwaladr University Health Board*.[20] In that report, we recommended that:

> "The failure to adhere to accepted budget processes is an issue of particular concern. We do not believe that budgets should be signed off with caveats and recommend that assurances should be provided to us that this practice has now been discontinued within the Health Board.
>
> "We also recommend that the Welsh Government seeks information from directors of finance at all health boards to ensure that the failures evident within the budget planning processes at the Betsi Cadwaladr University Health Board are not being replicated elsewhere."[21]

33. The Committee are concerned about this practice, as it demonstrates poor governance. It appears that this has reinforced a focus on short termism, with savings not being delivered until they are agreed.

34. The Committee believes that the Welsh Government should provide a strong lead for strengthening financial management in NHS bodies and we would reiterate our recommendation from our report on the *Governance Arrangements at Betsi Cadwaladr University Health Board*.

35. Furthermore, in our opinion, the Government's approach to in year funding in 2012-13 resulted in mixed messages for the NHS Bodies. The Auditor General found that:

> "The Department informed NHS bodies that that they would not receive any additional funding. On the one hand, this approach clearly encourages some NHS bodies to take the tough decisions and actions needed to break-even. However, some NHS bodies' financial planning for 2012-13 included, from the

[20] Governance Arrangements at Betsi Cadwaladr University Health Board, December 2013

[21] Ibid, recommendations 13 and 14, page 42

outset, an assumption that they would receive additional funding from the Department. In the event, the local health boards did indeed receive additional funding despite being told that they would not."[22]

36. The Committee believes this is not an appropriate way to manage health finances. The Government signed off plans from health boards which assumed additional funding when it had been clearly stated that there was no extra money available, and then in the end additional money was provided. This is a matter of concern for the Committee particularly when put with our concerns over the transparency of additional allocations.

37. The Committee believes that the move to three year financial planning and allocations should address in principle some concerns about financial management within the NHS. However, as discussed later in the report this must be implemented correctly to guarantee the financial issues in the NHS are dealt with appropriately. Recommendations seven and eight in Chapter four seek to address these concerns.

Service performance during 2012-13

38. The Auditor General's report recognises some general improvement in the performance areas of efficiency and stroke in 2012-13. The report also notes that there has been a reduction in healthcare-associated infections, although it raises a concern about the accuracy of the information and whether all incidents of infection have been recorded. This echoes concerns the Committee raised in our report on *the Governance Arrangements at Betsi Cadwaladr University Health Board*.[23]

39. However, the Auditor General's report found that the performance in both unscheduled and elective care is a major concern. At the time of drafting this report, the Committee were undertaking a separate inquiry into unscheduled care and therefore will draw conclusions separately on this.

40. As a Committee, we are concerned that rising elective waiting times are indicative of significant problems with health finances.

[22] Health Finances 2012-13 and beyond, paragraph 1.14
[23] Governance Arrangements at Bestsi Cadwaladr University Health Board, Chapter three Quality and Safety Arrangements

41. The Auditor General's report highlighted a significant reduction in elective activity in the final months of 2012-13. It also reports that the pressures on unscheduled care do not fully explain the reduction in elective activity and that financial considerations were also a significant factor. The Committee asked the Welsh Government whether the health boards had decided to postpone elective activity in order to break even. We were told that the extreme weather in winter of 2012-13 was a significant pressure on the healthcare system, and resulted in rising elective waiting times. The Director General said:

> "Analysis, both in Wales and in other parts of the UK, has confirmed that there was a combination of factors, some demographic and some to do with the weather—it was a particularly harsh winter—that caused very significant pressure on the unscheduled care systems. Health Boards made clinical decisions based on the priority that they gave to the most poorly patients, who needed to be admitted."[24]

42. The Deputy Chief Executive of NHS Wales stressed that:

> "I am absolutely convinced, from the analysis that we have undertaken, that all the pressures that took place during those last three months, and that went on into early summer, across the whole of the UK, were the primary reason we saw a reduction in elective activity over that time. The analysis is very clear. There was a big shift in terms of the capacity that was required in order to be able to deal with unscheduled care, and it was inevitable. … So, it is clear when you see what was lost during that time that that was not to be able to get to an economic envelope of any sort; it was to be able to provide the capacity."[25]

43. He went onto explain that at some points additional capacity was found in areas such as day case wards. Of the 310 extra beds provided by health boards, the Director General told us that:

> "… this was health boards taking decisions in quite extraordinary circumstances to create additional capacity. They also took a decision to postpone some elective work, simply because the beds were occupied by patients who had come

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[24] RoP, Public Accounts Committee, 5 November 2013, paragraph 91
[25] RoP, Public Accounts Committee, 5 November 2013, paragraph 94

through A&E departments and emergency routes. I think that they took decisions appropriately. They were using the budgets in a flexible way to meet the demands that were placed on them."[26]

44. The Chief Executive of Cardiff and the Vale University Health Board reassured the Committee that the cancellations were not related to trying to break even:

> "That is an important issue. From our perspective, during the period at the height of all those cancellations, it was the last thing that we wanted to do. It was not a part of our financial plan because that, in my view, is an extremely short-sighted manoeuvre if that is what you do. Those patients still need to be treated and it is quite likely that it will cost you even more money, because you will have to do it in premium rate time and all the rest of it. The reason why we cancelled as many patients as we did is for the fact that I explained earlier: we simply had little or no surgical capacity and, when we were overtopped with demand, those patients unfortunately went into the surgical elective bed base. That meant that we were physically unable to get patients into the hospital. That was our problem."[27]

45. The Welsh Government emphasised that the circumstances arising from last winter was a one in fifty year event. However, the Auditor General's report does not show that overall increase in demand was extraordinary.

46. Although it is difficult to establish a direct link between the reduction in elective activity and finance from the limited time we had available, the Committee believes that correlation between deterioration in service performance and the period of funding pressure is not a coincidence. The Auditor General reports that some NHS bodies reduced or delayed activity in order to make financial savings:

> "Increased demand is clearly a factor behind the declining performance, but it is unclear to what extent it explains all or indeed most of the problem. The Department's analysis of the

[26] RoP, Public Accounts Committee, 5 November 2013, paragraph 92
[27] RoP, Public Accounts Committee, 5 November 2013, paragraph 232

> problems in emergency care tends to focus on the 'demand side' issues. However, there are some critical 'supply side' issues that need to be explored further. In particular, our local work identified that the impact of financial pressures is a factor behind the decline in elective performance. Several local health boards have taken difficult decisions to allow performance against waiting times targets to slip in order to manage the financial pressures, although the extent to which such decisions are clearly expressed, documented and publicised varies."[28]

47. The Committee are concerned about the short term gains from cancelling elective procedures, as this puts further pressure on subsequent years. The Committee believes there are issues emerging around capacity and will explore this further during our inquiry into unscheduled care.

