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Public Accounts Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
17 July 2012

Meeting time:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1. Introductions, apologies and substitutions (9:00 - 9:05)

2. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:
Items 3, 4, 5 and 7.

3. Consideration of the Public Audit (Wales) Bill (9:05 - 9:30) (Pages 1 - 11)

4. Consideration of draft report 'Grants Management in Wales' (9:30 - 9:35) (Pages 12 - 60)

5. Consideration of draft report 'Progress in delivering the Welsh Housing Quality Standard' (9:35 - 10:00) (Pages 61 - 120)

6. Briefing from the Auditor General for Wales on the Wales Audit Office report 'Health Finances' (10:00 - 10:30) (Pages 121 - 165)
PAC(4) 16-12 - Paper 1 - Wales Audit Office report 'Health Finances'

7. Options for handling the Wales Audit Office report 'Health Finances' (10:30 - 10:45)

8. Papers to note (Pages 166 - 230)
PAC(4) 16-12 - Paper 2 - Correspondence from HM Treasury regarding Progress in delivering the Welsh Housing Quality Standard

PAC(4) 16-12 – Paper 3 – Correspondence from the Welsh Government regarding Progress in delivering the Welsh Housing Quality Standard

PAC(4) 16-12 – Paper 4 – National Audit Office report – Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland

Minutes of the previous meeting

By virtue of paragraph(s) vi of Standing Order 17.42

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12 July 2012

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WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Health Finances

Health Finances

I have prepared this report for presentation to the National Assembly under section 145A of the Government of Wales Act 1998.

The Wales Audit Office study team comprised Clare Stevens, Mark Jeffs and Matthew Coe under the direction of Gillian Body.

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Report presented by the Auditor General for Wales to the National Assembly for Wales on 12 July 2012

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Contents

Summary

1 Our report, *A Picture of Public Services 2011*, identified the significant financial and operational challenges facing the NHS in Wales. That report showed that the NHS in Wales faces a tougher financial settlement than the other three countries in the UK (further detail on the comparison to the rest of the UK can be found in *A Picture of Public Services 2011*). And it faces a significant and growing gap between the funding it needs to meet known cost pressures, and the actual funding it receives.

2 This report provides a more detailed assessment of the financial position across NHS bodies, and the financial challenges that the NHS faces. It analyses:

- historical financial data showing how the NHS has managed within its budget in the recent past;
- financial and other data showing how the Welsh Government and NHS bodies managed the financial pressures on the NHS in 2011-12; and
- the scale of the funding gap the NHS faces over the coming period, and the short-term and long-term challenges in light of the progress the NHS has made so far.

3 During the period covered in this report, the NHS in Wales has gone through significant structural change. On 1 October 2009, the system involving 22 local health boards commissioning services from nine NHS trusts came to an end. In its place, seven health boards are now responsible for planning and delivering healthcare services in seven regions. Two of the NHS trusts remain and are responsible for providing specialist services: the Welsh Ambulance Services NHS Trust and Velindre NHS Trust which provides specialist cancer services. There is also a new Public Health Wales NHS Trust. The changes in 2009 have seen the move away from a provider/commissioner system to a system based on integrated planning and delivery. In doing so, the Welsh Government intended that one of the benefits of this change would be to help to rectify some of the historic problems of financial planning and management in the NHS that we highlight in this report.

4 This report covers the period from 2006-07. During that period, the NHS bodies have worked within two sets of accounting rules, depending on whether they are a trust or a health board. One of the key financial requirements for health boards is the statutory financial requirement to break-even each and every year. Where they do not achieve break-even, their excess spend is deemed to be ‘irregular’ and the audit certificate on their financial statements would reflect this by receiving a ‘qualified’ regularity audit opinion. A qualified opinion could in turn impact on the audit opinion on the Welsh Government’s financial statements. For NHS trusts, the statutory requirement is to break-even, taking one year with another. However, the Welsh Government also requires them to break-even each year within a certain threshold of flexibility, and unlike health boards, any overspend within these thresholds is not deemed to be ‘irregular’ spend.

5 It is important to note that this report is primarily based on an analysis of the NHS financial position. The report is not intended as a detailed review of financial management across the NHS, nor is it intended to provide an evaluation of the impact of the structural changes in the NHS in recent years.

6 The key message from this analysis is that with the NHS and other public services facing unprecedented financial challenges, the historical patterns of the Welsh Government providing NHS bodies with additional money during the year to manage deficits is not sustainable. In recent years, the Welsh Government has worked with NHS bodies to improve cost control and make savings but more radical changes to health services are needed to ensure the NHS in Wales is financially sustainable.

In the past, despite rising budgets, improved financial monitoring and a greater focus on cost savings, NHS bodies have required additional year-end funding to break-even

7 The detailed flow of finances through the NHS in Wales is complex, but there is a simple overall framework. To start, the Welsh Government determines what proportion of its budget it will spend on health. The health budget is currently managed by the Welsh Government's Department of Health, Social Services and Children (the Department). The Department allocates the vast majority of the health budget to the individual NHS bodies to provide health services to the people of Wales. The NHS bodies are themselves responsible for managing the funding allocated to them and ensuring it is properly allocated to deliver health services.

8 Between 2006-07 and 2010-11, the Welsh Government's budget for health services in Wales rose every year as did the funding allocated to NHS bodies. Although the budgets rose each year, the NHS bodies have needed additional funding in order to break-even. Between 2006-07 and 2008-09, the Welsh Government provided additional funding to support service improvements in local NHS bodies by using underspends and contingency funding within its own central programme budget. However, in 2009-10 and 2010-11, the Department needed additional funding from central reserves (funding held within the Welsh Government's general reserve as yet unallocated to any specific department) in order that the overall health budget and local NHS bodies could break-even.

9 One of the major challenges in a service that is demand-led with increasing pressures is to establish a culture of cost control. At the start of each year, the Department sets out a clear requirement for NHS bodies to plan and manage within available resources whilst meeting agreed targets. Yet by the end of each year, the Welsh Government has provided additional funding to support service improvements and cover local deficits. The Welsh Government is under pressure to cover those deficits in part because accounting rules mean that its own accounts could be qualified as a result of overspends at one or more NHS body (see Paragraph 4).

10 The provision of additional funding makes it more difficult for local finance managers to emphasise the need for cost control to clinicians and operational staff, who may assume that funding for budget overspends will be found elsewhere. The Welsh Government intended that the reorganisation in 2009-10 would help address some of the underlying problems of financial management. By removing the commissioner/provider

split, the Welsh Government anticipated that there would be clearer accountability for managing finances. The Welsh Government has strengthened its monitoring of individual NHS bodies' finances during the year, by introducing more detailed financial monitoring forms which provided consistent and timely information on the forecast and to-date position every month.

11 The Welsh Government and NHS bodies have also strengthened their focus on cost control. In 2010-11, the Welsh Government set local bodies very tough financial targets, while retaining some contingency in its central budgets. This approach successfully focused attention on reducing costs, with NHS bodies reporting £310 million savings that year. However, the tough message that no further funding would be forthcoming was undermined when the Welsh Government provided additional funding from its own contingency and from Welsh Government reserves. There is a risk that the approach used in 2010-11 exacerbated perceptions held by NHS managers and clinicians that the Welsh Government has a hidden contingency fund which it will use to address deficits.

In 2011-12, NHS bodies again reported significant savings, and the Welsh Government has sought to put health finances on a more sustainable footing that helps break the cycle of additional year-end funding

12 In 2011-12, the NHS in Wales faced its toughest year since devolution. Predicting the precise scale of the funding gap that the NHS faced is difficult as establishing the exact level of cost pressures on the NHS is complex and there are several different official assessments. Using those, and 2010-11 as a baseline, we estimated that there was a funding gap in the order of £280 million to £380 million at the start of the financial year.

13 By the end of the financial year, the overall health budget and all of the individual NHS bodies had broken even. In larger part, this break-even was achieved due to significant savings by NHS bodies. However, the Department also had to access additional funding from Welsh Government reserves in order to break-even.

14 NHS bodies reported making £285 million savings in 2011-12. The largest areas of reported savings were staffing, including management costs, procurement and continuing healthcare. NHS bodies reported that around 87 per cent of the savings were recurrent, which means they will be sustained in future years. While it is positive that the vast majority of savings are recurrent, the level of non-recurrent one-off savings increased towards the end of the year as some NHS bodies struggled to deliver sufficient savings. In particular, there was an increase in

one-off procurement and staff savings, which suggest some NHS bodies delayed necessary purchases and staff recruitment until the new financial year. Also, it is likely that some of the savings were reinvested, so may have been used to improve quality rather than to save cash.

15 The savings reported by the NHS were not enough to bridge the funding gaps. In July 2011, the Welsh Government agreed to provide an additional £93 million from central reserves of which £63 million would be recurrent (ie, it will be added to budgets for future years) to NHS bodies. A further £40 million was added from the Department's own budget, providing a total of £133 million. An additional £12 million was also provided by the Welsh Government to one health board as 'brokerage' – ie, an advance on future funding, which would be reduced accordingly. In agreeing the funding, the Welsh Government emphasised that it intended to put NHS finances on a more sustainable footing and break the cycle of additional funding at the end of the year. The Welsh Government made clear that it expected NHS bodies to deliver within the revised budgets. But by the end of the financial year, three health boards required further funding of £12.4 million. The Welsh Government agreed to cover the deficits through 'brokerage', rather than simply provide additional resources, so (as set out above) future funding would be reduced accordingly.

16 In 2011-12, the Welsh Government continued to use its strengthened monitoring to take more timely action to address emerging issues. It intervened earlier in the year to provide the additional funding, thereby giving greater certainty to NHS bodies as to the extent of the total funding to be made available. By providing brokerage at the end of the year, rather than simply giving more money, the Welsh Government has come closer than in the past to backing up its message that no further funding will be available. Also, judicious use of brokerage potentially helps to address the short-term focus imposed by the requirement to break-even each year by allowing NHS bodies to break-even over a longer period, and potentially to take action to invest to save.

There are positive signs for long-term reform to address unprecedented future financial challenges but short-term funding gaps remain a concern

17 The NHS faces unprecedented financial challenges between now and 2014-15. Depending on which forecasts are used, NHS bodies need to manage cost and demand pressures in the order of £870 million to £1 billion between 2010-11 and 2014-15.

18 The NHS faces a particular challenge in 2012-13 and NHS bodies are developing three-year service and financial plans to ensure that the identified financial challenge can be met. It will be important that these plans are robust and deliverable. Going forwards, the NHS needs to sustain the savings it has already made, and increase the level of cash-releasing savings by around £250 million more each year. It is likely that many of the opportunities for making 'quick-wins' in terms of efficiency savings have already been taken up. As a result, future plans will need to focus increasingly on the more difficult areas for recurring savings: reducing costs by reforming and reshaping services.

19 The NHS is well aware of the challenges it faces. While there are positive signs in terms of long-term reform, ambitions set out in the NHS Five Year Framework will be increasingly challenging for the short term. The NHS Five Year Framework (covering 2010-11 to 2014-15) sets out the ambition to 'close the funding gap while simultaneously improving quality and maintaining service levels and jobs'. The ambition in relation to maintaining job levels is particularly challenging with a significant proportion of NHS spending accounted for by pay. In its recent five-year plan for the NHS workforce, the Welsh Government does not repeat the ambition of sustaining job levels. It sets a specific goal of reducing costs and ensuring workforce costs overall are affordable. Effective workforce planning, linked to changes in the way services are provided, becomes increasingly important, to manage the potential impact of changes to staffing levels on service levels and provision. The challenge for the NHS is that the reshaping of services is likely to take time to deliver, and the imperative for savings is more immediate, driven partly by annual financial targets.