[28] Health Finances 2012-13 and Beyond, paragraph 2.12

3. Key emerging issues for NHS Wales in 2013-14

The Current Position on NHS Finances Forecast end of year position for 2013-14

48. The Auditor General's report stated that NHS bodies started 2013-14 projecting an end of year deficit of £212 million:

> "As of April 2013, NHS bodies report a collective gross funding gap of £404 million for 2013-14 with planned savings of £192 million leaving a net funding gap of £212 million."[29]

49. The Committee questioned witnesses about what efforts have been made to bridge the gap in the budget over the year. Cardiff & the Vale University Health Board reported that it was behind with its plans:

> "At M[onth]6, the UHB has a deficit of £7.1m worse than its planned deficit of £16.2m (1.3%). There is a significant risk to achieving the in year financial position of approximately £15m."[30]

50. The Chief Executive of Cardiff and the Vale University Health Board told the Committee that this was because:

> "…we have had a number of issues that we had not anticipated, which have hit our bottom line, and which means that we need to do more work in the final months of the year to bring this in. …we are still very committed to delivering the numbers that we need to deliver and all of our effort is focused on making sure that that is what happens."[31]

51. The Chief Executive of Cwm Taf University Health Board outlined the situation in her Health Board as:

> "I started the year with an identified financial gap of £37 million. We had initial savings plans that took that down to £20 million. That gap now has reduced to £8 million and we are

[29] Health Finances 2012-13 and Beyond, page 48
[30] Written evidence, PAC(4)-28-13 (Paper 2), 5 November 2013
[31] RoP, Public Accounts Committee, 5 November 2013, paragraph 163

constantly working on additional plans and initiatives to address those reductions in costs."[32]

52. The Committee requested the up to date position and further analysis of the NHS finance position from witnesses, initially from the Welsh NHS Confederation and then from the Welsh Government during their evidence sessions in November 2013. The Director General provided the figures for month nine (December) and draft figures for month ten (January) to the Committee in February 2014:

Organisation	Forecast Surplus/Deficit Month 09	Draft Position Month 10
	£000's	£000's
Abertawe Bro Morgannwg	**-6,000**	**-3,000**
Anuerin Bevan	**-5,601**	**-5,100**
Betsi Cadwaladr	**-13,000**	**-7,500**
Cardiff & Vale	**-16,320**	**-19,320**
Cwm Taf	**-5,200**	**-4,500**
Hywel Dda	**-17,109**	**-18,109**
Powys	**-19,494**	**-19,410**
Public Health Wales	**0**	**0**
Velindre	**0**	**0**
Welsh Ambulance	**0**	**0**
NHS Wales	**-82,724**	**-76,939**

53. The figures show that NHS Wales is still facing a forecast deficit of almost £77 million at the end of January (month ten). As outlined later

[32] RoP, Public Accounts Committee, 12 November 2013, paragraph 11

in this chapter, the Welsh Government allocated an additional £50 million to NHS Wales in the second supplementary budget published February 2014. However, this still leaves a gap of £27 million which will need to be addressed.

54. The Committee experienced significant difficulties in obtaining accurate up to date information on the financial situation in NHS Wales. Although this information is published by health boards, it is not easy to locate and it is not done in a timely, transparent or consistent fashion. We asked the Welsh Government to supply the financial information at the end of December (month nine), but they were unable to provide us with this until two weeks into February (month eleven). It is concerning that such information is not available in a collated document within the same month that it is requested. We are concerned that this suggests the Welsh Government does not have a timely understanding of the finances of NHS Wales We believe this has a significant impact on the ability to scrutinise the financial performance of NHS Wales. The publication of the current financial position is essential for transparency and accountability.

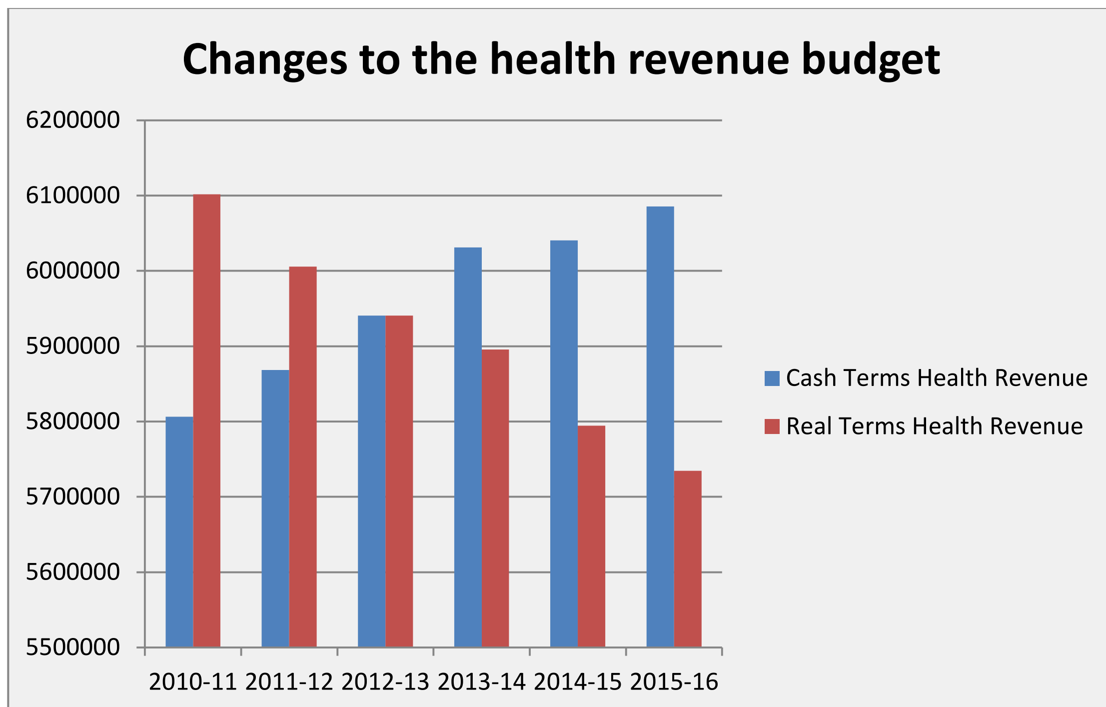
The Committee recommends, in order to enhance transparency and accountability, the Welsh Government publish, the monthly financial position of NHS Wales in a timely and accessible fashion.