20 The focus on meeting annual financial targets could encourage short-term thinking and actions, such as cutting or deferring expenditure at the end of the year to balance the books. In 2011-12, the NHS bodies needed to deliver around 40 per cent of their planned savings in just three months. There would be merit in exploring options, within current accounting rules, to develop a more flexible approach to encourage a focus on savings, reform and break-even over a longer period than one year. The Welsh Government has recognised the need to support service change and measure improvement over a longer period than one year. It has committed to a review of the financial regime, which it intends will be wide-ranging and lead to improvements across the financial system in the NHS.

21 There are clear signs of progress with longer-term reform of NHS services, so that they deliver high-quality services within the available resources. The Welsh Government has set a clear expectation that radical reform is needed. *Together for Health: A Five Year Vision for the NHS in Wales* reaffirms some of the key elements of reform that have previously been set out in Welsh Government visions for the NHS. The key difference between the current drive for reform and previous efforts is the growing recognition that the status quo is simply unaffordable.

22 The challenge is that there is a catch-22: the status quo is unaffordable but the process of delivering the reform itself carries a cost that may be difficult to fund. There is a 36 per cent cut in real terms in capital funding for the NHS across the current spending period. Capital is likely to be required to fund any infrastructure required to deliver the new, reformed ways of working. Other parts of the public service, like local government, can partly accommodate capital cuts by borrowing, but this is not an option for NHS bodies. In recent times, there has been a moratorium on Private Finance Initiatives in the NHS in Wales. There is, therefore, a major challenge for the NHS and Welsh Government to identify the costs of reform and the options to fund it.

Recommendations

R1	Despite reporting significant savings, NHS bodies required additional funding in recent years. In particular, there are challenges in achieving cash-releasing workforce savings. In order to help address the short-term funding gaps, **the Welsh Government should**: • **further support NHS bodies in sharing good practice on making cost reductions, particularly efficiency savings that do not impact on quality or service levels; and** • **provide challenge to NHS bodies as they develop their three-year plans to ensure they accelerate the cash-releasing savings from workforce planning while managing the risks to service levels and quality.**
R2	The longer-term sustainability of health services depends on radical reform of the way services are delivered and organised. The NHS faces a major challenge in funding that reform especially as there are large cuts to capital funding. **The Welsh Government should work with NHS bodies to identify the capital costs of reforming services, ensure these are properly prioritised within available resources and explore alternative options for funding or providing the necessary infrastructure that supports the reform of NHS services.**
R3	In recent years, the proportion of NHS bodies' funding that has been allocated during the financial year, instead of at the outset, has risen substantially. Whilst there are valid reasons for this, **the Welsh Government should ensure that NHS bodies are provided with as much detail as possible on funding before the start of a financial year to facilitate effective financial planning.**
R4	The Welsh Government has improved the monitoring information it gathers on NHS bodies' financial positions throughout the year. This improved information has helped the Welsh Government to take more timely decisions on funding pressures in the year. There are, however, some areas where the monitoring system could be strengthened further to provide a more accurate picture of the likely end-of-year position. **The Welsh Government should work with NHS bodies to:** • **ensure that the information on expected end-of-year out-turn is consistent across NHS bodies, in particular that they strike a similar balance between optimism regarding break-even and a realistic assessment of the challenge; and** • **ensure that, where possible, NHS bodies profile expected savings from central budgets and accountancy gains across the year in their monitoring returns to give a more realistic picture in-year.**
R5	There are several different official assessments of the cost pressures that the NHS faces between now and 2014-15, with differences between them. **To support better financial planning, and clarify the scale of the challenge the NHS faces and the savings that are required, the Welsh Government should:** • **update the assessment of the cost pressures on the NHS, which are currently set out in the Five Year Framework; and** • **consider this updated assessment against other measures of cost pressures from elsewhere in the UK public sector.**
R6	The resource accounting regime of the NHS has a short-term focus on breaking even within each financial year. This potentially makes it difficult for NHS bodies to create funds to invest in transformation and change in order to deliver savings in future years. **Within the current framework of resource accounting, the Welsh Government should assess the current requirement for health boards to break-even each and every year, and develop options that would enable NHS bodies to invest in new ways of working where these are likely to deliver savings in the future and enable them to break-even over a longer period.**

Part 1 – In the past, despite rising budgets, improved financial monitoring and a greater focus on cost savings, NHS bodies have required additional year-end funding to break-even

1.1 This part of the report examines in detail the funding for health in recent years, up to 2010-11. It sets out the pattern of health funding and spending. It assesses the factors that contribute to the cost and demand pressures that the NHS has faced. It also sets out developments in the Welsh Government's oversight and monitoring of the financial performance of NHS bodies.

1.2 During the period covered in this part of the report, the NHS in Wales has gone through significant structural change. On 1 October 2009, the system involving 22 local health boards commissioning services from nine NHS trusts came to an end. In its place, seven health boards are now responsible for planning and delivering healthcare services in seven regions. Two of the NHS trusts remain and are responsible for providing specialist services: the Welsh Ambulance Services NHS Trust and Velindre NHS Trust which provides specialist cancer services. There is also a new Public Health Wales NHS Trust. The Welsh Government intended that one of the benefits of these changes would be to help to rectify some of the historic problems of financial planning and management in the NHS.

1.3 This report covers the period from 2006-07. During that period, the NHS bodies have worked within two sets of accounting rules, depending on whether they are a trust or a health board. One of the key financial requirements for health boards is the statutory requirement to break-even each and every year. For NHS trusts, the requirement is to break-even, taking one year with another (see Paragraph 4).

Health budgets have risen each year between 2006-07 and 2010-11

Over the past five years, the health budget has increased above inflation every year although recent rises have been steeper in some other parts of the UK

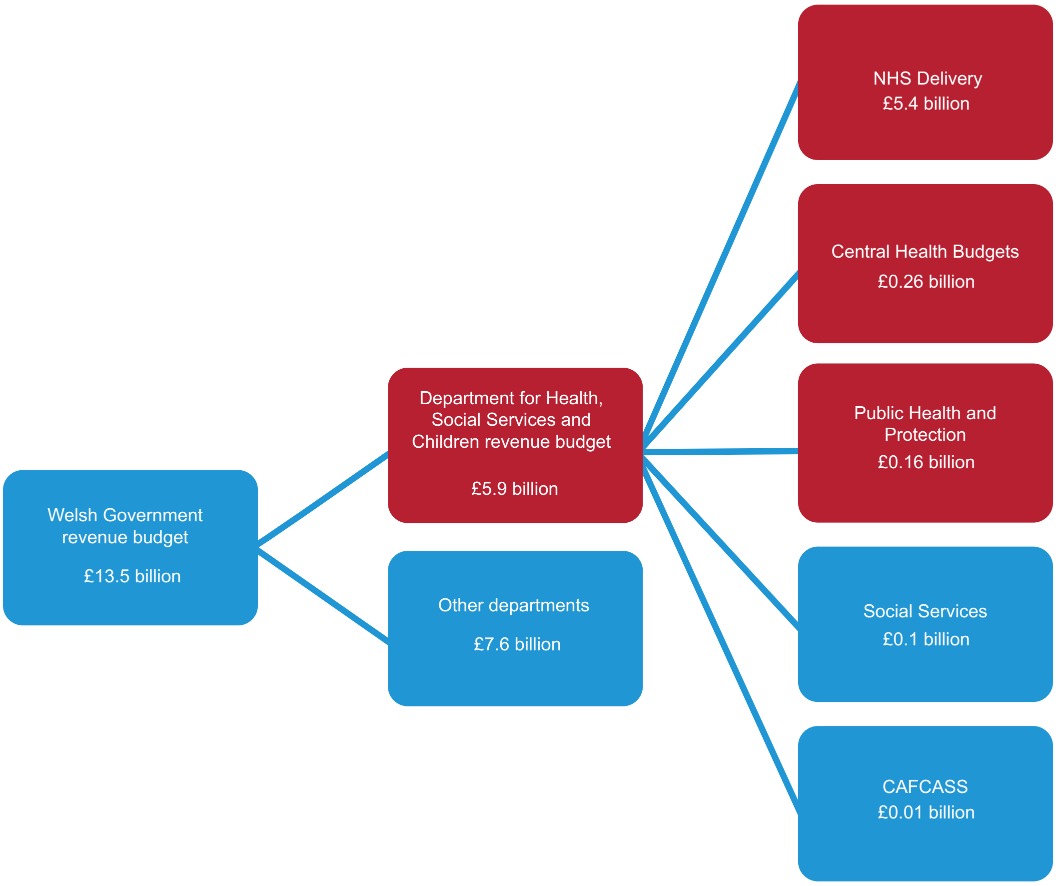
1.4 It is important to clearly set out which set of figures we are using for our analysis in this report. Each year, the Welsh Government sets a budget. The budget is split into what are known as 'Main Expenditure Groups' (MEGs). The MEGs reflect the structure of the Welsh Government, with each MEG representing a department. Health is part of a wider Department for Health, Social Services and Children (the Department). Therefore in focusing on health finances, we have excluded the non-health elements of the budget. Figure 1 sets out the structure of the Welsh Government's budget for health in the 2011-12 Final Budget[1]. All of the elements coloured in red in Figure 1 make up the 'health revenue budget'. This term covers all of the budgeted revenue allocated to spending on health. However, it should be noted that whilst the majority of this budget is provided to NHS bodies, there is an element that goes to non-NHS bodies, such as the Food Standards Agency, and for academic research and development. For Part 1 of this report, which examines historic funding, we focus on the overall health revenue budget. The three sub-categories of NHS Delivery; Public Health and Prevention; and Central Health Budgets were introduced in June 2010, which means

1 Although it is called the 'Final Budget' it is not usually the final version of the budget. The 'Final Budget' is the budget that is agreed by the National Assembly before the start of the financial year. During the year, the budget is updated through 'supplementary budgets'.

we cannot compare the lower-level categories over time. In Parts 2 and 3, we use the NHS Delivery line to examine cost pressures facing frontline health services.

1.5 Figure 1 shows how the Welsh Government apportions the health revenue budget between the various categories. However, the Welsh Government's budget does not set out exactly how much of the funding it intends to pass on to the various NHS bodies that deliver health services. Each year, the Welsh Government writes to the NHS bodies, setting out their 'allocations' for the year. Figure 2 shows the health revenue budget between 2006-07 and 2010-11. It shows that the vast bulk of the funding allocated to the health budget is allocated to the various NHS bodies. The amount allocated to each individual NHS body is primarily based on historic funding patterns. The remainder of the budget is allocated to a range of programmes, including public health programmes managed by the Welsh Government, and non-NHS bodies as touched on in Paragraph 1.4.

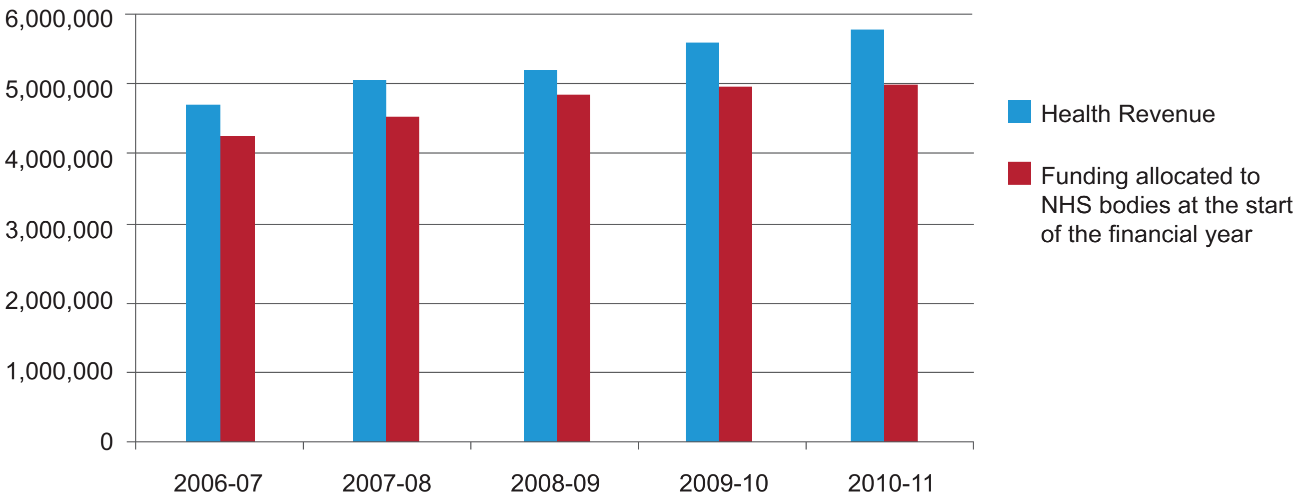
Figure 1 - Breakdown of Welsh Government 2011-12 Final Revenue Budget, focussing on health



Source: Wales Audit Office analysis of Welsh Government budgets

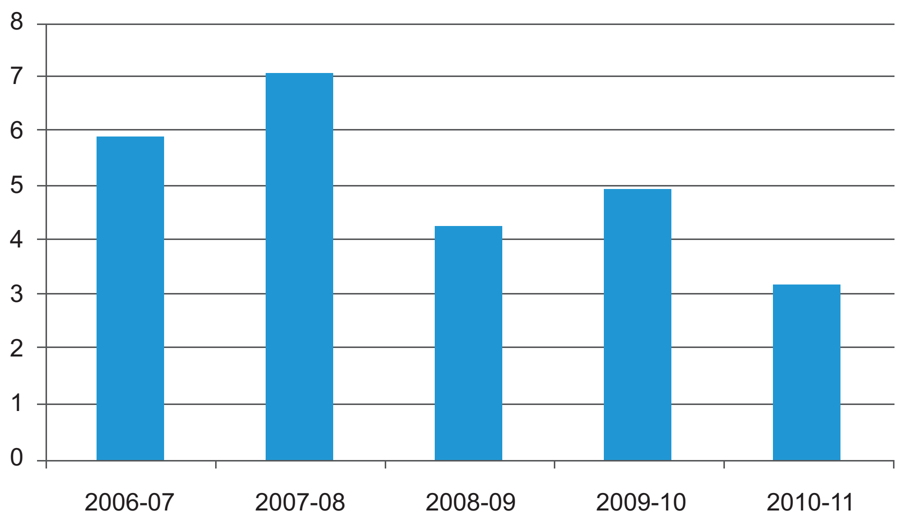
1.6 The health revenue budget has increased every year since devolution. Figure 3 shows that, over the past five years, the rate of increase has varied from around three per cent to as much as seven per cent, in cash terms. The rate of increase was higher in 2006-07 and 2007-08 than in later years. The health budget has seen significant increases, even after taking account of economy-wide inflation[2]. It is common practice to use the GDP deflators to calculate and report real terms budget changes, which is why we have used the deflators as the basis for Figure 4. However, it is widely accepted that cost and demand pressures in healthcare exceed inflation across the wider economy. Figure 4 shows that the health revenue budget increased ahead of economy-wide inflation in every year over the past five years.

Figure 2 - Health Revenue Budget 2006-07 to 2010-11 and funding allocated to NHS bodies at the start of the financial year



Source: Welsh Government final budgets and NHS bodies' allocation letters

Figure 3 - Cash terms increases in the health revenue budget (%)

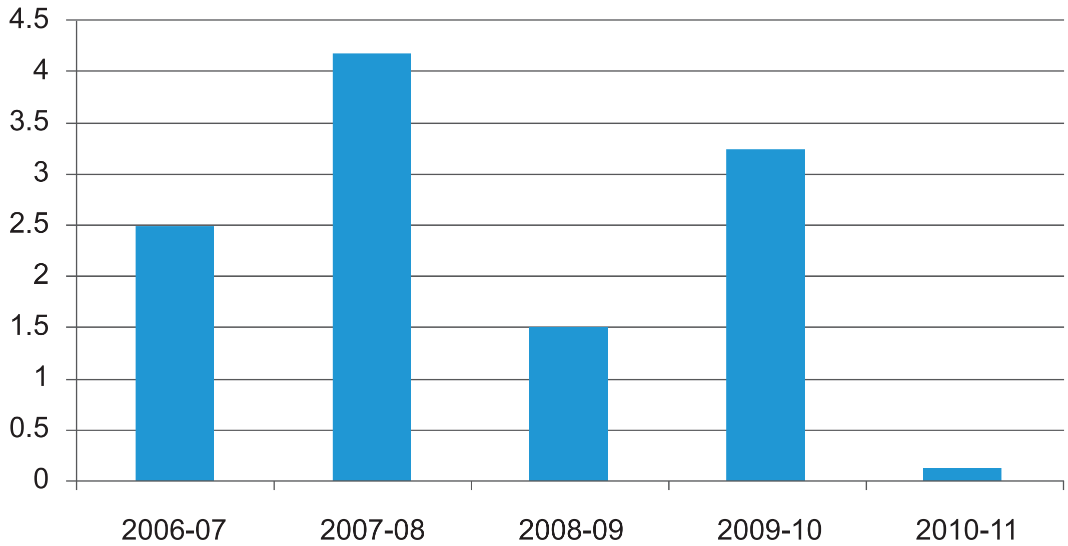


Source: Welsh Government final budgets

2 For this report, we have used the Treasury GDP deflator series issued in December 2011.

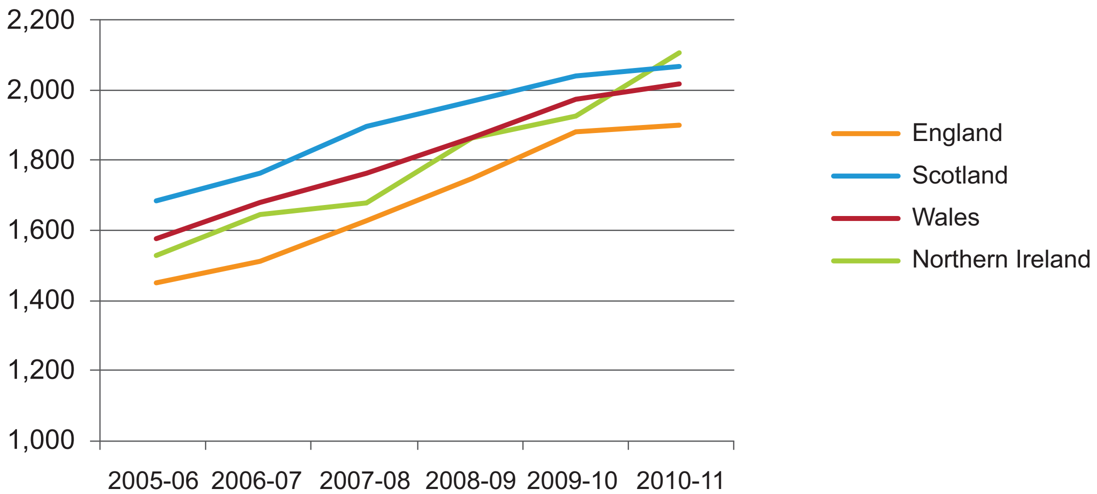
1.7 The pattern of spending rising year on year is mirrored across the UK. Figure 5 shows health spending per head of population in the different parts of the UK. It shows that Wales spent the second highest per head of population, behind Scotland until 2008-09, when it was overtaken by Northern Ireland. Wales remained ahead of England in 2010-11. However, health spending in England increased at a faster rate than in Wales between 2007-08 and 2009-10, although spending in Wales increased ahead of England in 2010-11. It is worth noting that Welsh spend per head is more comparable to English regions with similar demographics, such as North East England. The higher health spend per head in these more deprived areas are offset by much lower spends per head in areas such as South East England, lowering the overall spend per head for England shown in Figure 5.

Figure 4 - Real terms increase in health revenue budget (%)



Source: Wales Audit Office analysis of Welsh Government budgets

Figure 5 - Spending on health per head of population



Source: HM Treasury Public Expenditure Summary Analysis 2011

In recent years, the Welsh Government has had to draw from Welsh Government central reserves to enable NHS bodies to break-even

1.8 As noted above, there are two main elements to the health budget. There is the overall health revenue budget, which is voted for by the National Assembly, and within this, there is the NHS allocation: the funding allocated to individual NHS bodies. NHS bodies are given an initial funding allocation some months before the start of the financial year, but during the financial year additional funding may be provided to them as follows:

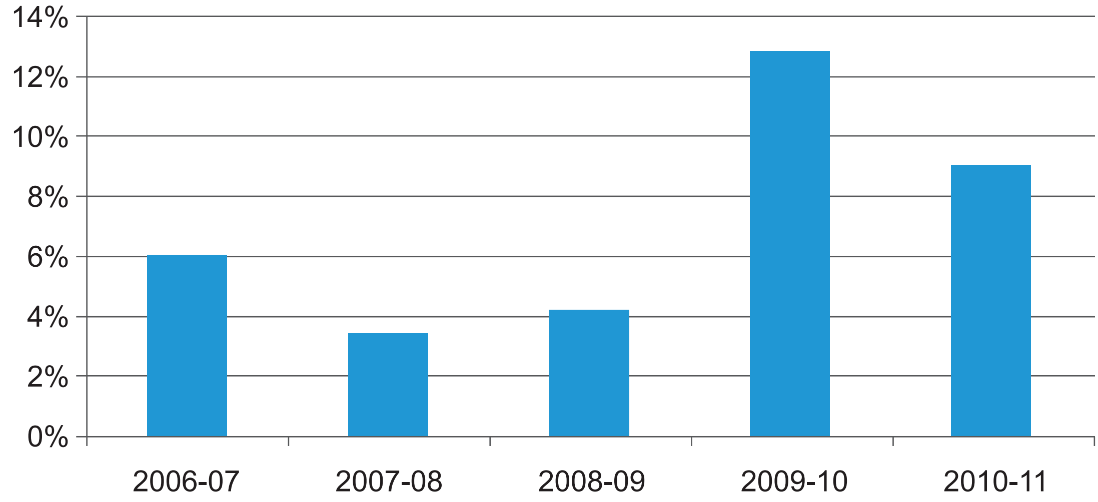
- additional allocation of planned and targeted in-year funding from within the overall health revenue budget, which is moved from central programmes to NHS bodies when finalised;
- funding from within the health revenue budget not initially planned to be distributed to NHS bodies, usually to meet additional pressures; and
- funding from Welsh Government central reserves in addition to the health revenue budget set out in the final budget, again usually to meet additional pressures.

1.9 Figure 6 shows the level of increase from NHS bodies' initial funding allocation to their final funding allocation at the end of the year.