55. The Auditor General shared with the Committee correspondence between himself and the Welsh Government. In this he raised concerns about the presentation of the additional funding for the draft budget for 2014-15. The draft budget narrative shows a 1.1 per cent real terms increase in the revenue allocated to NHS Delivery in 2014-15. However, the Auditor General explains that:

> "The difficulty of the reported year-on-year position is the use of the Supplementary Budget 2013-14 as a baseline. The baseline budget for health services in 2013-14 changed significantly as a result of the additional £150 million in-year allocation to health. Clearly, the additional funding for 2013-14 impacts on the year-on-year change between 2013-14 and 2014-15. Consequently, having taken account of this additional funding in 2013-14, it means that, in real terms, the NHS

Delivery revenue budget will be 1.6 per cent lower in 2014-15 than 2013-14."[33]

56. Indeed the presentation of the draft budget led the Finance Committee to conclude that the Government's 'clearest priorities are indicated by directing additional money towards the health service.'[34] However, the graph below shows the actual position with regards to cash terms health revenue versus real terms cash health revenue which shows a very different story to that laid out in the budget.



[35]

57. In responding to the Auditor General's concern, the Welsh Government acknowledged that this could be clearer and included a footnote to the comparable table to highlight that once the in-year allocation is included there is a real terms reduction in NHS funding in 2014-15.[36]

58. The Committee welcomes the action taken by the Welsh Government to address this issue; however we are concerned about

[33] Written evidence, PAC(4)-03-14 (ptn1), 28 January 2014
[34] Finance Committee, Welsh Government Draft Budget Report November 2013
[35] 'Health revenue' covers the revenue budgets for 'NHS Delivery', 'Central Budget' and 'Public Health and Prevention'. These budget lines form part of the overall Health and Social Care Departmental Budget. Real terms figures are in 2012-13 prices and have been calculated using the HM Treasury GDP deflator series released September 2013.
[36] Written evidence, PAC(4)-03-14 (ptn1), 28 January 2014

the lack of transparency. While we accept the Permanent Secretary's explanation that this occurred due to 'the standard approach that we [Welsh Government] have adopted to presenting numbers and that therefore there was no intention to mislead',[37] the Welsh Government must ensure that the information is clear and easy to interpret for everybody, as opposed to just those with an in-depth understanding of the figures.

59. This presentation of the NHS Wales budget is a further example of the need for more transparency in the information presented to allow for scrutiny of health finances to effectively take place.

The Committee recommends that the Welsh Government considers how it presents future budgets to ensure that it fully explains - in budget tables and the accompanying narrative report - the impact of any substantial changes following the supplementary budget on year-on-year comparisons.

Additional funding in 2013-14

60. The Minister for Health and Social Services announced on 17 October 2013, that the Welsh Government would provide an additional recurrent £150 million of resources from 2013-14.[38]

Townsend Formula

61. The additional £150 million was allocated to Health Boards and NHS Trusts via a "population share basis with a Townsend twist to it in taking some of the inequality dimensions of Townsend" according to the Health and Social Services Minister.[39]

62. The Townsend formula was devised by Professor Peter Townsend as part of the 2001 NHS allocation review. It allocates resources on the basis of population, adjusted for factors such as deprivation. The result of this allocation formula is that it does not always address the levels of deficit identified in budgets and the risks of each NHS body. The Director General said:

> "There is a formula that we use, the degree to which it is satisfactory has been the subject of debate over a number years. However, broadly, it provides a basis upon which we can

[37] Written evidence, PAC(4)-03-14 (ptn1), 28 January 2014
[38] Cabinet Written Statement, 17 October 2013
[39] RoP, Health and Social Services Committee, 17 October 2013, paragraph 405

allocate money to each health board to recognise its resident population, adjusted for some factors that recognise health need. So, for example, it would be weighted towards areas with greater health needs to ensure that the money available to a health board should more appropriately meet the needs of the population."[40]

63. The Committee questioned the witnesses about the use of a population based formula, and whether this is the best method for allocating funds. The Chief Executive of the Cardiff and the Vale University Health Board told the Committee that:

> "There are many moving parts and all sorts of factors that need to be taken into account. To my knowledge, there is not a perfect solution anywhere in the world."[41]

64. The Director of the Welsh NHS Condfederation said:

> "The Townsend formula is a very set formula, which probably does not have all the nuances of those different needs. So, it is one way of making allocations; it is the way that we have, and that is what we have to deal with."[42]

65. The Chief Executive of Cwm Taf University Health Board highlighted that:

> "…there is a question about whether or not things have changed since the original formulae were established, and there is an opportunity to look at whether the individual component parts of a population-based allocation formula need to change to reflect population changes. However, a fair share of the allocation, based on population, is the right thing to do, and not necessarily to chase deficits."[43]

66. The Committee would welcome a reassurance from the Welsh Government that the impact of utilising the Townsend formula will be fully considered. We are concerned that there is the potential for this formula to lead to a significant redistribution of resources between

[40] RoP, Public Accounts Committee, 5 November 2013, paragraph 21
[41] RoP, Public Accounts Committee, 5 November 2013, paragraph 176
[42] RoP, Public Accounts Committee, 5 November 2013, paragraph 24
[43] RoP, Public Accounts Committee, 5 November 2013, paragraph 29

NHS bodies, which may be very difficult for individual NHS bodies to manage.

67. In follow up correspondence to the Committee, the Director General informed us that:

> "Since the creation of the seven Local Health Boards in 2009, questions have been raised as to suitability of the current formula in meeting future needs. A commitment to review the allocation basis was given under the "Together for Health – Financial Regime" commitments. This review will be complex and will take some time to complete. It has started with a current focus on clarification of objectives, detailed scoping and project establishment. We anticipate the exercise will be completed in 2015."[44]

68. The Committee recognises that there is no perfect answer for allocating additional resources, and there is a need to achieve a balance between chasing deficits and fairly allocating funds based on the needs of the local population.

69. However, the Committee has concerns about the current method and would welcome a reassurance that value for money and transparency around additional funding will be considered in the review of the allocation basis, which the Director General referred to in his letter.

The Committee recommends that local population needs, value for money and transparency are key considerations in the scope of the Review of the Allocation Basis and that no significant changes be made to the allocation formula without full consideration of the potential impact of redistribution on local health services.

70. The Committee found that there was a lack of clarity around the intended purpose of the £150 million. It was unclear whether it was intended to bridge the financial deficit, fund new projects, or address the concerns raised through the Francis agenda.[45]

71. According to the Cabinet written statement, the money was intended to meet new demands and pressures in the current financial year. Later in the statement it claims that:

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[44] Written Evidence, PAC(4)-33-13 (ptn 1), 27 November 2013
[45] Mid Staffordshire NHS Foundation Trust Public Inquiry Final Report, February 2013

> "The additional £150 million announced for 2013/14 is being allocated to help meet the recognised service pressures arising from the Francis Review and to implement best practice standards including for example the national immunisation advice."[46]

72. Officials from the Welsh Government told the Committee that the money was to bridge the financial gap but that the gap was based on plans that take account of pressures on quality:

> "… the other question that you come back to is whether the £200 million is, to an extent, offset by the £150 million—do we still have a £200 million problem? That is the question, and the answer is 'no'. This offsets and reduces the scale of the problem that the NHS is facing."[47]

73. The Chief Executive of Cwm Taf University Health Board said she "would not want the Committee to think that that money was going into the bottom line of the NHS, because that would be abjectly wrong". She explained that:

> "…it is important that we look at that in its entirety, because some of the financial challenges that the NHS is experiencing are because of the need to make investments in these quality initiatives to deliver safe, sustainable care. So, there will be a significant impact of that investment on the financial position, because by improving some of the quality issues, we are actually able to reduce cost."[48]

74. The Committee understands the argument that quality issues were built into plans but we have not been convinced this happened, and have struggled to find any evidence that this was requested from Health Boards. Aside from the additional money for vaccines, it is hard to see that the £150 million has done anything other than gone into the bottom line of Health Boards. We feel that the allocation of this funding, is yet a further example of needing greater transparency in health finances as referred to in recommendations one and two of this report.

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[46] Cabinet Written Statement, 17 October 2013
[47] RoP, Public Accounts Committee, 5 November 2013, paragraph 19
[48] RoP, Public Accounts Committee, 12 November 2013, paragraph16

75. The second supplementary budget for 2013-14, published by the Welsh Government on 11 February allocated an additional £50 million for NHS Wales. This additional resource is being held centrally and then allocated to Health Boards based on need. The explanatory note states:

> "In order to ensure that there is sufficient budgetary cover to manage these risks within the DEL position, we are allocating an additional £50m to be held within the Health and Social Services MEG, as a contingency measure, in the event that some Local Health Boards are unable to achieve a breakeven position."[49]

76. It is unclear at the time of publishing this report how this funding will be allocated. Furthermore, the forecast deficit at the end of January in figures provided by the Welsh Government showed almost a £77 million deficit, which means even with the additional £50 million, there remains a gap of £27 million, and it is unclear how this will be addressed.

77. This further allocation of additional funds is a matter of serious concern for the Committee. It does very little to address the perception that there is a lack of incentive for NHS bodies to have to break even as they will always receive a bail out from central funds. Furthermore, the holding of the money centrally with little clarity over its allocation, or how the remaining deficit will be addressed creates further uncertainty.

Financial planning 2013-14

78. The Committee found that there was a significant lack of clarity over financial planning in 2013-14.

79. The Committee asked the Welsh Government about what they had required in terms of planning. The Director General told us that:

> "Again, just to go through it, at the beginning of the year, health boards and trusts were asked to develop plans, as I am sure that you would want us to do, that would meet their projections in terms of demand and unscheduled care pressures, appropriate planned care performance, and to

[49] Para 2.4, page 8 Welsh Government second supplementary budget explanatory note

develop appropriate staffing levels, for example, on their acute wards. They had to be quality assured plans. Those were the plans that they produced."[50]

80. It appears to us that the Welsh Government asked Health Boards to produce plans that delivered levels of quality and demand that Welsh Government knew they could not afford.

81. Furthermore, the Welsh Government took six months after the plans had been produced to decide whether or not to fund the financial gap identified in them. This seems a far from satisfactory approach to planning and the Committee believes this could have created considerable uncertainty in Health Boards which is likely to have compounded poor financial planning.

Implications of financial position for services

82. The potential deficit at the end of 2013-14,[51] could have a significant impact on services.

83. Cardiff and the Vale University Health Board lost ground on elective activity at the end of 2012-13. Its Chief Executive reported to the Committee that the Board would only make that up during 2014 and that things would not get better:

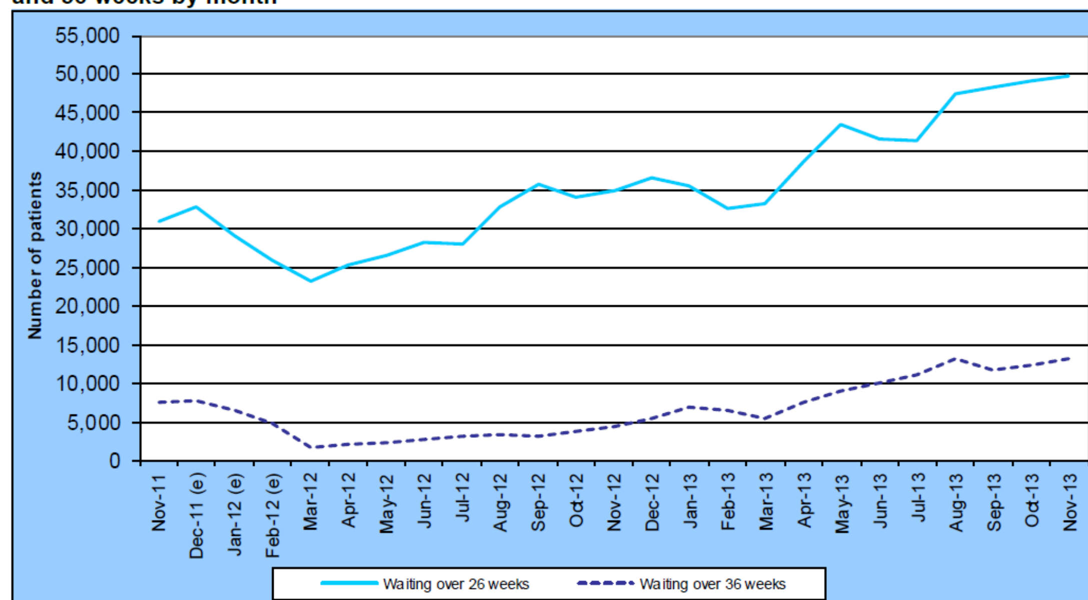
> "Through the entire winter, we lost about two weeks' worth of elective surgery in total. That is a lot. We are aiming, by the end of this financial year, to have delivered this year's activity and put that back. So, we should end this year with only a small improvement on the position that we started with a year ago, but we will have got back to where we started. Clearly, our plans going forward are then to eat into that and to make that better over time."[52]