1.10 There are a number of valid reasons for allocating some of this funding to NHS bodies during the year:

- some of the funding is demand-led, for which the Welsh Government assumes the risk and takes responsibility for meeting the costs;
- some of the funding is dependent on negotiations during the year, such as primary care funding where the final costs are known at the end of negotiations between GPs and the UK Government; and
- some funding is allocated to meet specific Welsh Government objectives following submission of plans by NHS bodies.

Figure 6 - Increase from initial allocation to NHS bodies to final allocation (%)



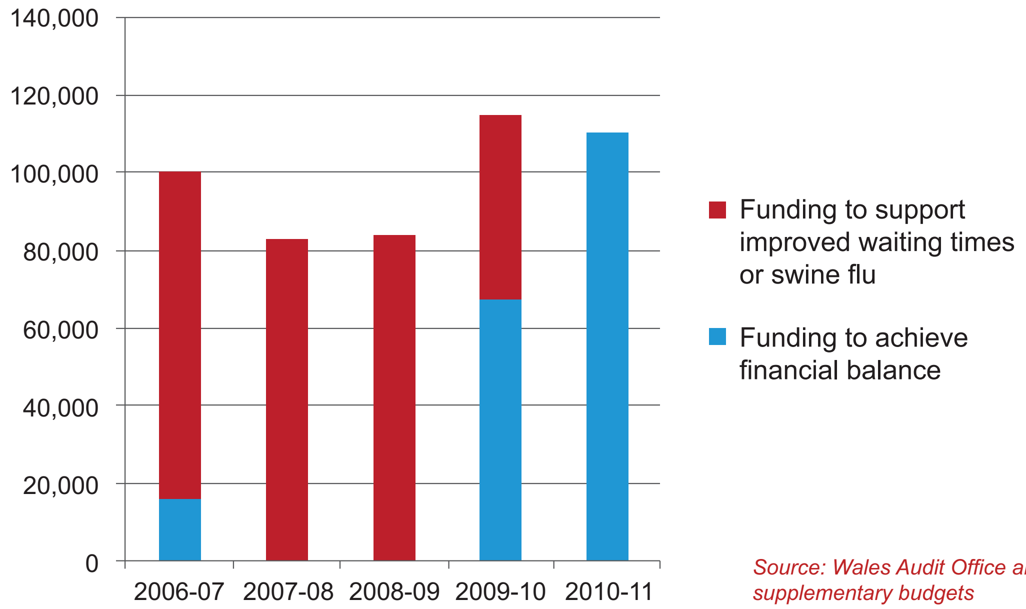
Source: Wales Audit Office analysis of NHS allocations data

1.11 The chart shows a significant increase in the proportion of funding provided within the year in 2009-10 and 2010-11 as compared with earlier years. In 2009-10, the change in organisational structure of the NHS meant that the allocation of significant funding to NHS trusts would now be made via the health boards rather than directly from the Welsh Government. For example, in 2009-10, 4.6 per cent of the overall 13 per cent increase related to non-recurrent depreciation and impairment charges that would have been funded directly to NHS trusts in previous years. Whilst the allocation of funding to NHS bodies during the year is a practical response to the changing NHS environment, it remains essential that NHS bodies are provided with as much detail as possible before the start of a financial year to enable effective financial planning.

1.12 An element of the increases shown in Figure 6, and in addition to the routine funding increases referred to above, is additional funding provided by the Department to NHS bodies from within its own health revenue budget to enable them to break-even.

The final element of the additional in-year funding, shown in Figure 6, is that provided by the Welsh Government to NHS bodies from central reserves. These amounts are shown in Figure 7 and their nature has changed significantly across the years. Much of the additional funding in 2006-07, all of it for 2007-08 and 2008-09, and £21 million in 2009-10 was funding to support improvements in waiting times. Also, £20 million of the additional funding from reserves in 2009-10 was to cover the costs of swine flu and NHS reorganisation. However, in 2009-10 and 2010-11, the Welsh Government needed to provide additional funding from reserves primarily to enable NHS bodies to break-even. In 2010-11, the additional funding to the NHS from reserves accounted for 42 per cent of the Welsh Government's reserves.

Figure 7 - Additional funding provided to NHS bodies from central reserves



Source: Wales Audit Office analysis of Welsh Government supplementary budgets

Overspends are likely to be partly explained by activity to improve access to, and quality of, health services as well as demand and inflationary pressures

1.13 The NHS faces a range of cost pressures that mean that it needs more money each year just to stand still. Pay is a major driver of cost; the overall pay bill at local NHS bodies has risen by 25 per cent or £576 million between 2005-06 and 2010-11. Pay increases account for 17.5 of the 25 percentage point increases, with pay increasing by an average of 3.5 per cent each year over that period. It is important to note that the increase in pay comprises both the headline 'pay rise' as well as what is known as 'pay drift'. Examples of pay drift include staff moving up 'spine points' within their grade, and rises for national insurance, which increases the overall pay bill. The remainder of the increase in pay is due to the number of Whole Time Equivalents (WTEs) increasing from 68,686 to 73,074 over the period – a 6.5 per cent increase (4,388 WTEs).

1.14 Medicines are another key driver of cost. The total NHS body spend on drugs, appliances and clinical supplies in 2005-06 was £855 million. The total cost in 2010-11 had increased to over £1 billion, an 18 per cent increase, averaging a 3.5 per cent increase each year.

1.15 Demand is a driver of costs over the long term. Our report, *A Picture of Public Services*, identified the demographic factors, particularly age-related spending, that push up demand on the NHS over time. The Kings Fund and Institute of Fiscal Studies[3] have estimated that rising demand accounts for around 1.1 per cent real terms increase in cost each year. There are also lifestyle factors, such as alcohol and obesity, which place increasing demands on health services.

1.16 The push for improvement in access and quality of care also contributes to the cost increases within the NHS. Plans, including targets, to lower waiting times, reduce healthcare-acquired infections and improve quality of care sometimes require additional activity and cost. Over the past decade, there have been longstanding commitments to increase funding to the NHS in order to support and enable these improvements. The Kings Fund produced an analysis of what it called the 'productivity gap' in the NHS in England[4]. It concluded that more than half of the 'productivity gap' facing the NHS in England is due to planned improvements in access and service quality. While these costs are not directly reported in budgets and accounts, they are reflected in rising levels of staff – and staff costs – to deliver the activity to meet the access and quality improvements.

1.17 There are some differences as to the precise methods to measure cost pressures faced by the NHS. In late 2009, the National Finance Agreement which drew on data and work provided by the NHS bodies to the Welsh Government, forecast cost pressures in 2010-11 of some 7.2 per cent. However, in June 2010, the Welsh Government published its Five Year Framework, which set out both the inflationary pressures and demographic and demand growth assumptions that it assessed the health service in Wales faced from 2010-11 to 2014-15. The Five Year Framework assessed the inflationary and activity pressures for 2010-11 as being from 3.7 per cent to 4.4 per cent. Whilst these two methods use different approaches for financial planning purposes, it would be beneficial for a common method and set of assumptions to be developed and used.

3 Kings Fund and Institute for Fiscal Studies, *How cold will it be? Prospects for NHS funding 2011-17*, 2009

4 Kings Fund, *Improving NHS productivity: More of the same not more with the same*, 2010

Following reorganisation, the Welsh Government strengthened financial monitoring of NHS bodies and increased the focus on cost control but sent mixed signals regarding the availability of additional funding

Following the 2009-10 restructuring, the Welsh Government strengthened its monitoring of NHS bodies' financial performance and set tough financial targets for 2010-11 which ensured a greater focus on cost control although additional funding was still required

1.18 Following the 2009-10 restructuring, the Welsh Government has monitored the financial performance of NHS bodies more closely. One of the intended benefits of the reorganisation, which has resulted in fewer bodies and less scope for confusion over who is accountable for funding, was to help to facilitate improved financial management. In 2010, the Welsh Government introduced more detail to the monthly monitoring procedure, which requires NHS bodies to submit detailed returns to the Welsh Government within two weeks of each month-end. These monitoring forms require the NHS bodies to provide timely and consistent information on their financial position. They also require NHS bodies to report on overspends as they occur and to forecast the likely end-of-year position in light of progress to date. The Welsh Government also introduced regular meetings between the Department's Director of Finance and the directors of finance in NHS bodies to discuss progress against financial targets.

1.19 Alongside the strengthening of monitoring arrangements, the Welsh Government set NHS bodies very tough financial targets at the start of the year. While the health revenue budget increased by around three per cent, the funding allocated to NHS bodies increased by just 0.7 per cent. The Welsh Government made clear that it expected NHS bodies to manage within this small, below-inflation uplift. This approach reflects the Welsh Government's intention to press NHS bodies to deliver significant cost reductions while also retaining flexibility to provide additional funding from within the health revenue budget should it be required. Given the small uplift in funding allocated to NHS bodies, they collectively set themselves the target of making £413 million savings, and subsequently reported delivering £314 million savings. These reported savings potentially represent a significant achievement by the NHS. It is, however, likely that some of those reported savings were not cash-releasing and therefore did not directly contribute to bridging the funding gap in that year (see Figure 8). The net result was that the NHS bodies required considerable additional funding in 2010-11. The Department was unable to manage this need within the health revenue budget and had to provide an additional £110 million from Welsh Government reserves.

Figure 8 - Reconciling reported savings in 2010-11 to the budget and cost pressuresion

Paragraph 1.17 reported the complexity in accurately assessing the cost pressures facing health budgets in 2010-11. Taking account of those different approaches, and the underlying deficit from 2009-10, we calculate that there was a funding gap of between £126 million[5] and £281 million[6] across the health revenue budget. These figures suggest there would have been a surplus, had all of the savings been cash-releasing and used to bridge the funding gap. However, as Figure 7 shows, the Welsh Government had to provide an additional £110 million to the NHS from its reserves.

In part, the difficulty reconciling the reported savings to the budget and cost pressure forecasts could be explained by the different types of savings that NHS bodies make. Not all savings are cash-releasing. It is possible that a significant proportion of the reported savings were reinvested in improvement activity, and therefore did not contribute directly towards bridging the funding gap. It is also likely that some of the savings represented 'cost avoidance', for example containing cost rises in particular goods or services to below inflationary cost pressures set out in the Five Year Framework and the National Finance Agreement. The NHS is also supporting strategic service change through the reinvestment of some cash-releasing savings into new models and settings of care.

1.20 The improved financial monitoring meant that the Welsh Government was aware of the need for additional funding earlier than in previous years. It recognised that further funding would be required and made the additional funding available to the NHS bodies in December 2010, rather than waiting to the end of the financial year.

The Welsh Government recognises that the provision of additional funding poses some challenges in terms of developing a culture of cost control

1.21 One of the major challenges in a service that is demand-led with increasing pressures is to establish a culture of cost control. The Welsh Government has set out a clear requirement for NHS bodies to plan and manage within available resources whilst meeting agreed targets. However, the Welsh Government has also provided additional funding during the financial year that has supported NHS bodies to meet those targets and break-even. Where NHS bodies overspend, the Welsh Government is under pressure to cover those deficits: in part, because accounting rules mean that its own accounts could be qualified as a result of overspends at one or more NHS body. Having its accounts qualified would be uncharted territory for the Welsh Government, and while the precise consequences are uncertain, it would be likely to cause significant reputational harm to the Welsh Government.