84. Evidence from the Welsh Government suggested that there had been a catch-up in September 2013 in terms of patients waiting over 36 weeks and that Health Boards could regain ground by March 2014 if there were no winter pressures. It appears to the Committee that assuming the rate of catch-up in September 2013 would continue across the year seems highly optimistic and quite unlikely. In fact, the

[50] RoP, Public Accounts Committee, 5 November 2013, paragraph 5
[51] Health Finances 2012-13 and beyond, July 2013
[52] RoP, Public Accounts Committee, 5 November 2013, paragraph 236

chart below, published by the Welsh Government in January 2014, shows that despite the catch up in September, there was an increase in 36 week waits in October 2013 and November 2013.

Chart 1: Number of patients waiting to start treatment, with referral to treatment times of over 26 and 36 weeks by month



[53]

85. The Welsh Government provided the Committee with the table below which shows the number of short notice postponements at an all Wales level since April 2012. According to the information from the Welsh Government these postponements follow decisions based on clinical priorities and the requirement to use capacity to meet the needs of the most urgent or ill patients. The Committee notes that the figures show an increase in the number of postponements in all months in 2013/14 apart from June and December.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	255	272	262	297	157	109	234	264	300	1123	583	902
2013/14	1219	312	195	415	235	341	262	390	245[54]			

86. During the evidence session, the Welsh Government referred to profiling and doing fewer procedures over winter to accommodate pressures that are predictable, as did The Chief Executive of Cwm Taf University Health Board, who told us that:.

[53] Welsh Government NHS Wales Referral to Treatment Times – November 2013, published 9 January 2014. (Accessed 23 January 2014)
[54] The information for December 2013 was un-validated at the point of sending the information to the Committee, although Welsh Government expected to confirm a lower number of postponements in December 2013 in comparison with the same period of 2012.

> "… we proactively look at the things that we know we can monitor and measure and then we take action where we can appropriately to prevent the impact of that. However, we also know, for example, that post-bank holidays we get surges of activity, because families try to keep granny well and at home over Christmas and the new year and keep people going, and then in the new year, we get a surge of activity, so we plan for that. We profile our elective activity differently for the couple of weeks after Christmas so that we can maximise bed availability and staff availability for what we know is predicted demand."[55]

87. The Committee welcomes this more proactive approach to profiling potential pressures, as this may relieve some of the problems which occurred during the winter of 2012-13, and which, according to the figures above, have continued during 2013-14.

88. The Committee also has a number of concerns about work-force savings and staffing levels. We were told by witnesses that there has been a move to change practices to enable quality/ service to be sustained with fewer staff. The Committee welcomes this undertaking from Health Boards, but we are concerned about the extent to which these changes can be delivered given the short timescales required by the immediate financial pressures.

89. The Committee also raised concerns with witnesses about the management of planned activity and capacity. We were told that Health Boards had been trying to reduce the length of stay in order to reduce bed numbers.

90. The Committee are concerned about the closing of beds, as we believe these should be used to catch-up on and sustain elective care. We would like to see the re-directing of the capacity to address declining elective performance. We note the comments from the Chief Executive of Cardiff and the Vale University Health Board that:

> "The demand has not gone down; the demand has gone up. …. What I am saying is that we have found a way of managing that demand more efficiently, which has led to us needing fewer beds than we needed this time last year. The good news is that that means that we now have some surgical capacity and empty beds that we can plan to bring online should we get more

[55] RoP, Public Accounts Committee, 12 November 2013, paragraph 43

demand during the winter. That is part of our plan for this year. All other things being equal, we are in a better place, by virtue of the changes that the clinical teams have delivered, this time than we were at the same time last year, because we have more capacity."[56]

91. During the course of the Committee's inquiry, some health boards suspended or considered suspending elective procedures over the winter months in order to address the anticipated pressures, which we believe is indicative of pressures that NHS bodies are facing this year. This is also highlighted in the figures for elective procedure cancellations provided by the Welsh Government. This is a matter of serious concern for the Committee not least because we view it as an ineffective way to manage budgets - it builds up financial pressures and, potentially, means expensive clinicians, facilities and equipment being idle for this period. We agree with the principle of planning and scheduling elective work, to accommodate the pressures of winter care and would welcome further information on how this is done and whether it is a manageable approach going forward.

The Committee recommends that the Welsh Government commission a piece of work to consider approaches to profiling potential pressures and how this can be used as an effective management tool within the NHS Wales.

[56] RoP, Public Accounts Committee, 5 November 2013, paragraph 234

4. The Need to do Things Differently

92. From the findings in both the Auditor General's report, and the Committee's previous report on *Health Finances,* it is apparent that there is a need for substantial change in the Health Service. This is not a new concept, but it is something which must now be acted on as a matter of urgency to ensure health finances are managed more effectively. This chapter explores some of the areas where change is needed.

Financial Planning

Three year planning

93. Paragraph 1.28 of the Auditor General's report states that the financial plans submitted by NHS bodies to the Department at the beginning of the 2012-13 financial year were generally not robust and that just one NHS body had a plan that clearly showed how expenditure was matched by income and funding at that point. It is essential for health bodies to better plan finances to ensure that the budget is appropriately used.