1.22 There are concerns that the focus on breaking even at the end of the financial year encourages an excessively short-term focus. At a meeting of the Public Accounts Committee of the National Assembly, the Chief Executive of Aneurin Bevan Health Board described the challenge of delivering a break-even on the £6 billion health budget as akin to 'landing a jumbo jet on a postage stamp'.

5 This figure is based on the gap between the actual 3.2 rise in the heath revenue budget and the 4.4 per cent cost pressures identified in the Five Year Framework, plus £60 million underlying deficit from 2009-10.

6 This figure is based on the gap between the actual 3.2 rise in the heath revenue budget and the 7.2 per cent cost pressures identified in the National Finance Agreement, plus £60 million underlying deficit from 2009-10.

1.23 Over the years, an apparent pattern has emerged where the Welsh Government tells NHS bodies that no further funding will be made available but then provides support that covers deficits. There is a risk that this pattern makes it more difficult for finance managers to emphasise the need for cost control to clinicians and operational staff, who may assume that funding for budget overspends will be found from elsewhere.

1.24 There is a risk that the approach to funding at the start of 2010-11 may have exacerbated the perceptions of a hidden pot for funding overspends. Withholding a relatively large amount of funding, setting ambitious targets and sending out a tough message that no further funding would be available was risky. Holding a contingency to manage unexpected events is sensible, but needs to be carefully communicated to avoid NHS bodies and staff making their own assumptions about the size of such a contingency fund. And there are also risks associated with a tough 'no further funding' message when it is clear to many within the NHS that some contingency was available. The tough message was undermined when additional money was subsequently made available. The combination of factors may have contributed to perceptions that there is a hidden pool of money to fund deficits. Parts 2 and 3 show that the Welsh Government has learnt lessons and is moving towards greater transparency over funding and backing up its messages on not providing further funding at the end of the year.

Part 2 – In 2011-12 NHS bodies again reported significant savings, and the Welsh Government has sought to put health finances on a more sustainable footing that helps break the cycle of additional year-end funding

2.1 This part of the report examines the scale of the NHS funding gap in 2011-12, and the action taken by the Welsh Government and the NHS bodies to close that gap by the end of the financial year. It examines:

- the scale of the funding gap at the start of the year;
- the reported savings that NHS bodies made and progress in staying within budget across the year;
- the additional funding required to enable the break-even position; and
- the oversight and monitoring of progress by the Welsh Government.

In 2011-12, there was an in-year funding gap in the order of £280 million to £380 million at the start of the financial year

2.2 As set out in Part 1, the NHS faces a range of cost pressures and precisely identifying the scale of the 'funding gap' – the difference between the funding allocated to NHS bodies and the estimated cost and demand pressures – is complex. There are three different versions of the funding gap, based on:

- cost and demand forecasts from the NHS Five Year Framework;
- forecasts from the National Finance Agreement, based on health boards' own assessments; and
- NHS bodies' own collective assessment of the funding gap.

2.3 Figure 9 shows the funding gap based on the NHS Five Year Framework and the National Finance Agreement. We have used the NHS Delivery line from the budget (see Appendix 1 for an explanation). The NHS Five Year Framework estimates cost and demand pressures amounting to around 3.3 per cent in the year. Using these estimates, there was a funding gap in the order of £280 million. While this may seem low, it reflects the fact that there has been a wage freeze across the NHS. The National Finance Agreement estimates cost pressures of 5.2 per cent.

2.4 At the start of the year, the NHS bodies themselves identified an in-year gap of £279 million. NHS bodies also had an underlying deficit[7] from 2010-11 of £187 million. In order to bridge the in-year gap and eradicate the underlying deficit, NHS bodies identified a total funding gap of £466 million. Collectively, NHS bodies had plans to find £267 million savings to partly bridge the funding gap.

7 The underlying deficit is calculated each year by taking account of non-recurrent income, expenditure and non-recurrent savings.

Figure 9 - Funding gap in 2011-12

Revenue (millions)	2010-11	2011-12
NHS Delivery budget	£5.47 billion	£5.37 billion
Cost pressures in NHS Five Year Framework		3.3%
Cost pressures in National Finance Agreement		5.2%
Funding gap using Five Year Framework		£279 million
Funding gap using National Finance Agreement		£383 million

Source: Wales Audit Office analysis of Welsh Government budgets and cost pressure estimates
Note: To show the gap at the start of the financial year, the figure for 2010-11 includes additional funding allocated in two supplementary budgets (totalling £5.506 billion less non-cash funding). The figure for 2011-12 reflects the budget at the start of the financial year, as set out in the Final Budget 2011-12 approved in December 2011, and does not include the additional funding allocated in the year.

NHS bodies reported savings of £285 million in 2011-12 but received additional funding of £157.4 million from the Welsh Government to address cost pressures and achieve break-even

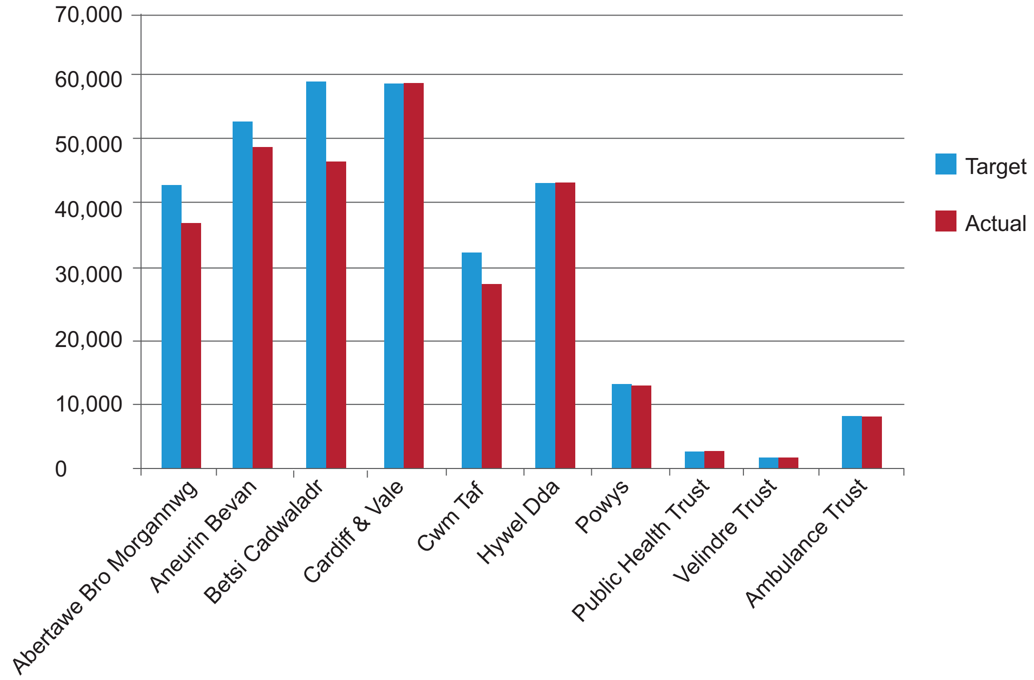
NHS bodies reported savings of £285 million in 2011-12, marginally behind the final target and including significantly more one-off savings than originally planned

2.5 Across the year, the NHS bodies increased the level of potential savings identified from £267 million (Paragraph 2.4) to £312 million. At the end of March 2012, NHS bodies reported having made £285 million savings. This figure is lower than the £314 million savings reported for 2010-11, but is still a significant achievement. However, it is not clear if this represents a substantive reduction in the level of cost savings or more rigorous reporting and classification of the savings. Figure 10 sets out the level of reported savings against targets.

2.6 Figure 11 shows the categories of reported savings. Workforce cost is by some margin the largest area of saving, with £85 million of reported savings through workforce modernisation and a further £7 million from reductions in management costs. However, in both categories, NHS bodies did not meet the collective savings targets. Procurement and other non-pay is the next largest area of savings; with the £66 million reported savings exceeding the target of £57 million. The third-largest area of savings is continuing healthcare where, again, the reported £44 million savings exceeded the plan for the year.

2.7 The health boards struggled to meet their targets for savings on medicines management. They intended that this area would deliver the second-highest level of savings but actually only delivered the fourth highest. The monitoring returns show that five out of the seven health boards exceeded their budgets for primary care prescription drugs, with a combined total overspend of £20 million. Health boards overspent on 'clinical supplies' in secondary care, which includes medicines supplied in hospitals, by some £36 million.

Figure 10 - NHS bodies' reported savings compared to target savings 2011-12



Source: Wales Audit Office analysis of month 12 monitoring returns

2.8 Figure 11 shows the two core types of savings: recurrent and non-recurrent. Recurrent savings are sustainable savings that should be saved in future years (so represent a permanent cost reduction). Examples of such savings include reducing the unit cost of purchasing an item in a long-term contract, or changing the way a service is organised so that it can be permanently delivered by fewer staff. Non-recurrent savings are one-off cost reductions. Examples include delaying purchasing an item until the new financial year or delaying recruitment to a post that will ultimately need to be filled. It is positive that 87 per cent of savings are reported as being recurrent. However, the level of non-recurrent savings has increased substantially towards the end of the year. In December 2011, NHS bodies forecast that just £23 million of the savings would be non-recurring, compared to the final position of £38 million non-recurrent savings. The areas where non-recurrent savings increased most in the final few months were workforce and procurement.

2.9 Figures 12 and 13 show how the savings were accumulated over the year and the split between recurrent and non-recurrent savings. Those health boards which achieved savings more evenly through the year (demonstrated by a straighter line in Figure 12), generally achieved a higher level of recurrent savings, whilst those health boards whose savings were achieved more towards the year-end (demonstrated by a curved line), relied to a greater extent on non-recurrent savings.

The Department required an additional £93 million from central reserves, including £63 million made recurrent to address historic shortfalls and £30 million to support Hywel Dda

2.10 The Welsh Government recognised earlier in the financial year that the NHS bodies were unlikely to meet their financial targets and break-even. All of the health boards, bar one, were forecasting a significant end-of-year deficit. The Cabinet of the Welsh Government considered the position in July 2011, based on 2011-12 financial plans and May 2011 monitoring reports, and agreed to place the

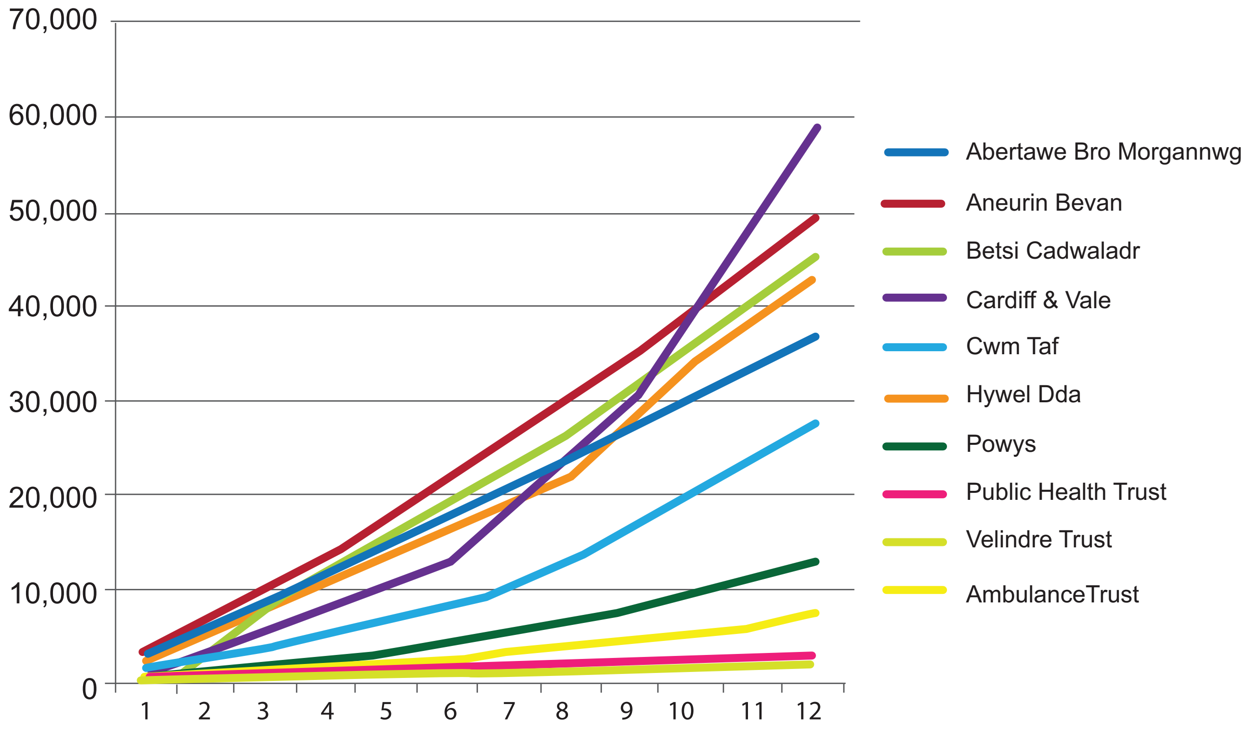
Figure 11 - Categories of reported savings in 2011-12

Savings Catagories	Full-year plan		Full-year actual		Comprising...	
	£000's	%age	£000's	%age	Recurrent £000's	Non-recurrent £000's
Workforce Modenisation	111,392	35.7%	84,551	29.7%	74,609	9,942
Medicines Management (Primary & Secondary Care)	51,330	16.5%	42,710	15.0%	40,331	2,379
Procurement & Other Non Pay (excl Energy)	56,882	18.2%	65,991	23.1%	45,002	20,989
CHC (excl DTOC)	36,094	11.6%	44,447	15.6%	43,600	847
Externally Commissioned Services	32,726	10.5%	28,548	10.0%	25,971	2,578
Management Cost Reductions	9,078	2.9%	7,844	2.8%	7,009	835
Estates / Energy	5,899	1.9%	4,460	1.6%	4,433	27
Specialist Services	6,808	2.2%	4,946	1.7%	4,929	16
Shared Services	1,584	0.5%	1,620	0.6%	1,585	35
Total	311,792	100%	285,117	100%	247,468	37,648
					86.8%	13.2%

Source: Month 12 monitoring returns

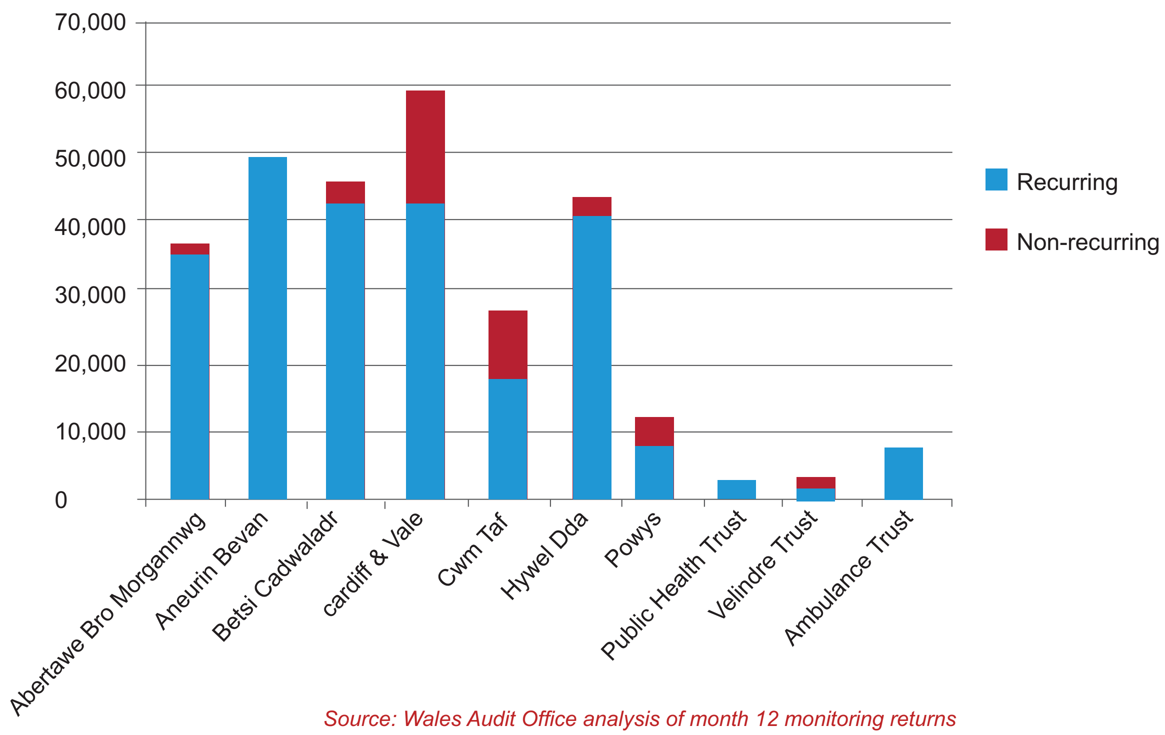
NHS on a more sustainable footing; a situation which had previously been resolved on an ad hoc basis each year with additional funding later in the year. It was therefore agreed to provide NHS bodies with an additional £133 million (£93 million from central reserves, £40 million from within the Department's budget). The Cabinet agreed that £63 million of the additional funding would be recurring, and would be included in the Department's future years' budgets. In addition to this funding, the Department agreed to provide 'brokerage' of £12 million to Cardiff and Vale University Health Board. This is a 'draw forward' of funding from 2012-13 and 2013-14; funding for those years will be reduced by £6 million each. The funding was provided primarily to ensure the Health Board met its 2011-12 financial targets, but also to support an Accelerated Improvement Programme (to underpin successful delivery across the three principal domains of performance: quality, finance and access).

Figure 12 - Accumulation of savings through the year



Source: Wales Audit Office analysis of month 12 monitoring returns

Figure 13 - Split of savings between recurrent and non-recurrent



Source: Wales Audit Office analysis of month 12 monitoring returns

2.11 The provision of additional funding on a recurrent basis and at an earlier stage in the financial year marks a change to previous years and appears to reflect an aim for greater transparency in the approach to funding the NHS. In communicating its decision, the Welsh Government was careful to emphasise that the funding was to address historical funding issues once and for all. Having provided this funding, the Welsh Government emphasised that it expected health boards to be able to achieve their financial targets.

2.12 However, it became clear that three health boards – Aneurin Bevan, Cwm Taf and Powys – would still not achieve their financial targets and would require further funding. In a marked change from previous years, the Department provided a further £12.4 million as brokerage, ie as a ‘draw forward’ of funding from future years, to ensure these health boards met their financial targets. Their funding in 2012-13 will be reduced by the same amount.

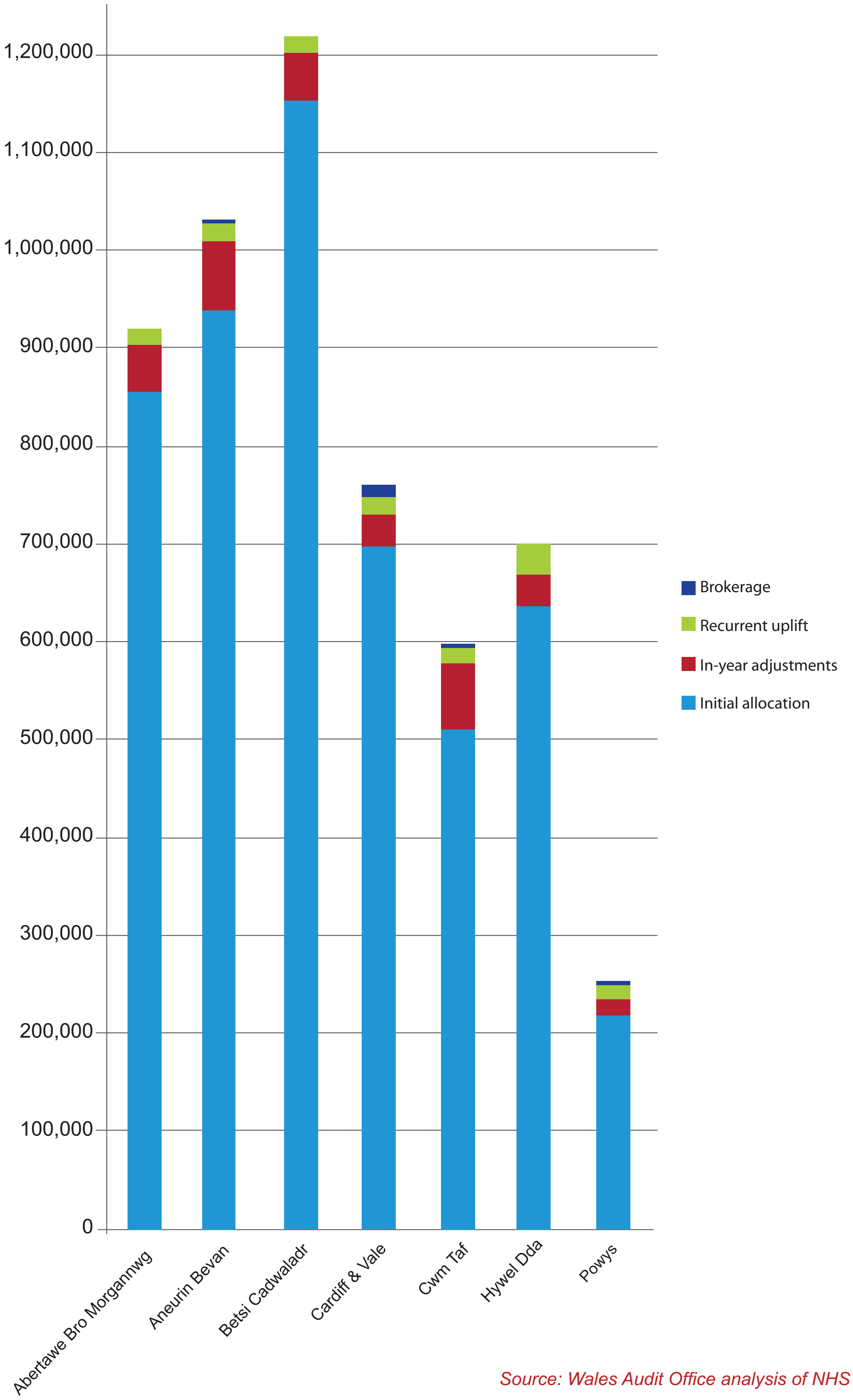
2.13 Figure 14 below sets out this funding split graphically. The additional brokerage provided to Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys Health Boards was only 0.4 per cent of overall funding in the year.

Comparing cost pressures, savings and additional funding suggests that some of the reported savings may not have been cash-releasing

2.14 Not all savings are actually reductions in cost that free up cash. Sometimes savings create additional capacity that is reinvested in other areas, rather than banked as a hard-cost reduction. Our own work in previous years auditing efficiency gains has shown that it is often very difficult to verify absolutely whether reported savings are efficiency savings or cuts, and whether they are cash-releasing savings or productivity gains.