94. The Government introduced the NHS Finance (Wales) Bill in September 2013 which became an Act on 27 January 2014. This legislation introduces concept of three year plans. The aim of this is to ensure health board plans are affordable The Director General told us that:

> "That goes to the heart of this planning process. The financial regime has to be predicated on a planning process that pays as much attention to month 1 as to month 36. Therefore, that is why the health board plans, and the trust plans, individually and collectively, have to be affordable. ... Therefore, the plans that we are asking health boards for are ones that we want to show sustainability. They are not just a question of how we can get through the next 12 months, and the further 12 months; it is not a bolting together of three one-year plans; it is a genuine three-year plan that shows an evolution in service delivery models;... They have to be realistic and robust plans that allow

> us to look to the future with the confidence that we would want in the NHS in Wales."[57]

95. The Director General told the Committee that managing very significant budgets, in the context of producing three-year future strategic operational plans, would be challenging.[58] He assured the Committee that:

> "… we are paying particular attention in the three-year plans is to ensure that we do not simply frontload all the financial pressures, so that everything is rosy in year three. We need to be very rigorous in ensuring that the balance is distributed, as different health boards will be in different positions."[59]

96. The move to three year planning was welcomed by the Cardiff and the Vale University Health Board. Its Chief Executive said:

> "One of the very important signals, I think, that the system is sending to health boards and all this talk of moving from a one-year to a three-year financial regime is extremely powerful, because it moves us away from a focus on the end of any one year. When you focus on a single year, boards' minds inevitably get very focused on 31 March, and I think that that tends to diminish the focus on the underlying financial position, because you are trying to get over the line each year."[60]

97. The Committee welcomes the recognition from Welsh Government and other witnesses about the need for three year plans to be affordable and sustainable; and to reflect 'an evolution in service delivery models'.[61] While we welcome three year plans, we do have concerns about ensuring that the quality, which is lacking from plans at present, is incorporated into three year plans.

98. The Chief Executive of Cwm Taf University Health Board explained that the NHS Wales had been working with Welsh Government to develop guidance about planning. She also explained that there was a peer review system in place for the three year plans, which was a new development. She told the Committee that:

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[57] RoP, Public Accounts Committee, 5 November 2013, paragraph 147
[58] RoP, Public Accounts Committee, 5 November 2013, paragraph 31
[59] RoP, Public Accounts Committee, 5 November 2013, paragraph 142
[60] RoP, Public Accounts Committee, 5 November 2013, paragraph 190
[61] RoP, Public Accounts Committee, 5 November 2013, paragraph 147

"For me, the real issue is having strong service plans, because our workforce and financial plans have to arise from strong service plans that meet the need. The big debate that has to take place is about what the shape of the NHS will be going forward, where services are going to be delivered and in what way. We almost have to turn our planning framework completely on its head—we are no longer looking at financial planning as a discipline in isolation; we are looking at strong service planning to meet quality standards that also work within the resources that we have."[62]

99. The Committee believes that the proposed move to three year financial planning will provide health boards with some helpful flexibility but we are concerned health boards will need to be disciplined each year to ensure health spending will still be within the total Departmental budget.

100. The Committee welcomes the assurance from Welsh Government and The Chief Executive of Cwm Taf University Health Board that there is more rigour around three year planning and that there are greater links between service, work-force and finances. In particular, we welcome the reference to benchmarking and engagement of clinicians in planning and designing changes.

101. However, the Committee remains concerned about the delivery of the Health Board plans given the constraints. As the Auditor General's correspondence exchange with the Permanent Secretary shows[63] the additional funding for future years is still relatively limited in comparison to the scale of cost and demand pressures. We also note the comments made by the Wales NHS Confederation, who highlighted the difficulty of transforming services while managing immediate demand and cost pressures.[64]

The Committee recommends that the Welsh Government sets out the process for agreeing the three year budgets for health boards and how this differs from current processes, as well as how it intends to resolve any disputes that may arise during this process.

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[62] RoP, Public Accounts Committee, 12 November 2013, paragraph 87
[63] Written evidence, PAC(4)-03-14 (ptn1), 28 January 2014
[64] RoP, Public Accounts Committee, 12 November 2013, paragraph 5

The Committee further recommends that given the risks of financial planning over 3 years, the Welsh Government should require:
a) Fully balanced plans over three years for each Health Board with supporting detail;
b) Collective financial planning showing how budgets will balance across the whole NHS every year (so as to stay within DEL);
c) Detailed contingency plans setting out how Health Boards will respond if planned savings from up-front investment do not materialise and/ or there are additional cost pressures. These contingency plans should include an assessment of risks to patients/ services.

External Expertise and Sharing Good Practice

102. A number of health boards have brought in external expertise to help manage their finances. The decision to call in external expertise varies between health boards, with some boards requesting additional support, and others being required to utilise external support by the Welsh Government to address concerns about their budgetary controls. The Director of Finance for Department of Health and Social Services in the Welsh Government, told us that:

> "Cardiff has already taken support, Betsi has support in currently working with it to look at the opportunities for generating savings and efficiencies, and Powys has taken support on that basis, as has Hywel Dda."[65]

103. The Welsh Government informed us that they encouraged those health boards requiring brokerage to use external support. While Cardiff and the Vale University Health Board explained that they decided to bring in external expertise to:

> "… understand how we got into a position of not in a recurrently balanced position. The second was to understand how we could get to a situation last year where we delivered the very best possible result that we could. Thirdly, and most importantly, we needed to understand how we could build our way out of that system, or that situation, with robust plans that

[65] RoP, Public Accounts Committee, 5 November 2013, paragraph 14

> drew on the evidence from around the world and across the UK of what others are doing that we could learn from."[66]

104. The Committee questioned the Director General about the costs of utilising external expertise:

> "In terms of the costs, they are borne by the health boards, and as such I would not have the information specifically about how much each of those exercises costs. That information would be held at health board level."[67]

105. The Welsh Government subsequently provided the Committee with further information about the cost and nature of external expertise. This information highlighted that there was a broad range of work which was being commissioned and the range of costs from £80k to £791k. Full details of the costs can be found in the correspondence from the Director General dated 27 November 2013.[68]

106. The Committee expressed a concern that the utilisation of this external support may be indicative of a lack of expertise within health boards. We were pleased that the Wales NHS Confederation felt that:

> "There will always be times for short interventions, when it is appropriate to get some expertise in to help people. However, we could not support the NHS in Wales being dependent on external consultancy to help us to do our business. That is not something that we would endorse or support. However, there are times when having some specialist expertise around a specific issue is the appropriate thing to do, but that has to be considered in the round, in terms of the appropriate use of public resources."[69]

107. The Director General argued that:

> "I do think that it is wise that, at times, they take advantage of external support, to get expertise. The benefits of doing so, I think, are evident in Cardiff and Vale, and other health boards are taking advantage of that. I think we could argue from a contrary point of view that, if at times the NHS is a little bit too

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[66] RoP, Public Accounts Committee, 5 November 2013, paragraph 196
[67] RoP, Public Accounts Committee, 5 November 2013, paragraph 32
[68] Written evidence, PAC(4)-33-13 (ptn1), 27 November 2013
[69] RoP, Public Accounts Committee, 12 November 2013, paragraph 89

‘We are masters of all our information and planning’, we could be accused of being a little introspective and not sufficiently open to external influence.”[70]

108. Alongside developing expertise, the Committee are keen to see better sharing of good practice going forward in the NHS. The Chief Executive of Cwm Taf University Health Board told the Committee that:

> “That is something that, in pockets, we do very well, but systematically, we are not as good as we should be in the NHS. Through the Wales Audit Office, we have a system of sharing good practice that has been helpful to us. Where Wales Audit Office is picking up good practice, it is making that available to the NHS. We also have good-practice-sharing mechanisms within the NHS, but the only way that we will ever get that properly embedded is if we plan services together, across boundaries, and that that is led by clinicians. That is the journey that we are on as an NHS now.”[71]

109. For us, this reiterates the need for strong plans and the need for a significant change in working practices. Good practice must be shared at all levels of the NHS Wales from managers to clinicians to nurses. This should guarantee a significant impact and benefit to the way the NHS Wales works for a minimal cost.

110. The Committee is concerned about the costs of external support given the apparent lack of guidelines around the use of support. We are concerned that there appears to be no formal guidelines for what external expertise should be used for, or any trigger points for when health boards should be required to use it. Furthermore, we would like to see the development of expertise within the NHS Wales and mechanisms for sharing this information. This is vital to ensure that the NHS Wales move forward in the best way and ensure value for money.

The Committee recommends that the Welsh Government produce a clear set of guidelines for the utilising of external expertise for financial planning. This should include information on trigger points as part of the financial management process when Welsh NHS bodies would be required to use external support.

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[70] RoP, Public Accounts Committee, 5 November 2013, paragraph 31
[71] RoP, Public Accounts Committee, 12 November 2013, paragraph 91

The Committee recommends that the Welsh Government works with Health Boards to develop mechanisms for sharing financial/service planning and management good practice across the NHS Wales at all levels. This could involve using the model of the Wales Audit Office Good Practice exchange.

Future Pressures

Reconfiguration and Transformation of Services

111. The NHS Wales is currently undergoing a process of reconfiguration and transformation. The Auditor General's report suggested that transformation offers the opportunity to put the NHS Wales on a sustainable footing for the long-term.

112. In giving evidence, the Director General suggested that transformation needs to go further and faster:

> "One of the most helpful observations in the Wales Audit Office report, in a sense, was that we need to go further, and faster, with some of the changes; that is what I read, and I think that we would concur with that. That is not just in terms of hospital changes, because some of the changes in hospitals are to do with issues of quality and safety—which are, obviously, important, and we need to address those—but we also need to ensure that there is no confusion with those being the financial solutions. Some of the changes that we are currently consulting on, and will be taking forward, subject to the outcomes of consultation, are not major contributors to the financial challenge that we face ahead."[72]

113. The Committee notes that the scope of reconfiguration only covers a relatively small part of what the NHS Wales does, and therefore will only have a limited impact on the budgets. The limited financial information available from health boards does not allow the Committee to conclude whether reconfigured services may be cost effective and deliver more value for money.

114. A key part to ensuring transformation is successful will be learning from elsewhere. The Chief Executive of Cardiff and the Vale University Health Board told the Committee that:

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[72] RoP, Public Accounts Committee, 5 November 2013, paragraph 132

> "… we have invited the King's Fund to visit Cardiff. We wanted it to give us the benefit of its learning from how systems have integrated across the UK, and to give us an accelerated opportunity to draw on that experience and to deploy that learning from elsewhere."[73]

115. The Committee welcomes Cardiff and the Vale University Health Board's clear commitment to learn from the best to change service delivery, but we want greater assurance that other NHS Wales bodies are doing the same, in order to have confidence that the maximum value for money is being achieved in the NHS Wales.

116. The Wales NHS Confederation highlighted that it is difficult to see how the investment in transformation will be funded. They emphasised that NHS Wales bodies need to take on a collective NHS Wales wide view of the finances. However, with all the health boards predicting substantial over-spends in 2013-14, it is hard to see where any surpluses will come from to fund investment or what impact this will have on the health budget. For example, Cardiff and the Vale University Health Board has clearly set out its plan to invest in 2013-14 but not break even - it is not clear what the consequences are of this in terms of the overall health budget and any impacts on other NHS bodies. The Chief Executive of Cwm Taf University Health Board told the Committee that:

> "… we cannot look at any one organisation as an island when it comes to transformational change. I do think that, in the context of austerity, and in the context of our need to drive up clinical standards, we are on the cusp of a really significant system redesign in Wales, which I am quite excited about, because I think that that gives us an opportunity to deliver a better health service. However, we will not do that if we work very much in an insular, 'This is my resource, this is my money, this is my workforce' kind of way, and we will not get the best that we can for the people of Wales."[74]

117. The Committee notes the potential of transformation and reconfiguration to develop better financial, service and workforce planning which is essential for health finances going forward. However, we are concerned that this process has to be about

[73] RoP, Public Accounts Committee, 5 November 2013, paragraph 186
[74] RoP, Public Accounts Committee, 12 November 2013, paragraph 51

delivering the best quality for patients and should not be viewed as a systematic cost-cutting exercise.

Staffing

118. The Auditor General's report makes a number of references to savings being made in workforce modernisation both in 2012-13, and 2013-14. The report raises concerns about the sustainability of this approach and looking to the future this is a significant area of concern for health finances. The Chief Executive of Cardiff and the Vale University Health Board informed the Committee that staff costs were 61% of his 'influenceable costs' He said that:

> "... It would be inconceivable for me to sit here and say that we can deliver all of that and still have exactly the same number of people working in an organisation being paid exactly the same going forward. That would be intellectually dishonest. I cannot and will not argue that. The question is whether we could find a way of delivering the same or better quality of care by organising ourselves more effectively by delivering services more intelligently and by focusing on the evidence and on what that tells us. The answer to that question, I think, is a very large 'yes'."[75]

119. The Chief Executive of Cardiff and the Vale University Health Board further explained that the Health Board had developed their workforce reduction plan by considering how other organisations worked and whether the Health Board could adapt their working practices to be more efficient.