2.15 We have not sought to verify the £285 million savings that NHS bodies have reported. However, by comparing the estimated funding gaps at the start of the year (Paragraphs 2.3 to 2.4 and Figure 9) and the additional funding provided through the year, it is possible to produce a rough indicator of the potential split between cash-releasing and other types of savings. Figure 15 indicates that cash-releasing savings required in the year accounted for between £309 million and £413 million of the reported savings. It also suggests that, once one-off savings of £38 million (see Figure 11) are excluded, sustainable recurrent savings were between £271 million and £375 million. There remains an underlying deficit of £125 million to address in 2012-13.

Figure 14 - Health board funding allocation 2011-12 in £'000s



Source: Wales Audit Office analysis of NHS allocations data

2.16 Of all the categories of savings, workforce modernisation appears most likely to include non-cash releasing savings. Our experience of auditing efficiency savings in the past suggests that areas such as procurement tend to be clearer in terms of whether goods and services were, or were not, purchased more cheaply. Workforce savings are often more difficult to translate into cash savings; it is often difficult to release cash from improvements that free up a proportion of a staff member's time. Instead, that time is often reinvested in other activity. Monitoring data on workforce costs and levels suggest that savings in this area have indeed been reinvested in other areas. Five of the seven health boards overspent their budget for pay, some quite significantly. Health boards collectively spent £83 million more on pay than planned at the start of the year and the total NHS pay bill for secondary care increased by £48.8 million (two per cent) from 2010-11 to 2011-12. The number of staff employed in the NHS increased, from 78,041 WTEs in 2010-11 to 78,602 in 2011-12, rather than decreased as may be expected in light of the reported savings. An increase in staff is not necessarily a sign of increasing cost, it may be lower cost to take on new staff and reduce the use of expensive agency staff. There has been some overall progress in reducing reliance on agency staff, with variation between NHS bodies, but only one health board (Powys) has met the target of keeping agency spend to 0.8 per cent of the pay bill across the year. Two of the three NHS trusts also met the target.

Figure 15 - Indicative analysis of cash-releasing savings based on cost pressure estimates

	Five Year Framework estimates	National Finance Agreement estimates
Estimated funding gap at the start of the financial year	£279 million	£383 million
Plus underlying deficit brought forward	£187 million	£187 million
Total funding gap	**£466 million**	**£570 million**
Less additional funding provided including brokerage	£157 million	£157 million
Cash-releasing savings required	**£309 million**	**£413 million**
Indicative recurrent cash-releasing savings (cash-releasing less non-recurrent savings in Figure 11)	£271 million	£375 million

Source: Wales Audit Office analysis of NHS allocations data and monitoring returns

The Welsh Government has changed its approach to provide £63 million of this additional funding on a recurrent basis and use brokerage to reinforce a tougher message to NHS bodies

2.17 Detailed monthly monitoring reports are required to be submitted by all NHS bodies by the tenth working day of the following month. The reports require detailed information on the financial position to date and forecasts to year-end for a number of areas including under or overspend against funding allocation and savings plans.

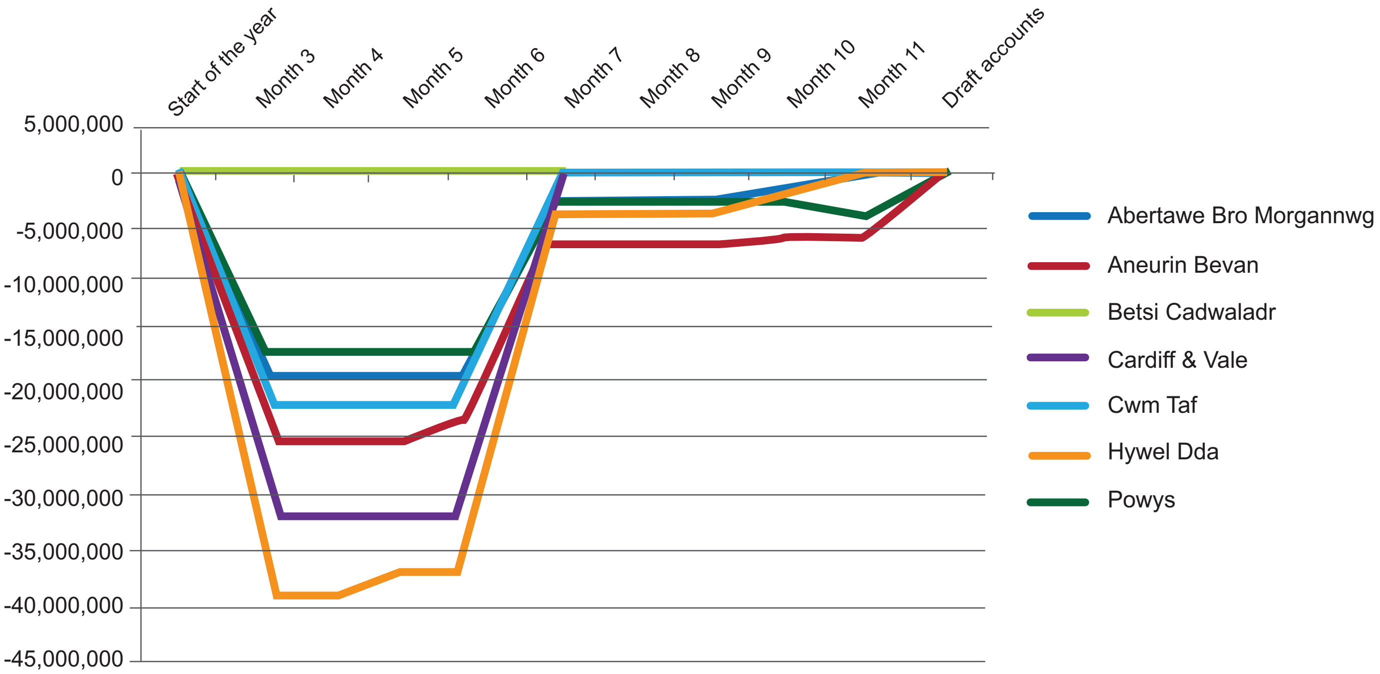
2.18 The forecasting pattern set out in Figure 16, reported through the year by health boards, is consistent with the funding allocation story set out in the section above. Health boards reported a total forecast overspend of £155 million at month 3 with minimal change to this estimate until month 7, when the £133 million funding uplift and £12 million brokerage were provided, reducing the forecast out-turn to £16 million. Further brokerage in month 12 of £12.4 million brought all health boards into a break-even position in their draft financial statements.

2.19 The Welsh Government used the strengthened monitoring return forecasting to assist with their earlier identification of financial problems. At month 6, financial positions were assessed and the funding uplift of £133 million to health boards and the £12 million of brokerage to Cardiff and Vale University Health Board were confirmed in October 2011. All health boards received £17 million with the exception of Hywel Dda and Powys Health Boards who had £33 million and £15 million respectively. The allocation was made taking into account relative sizes of health boards and the scale of financial risk being managed, with particular support to Hywel Dda in line with their four-year package of tapering financial support.

2.20 Also, by providing ‘brokerage’, rather than simply giving extra money, the Welsh Government stuck to its ‘no additional funding’ message in a way that it had not in previous years. The use of brokerage, which in effect allows health boards to break-even over a number of years, partly addresses the challenge posed by accounting rules that require break-even each and every year.

2.21 The Welsh Government is carrying out a review of the financial plans of the four health boards that required brokerage at the end of the year. It is also carrying out work at Betsi Cadwaladr and Hywel Dda Health Boards. The Welsh Government intends that these reviews will support health boards in strengthening their financial planning and management. It also intends that the reviews will emphasise the accountability of health boards for managing their finances.

Figure 16 - Health board forecast out-turn through 2011-12



Source: Wales Audit Office analysis of 2011-12 monitoring returns

2.22 Over the year, there have been some difficulties with the Welsh Government's monitoring information. Several of the health boards included large savings from central projects in the final month of the financial year. As a result, the monitoring forms across the year were showing that NHS bodies were likely to deliver a larger deficit than actually occurred. Where possible, those savings should be profiled over the year to facilitate monitoring and planning. Also, the approaches of different health boards may not be entirely consistent, with some striking a cautious note and others including more optimistic forecasts. For example, Betsi Cadwaladr Health Board predicted break-even in every month of the year, despite having an in-year deficit and accessing an additional £17 million in October. Cwm Taf Health Board predicted it would break-even in month 11, but required brokerage at the end of the year.

Part 3 – There are positive signs for long-term reform to address unprecedented future financial challenges but short-term funding gaps remain a concern

3.1 This part of the report examines the financial pressures facing the NHS over the period to the end of the Spending Review (2014-15). In particular, it explores the short-term pressures that the NHS faces to break-even in this financial year (2012-13). It also sets out the financial position to 2014-15, based on the Welsh Government's budget, and sets out the longer-term challenges facing the NHS as it moves into a period of significant reform of service delivery.

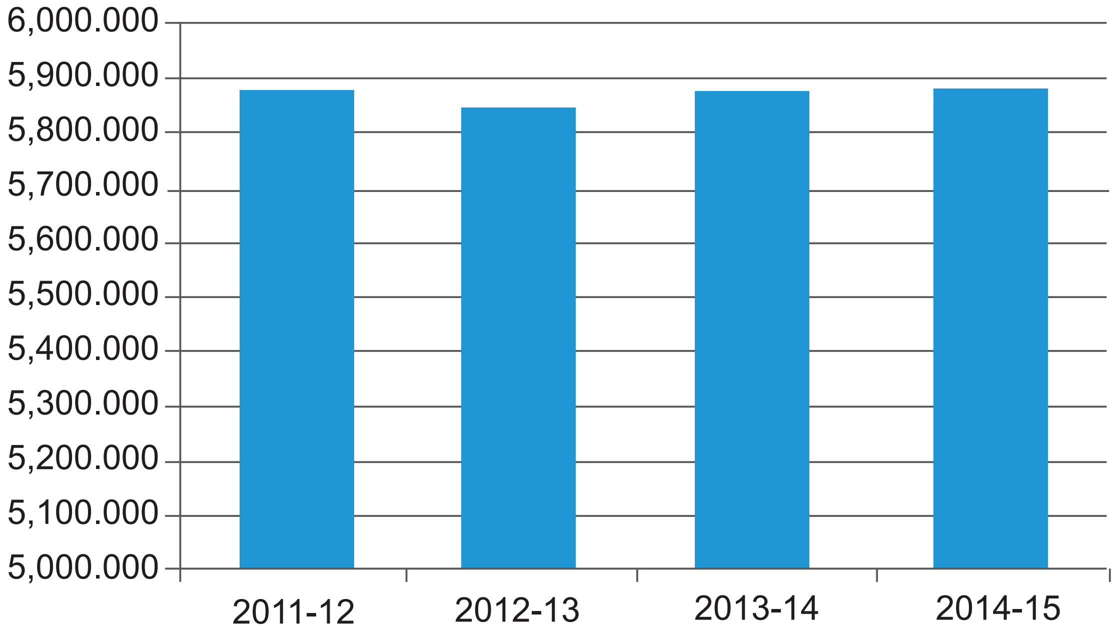
The NHS faces real terms cuts until 2014-15 with a significant and growing funding gap

The NHS faces unprecedented financial challenges with real terms cuts to health budgets every year to 2014-15

3.2 Figure 17 sets out the changes to the health revenue budget in cash terms between 2011-12 and 2014-15. These figures include additional recurring funding allocated by the Welsh Government in the December 2011 Final Budget. The Welsh Government agreed additional recurring funding for the health revenue budget in December 2011. In agreeing this funding, the Welsh Government accepted that the NHS should be placed on a more sustainable footing and that previous non-recurrent supplementary budget allocations should be made recurrent. Nonetheless, once inflation is factored in, there is a real terms cut every year in the health revenue budget (Figure 18). By 2014-15, the revenue budget is likely to be around 10 per cent lower in real terms than 2010-11. As we reported in *A Picture of Public Services 2011,* the NHS in Wales faces the toughest financial settlement over this period of any of the countries in the UK[8].