120. During the course of evidence gathering, the Committee were made aware of a number of issues with the terms and conditions of NHS staff in Wales. The Chief Executive of Cardiff and the Vale University Health Board informed the Committee that his Health Board had estimated that the consultant contract was 14% less cost effective than in England. He indicated that this was:

> "…to do with the way in which the sessions are calculated and the expectation about the number of parts of the week that a

[75] RoP, Public Accounts Committee, 5 November 2013, paragraph 202

> consultant might spend in supporting clinical activities rather than delivering direct clinical services."[76]

121. The Chief Executive of Cardiff and the Vale University Health Board acknowledged that the Health Board's analysis of the consultant contract was open to 'a little bit of challenge'. He provided the Committee with a detailed explanation showing that the basis of the 14% figure was that the Welsh contract sets a 37.5 hour working week for consultants compared to 40 hours in England, combined with differences in the split between direct clinical sessions and other supporting professional activity. However, we note that the Auditor General's report on the consultant contract[77] showed that in practice consultants in Wales were working an average of 42 hours a week, delivering 8.3 direct clinical sessions, rather than the 7 sessions referred to in The Chief Executive of Cardiff and the Vale University Health Board' letter. The Committee accepts that there are differences in the contract but is unclear on the extent to which, in practice, there is significant variation between the amount of direct clinical activity carried out in England and Wales.

122. The Chief Executive of Cwm Taf University Health Board explained the rationale for the differences in the contract between England and Wales and indicated that terms and conditions in general were under discussion :

> "… when the new contract came in in England, Wales negotiated an amended consultant contract to try to improve recruitment and retention in Wales. We are now in discussion with all our trade unions about contract terms and conditions. That will be something that will be discussed with the British Medical Association."[78]

123. The Chief Executive of Cardiff and the Vale University Health Board also identified differences in the terms and conditions of other NHS staff, covered by Agenda for Change, compared with England that could impact on cost:

> On the Agenda for Change in Wales, there are some key differences. For example, if you change someone's role, you

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[76] RoP, Public Accounts Committee, 5 November 2013, paragraph 206
[77] Link to AGW report and reference to PAC inquiry and report
[78] RoP, Public Accounts Committee, 12 November 2013, paragraph 75

> follow the right route and the right process, and you redeploy that person into a new situation—let us say that you do not require all of the skills that they previously had, and that you are effectively putting them into a lower graded post—in Wales they can have up to 15 years of pay protection. You can make the change, you can go through all of the difficult tasks associated with that, but actually, from a cost perspective, nothing happens for 15 years. That is not what happens in England. Those arrangements are different

124. Given the challenges facing the NHS Wales finances and the limited resources available, the Committee recognises that a number of difficult decisions about staffing and delivering services will need to be made in the future –as illustrated by the decision made by the Cardiff and the Vale University Health Board to reduce its workforce – and would urge the Government to provide the support necessary for these decisions.

The Committee recommends the Welsh Government examine whether the differences in terms and conditions between Wales and England have led to differences in cost-effectiveness and whether these are offset by benefits to recruitment and retention. The findings should inform discussions about the terms and conditions to ensure Wales is able to attract the right calibre of staff while achieving optimum value for money.

In light of the move to disinvest in services, the Committee recommends that the Welsh Government provides the costs relating to pay protection in the NHS Wales. This will enable the cost and value of this policy to be determined.

Prioritisation and disinvestment

125. A key recommendation in the Auditor General's report is to look at prioritisation and consequent de-prioritisation of some areas. It is recommended that the Department and NHS Wales bodies should work together to develop a robust framework for reviewing priorities and managing risks in those areas of service delivery that assume a lower priority.

126. The Wales NHS Confederation told the Committee that something would have to give and that there is a need to disinvest in services but they were not clear as to what. The Chief Executive of Cwm Taf

University Health Board went onto refer to differential waiting times for elective care based on clinical priority:

> "It is a real challenge, because if you are waiting for surgery, that wait for you, personally, is a major issue, but we know that for some people waiting 26 weeks, there could be a deterioration in their clinical condition in that time, so they should not wait 26 weeks. For other types of procedures, waiting 52 weeks would not necessarily mean an absolute deterioration in people's health. So, I think that the real issue is how we put some intelligent clinical prioritisation alongside targets so that what we are doing is the best for clinical outcomes for patients as opposed to an arbitrary timescale that we are working to."[79]

127. A number of witnesses raised concerns about the targets the health boards were required to work to, as although they recognised the importance of targets there was a need to consider what they are trying to achieve. The Director of the Welsh NHS Confederation told the Committee that:

> "Targets are important; they can play an important part and they are a useful benchmark. We have to make sure that targets are the right ones, and there are discussions about whether some of the targets that we have are the right ones, and that we are measuring process rather than outcomes for individuals and patients."[80]

128. The Committee are concerned about the process of disinvesting in services and would urge the Welsh Government to provide the necessary support for this process. Furthermore, we believe the process needs to include consideration of the targets. This will help to ensure that the focus is on outcomes for patients, which should achieve optimum value for money.

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[79] RoP, Public Accounts Committee, 12 November 2013, paragraph 108
[80] RoP, Public Accounts Committee, 12 November 2013, paragraph 102

Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed in full at www.senedd.assemblywales.org/mgIssueHistoryHome.aspx?IId=1311.

Tuesday 24 September 2013

Huw Vaughan Thomas	Auditor General for Wales
Mark Jeffs	Performance Specialist, Wales Audit Office
Geraint Norman	Financial Audit Manager, Wales Audit Office

Tuesday 5 November 2013

David Sissling	Chief Executive, NHS Wales
Kevin Flynn	Deputy Chief Executive NHS Wales
Martin Sollis	Director of Finance, Welsh Government
Adam Cairns	Chief Executive, Cardiff and Vale University Health Board

Tuesday 12 November 2013

Helen Birtwhistle	Director, Welsh NHS Confederation
Allison Williams	Chief Executive, Cwm Taf University Health Board

List of written evidence

The following people and organisations provided written evidence to the Committee. All written evidence can be viewed in full at www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=4181&Opt=3

Organisation	*Reference*
David Sissling, Chief Executive, NHS Wales	PAC(4)-28-13 paper 1
Adam Cairns, Chief Executive, Cardiff and Vale University Health Board	PAC(4)-28-13 paper 2
Helen Birtwhistle, Director, Welsh NHS Confederation	PAC(4)-29-13 paper 1
Adam Cairns, Chief Executive of Cardiff and Vale University Health Board	PAC(4)-32-13 (ptn1)
David Sissling, Chief Executive, NHS Wales	PAC(4)-33-13 (ptn1)
Huw Vaughan Thomas, Auditor General for Wales	PAC(4)-03-14(ptn1)
Huw Vaughan Thomas, Auditor General for Wales	PAC(4)-04-14 (ptn1)
Huw Vaughan Thomas, Auditor General for Wales	PAC(4)-05-14(ptn1)
David Sissling, Chief Executive, NHS Wales	PAC(4)-06-14 paper 4