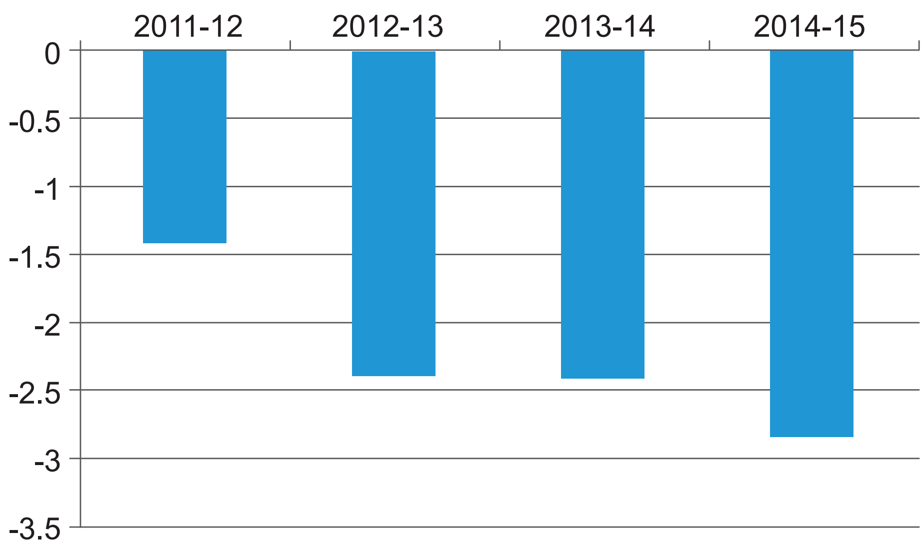
8 Figure 18 differs from the figures used in *A Picture of Public Services 2011*. For consistency within this report, we include all health revenue funding within the Welsh Government's budget. In *A Picture of Public Services*, we used only the 'NHS Delivery' line in the budget. Also, Figure 18 takes account of the impact of supplementary budgets and we have used a more recent set of GDP deflators to calculate the impact of inflation in setting out the real terms budgets.

Figure 17 - Health revenue budgets (£)



Source: Wales Audit Office analysis of Welsh Government budgets
Note: The figure for 2011-12 is based on the Final Budget 2011-12, published in February 2011, plus further funding set out in supplementary budgets. The figures for 2012-13 to 2014-15 are based on the figures in the Final Budget 2012-13 published in December 2011.

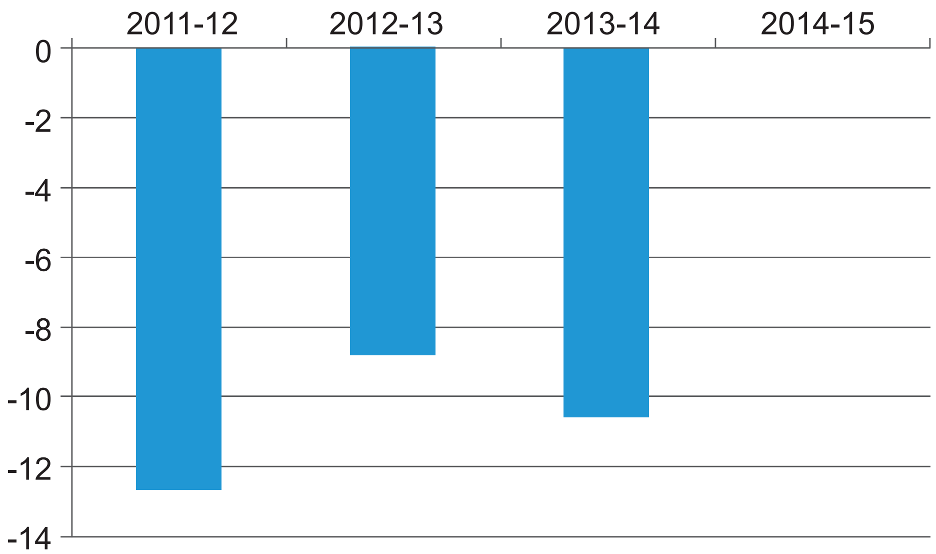
Figure 18 - Real terms decreases each year to health revenue budgets (%)



Source: Wales Audit Office analysis of Welsh Government budgets
Note: The figure for 2011-12 is based on the Final Budget 2011-12, published in February 2011, plus further funding set out in supplementary budgets. The figures for 2012-13 to 2014-15 are based on the Final Budget 2012-13 published in December 2011.

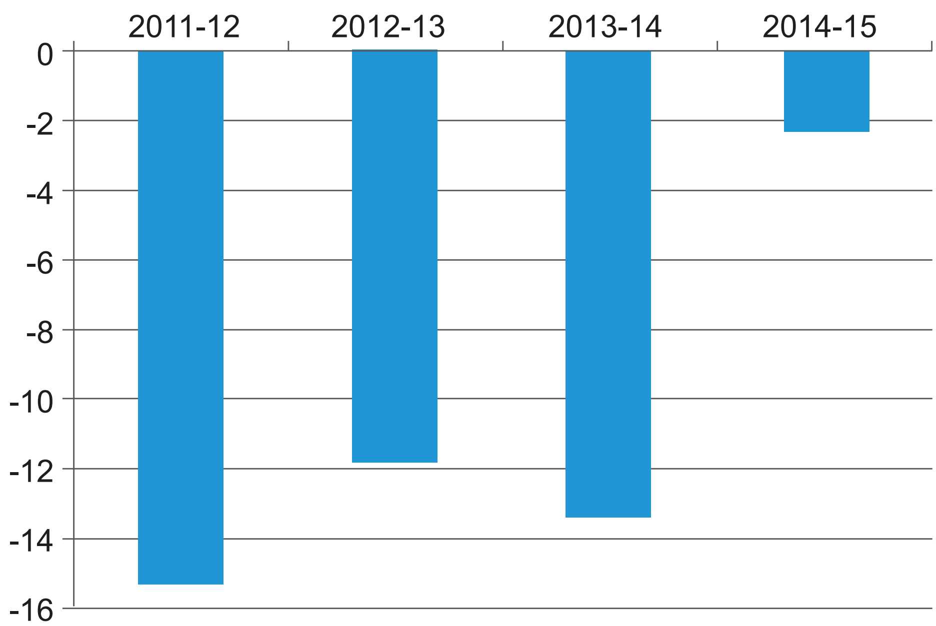
3.3 In common with other parts of the public service, the largest cuts fall on capital spending. Capital is the funding that NHS bodies use to create or develop infrastructure, such as hospitals, surgeries and other assets. The Welsh Government's budget shows that in cash terms, the capital budgets for health reduce each year other than 2014-15 (Figure 19). In real terms, there is a reduction every year (Figure 20) and the capital budget for health will be around £1.1 billion (36 per cent) lower in 2014-15 than 2010-11.

Figure 19 - Cash terms reduction to health capital budget year on year (%)



Source: Wales Audit Office analysis of Welsh Government budgets

Figure 20 - Real terms reduction to health capital budget year on year (%)



Source: Wales Audit Office analysis of Welsh Government budgets

There is a significant gap between the funding required to meet expected demand and cost pressures and actual budgets

3.4 The Five Year Framework sets out the estimated demand and inflationary pressures facing the NHS to 2014-15. The Five Year Framework sets out 'low-cost' and 'high-cost' scenarios. Since the forecasts were produced, inflation forecasts have been revised upwards quite significantly. Therefore, the 'high-cost' scenario is likely to better reflect the actual cost pressures on the NHS, but even the high-cost scenario may understate the true funding gap. Figure 21 updates the position reported in our report, *A Picture of Public Services 2011*, to include the figures from the Welsh Government's final 2012-13 budget and to take account of additional funding from reserves in 2010-11 and 2011-12. Using 2010-11 as a baseline, we estimate that the NHS faces a funding gap in the order of £873 million by 2014-15.

Figure 21 - Funding gap based on NHS Five Year Framework and 'NHS Delivery' line from Welsh Government budget

Revenue (millions)	2010-11	2011-12	2012-13	2013-14	2014-15
NHS Delivery budget	5,467	5,500	5,492	5,507	5,497
Cost pressures in low-cost scenario	3.7	2.6	2.6	2.6	2.6
Cost pressures in high-cost scenario	4.4	3.3	3.8	4.1	4.4
Funding required in low-cost scenario	*	5,609	5,755	5,905	6,058
Funding required in high-cost scenario		5,647	5,862	6,102	6,371
Cumulative funding gap in low-cost scenario	*	-109	-263	-398	-561
Cumulative funding gap in high-cost scenario	*	-147	-370	-595	-873
Year-on-year funding gap in low-cost scenario		-109	-154	-135	-163
Year-on-year funding gap in high-cost scenario		-147	-223	-225	-278

Source: Wales Audit Office analysis based on NHS Five Year Framework forecasts and figures from the Welsh Government's final budgets and supplementary budgets. The 2010-11 published NHS Delivery budget figure was £5,506 million but has been adjusted to £5,467 million for non-cash items. The figures for 2011-12 include the additional funding allocated in the June 2011 and February 2012 supplementary budgets, which helped to reduce the gap within the year.

3.5 While the Five Year Framework has set out cost forecasts underpinned by detailed analysis, the Welsh Government has recently been reporting the cost pressures on the NHS using a different set of figures. In its narrative to the draft budget, the Welsh Government estimated indicative cost pressures of around four to five per cent a year; with savings required in the order of £250 million a year. These figures suggest that the NHS faces a larger challenge than outlined in our report *A Picture of Public Services 2011*. In particular, if the annual pressures on the NHS in 2011-12 are in the order of £250 million a year, as set out in the National Finance Agreement and budget narrative, it will need to reduce costs by around £1 billion between 2010-11 and 2014-15.

The NHS faces a major challenge to manage within budget in the short term

3.6 The funding gap is potentially larger than suggested by either estimates. Those figures are based on the NHS bodies starting with a clean slate. However, four health boards collectively start the year needing to find around £24.4 million to replace the funding 'brokered' to 2011-12 from future years. Further, the estimates assume that each year the NHS bodies are able to sustain all of their savings from the previous year. As Part 2 showed, in 2011-12, NHS bodies had to ramp up the level of non-recurrent savings at the end of the year. To make up the gap left by the non-recurrent savings, NHS bodies will need to make an additional £38 million savings.

3.7 It is likely that the NHS will find it increasingly difficult to continue to make large savings in transactional areas, such as procurement. With two years of financial pressures, it is likely that many of the easy-to-deliver 'low-hanging fruit' have already been exploited. The fact that NHS bodies needed to ramp up the level of non-recurrent savings at the end of 2011-12 is a sign that they are finding it hard to make sustainable recurrent savings in the short term. NHS bodies will therefore need to increasingly look to more fundamental and transformational changes to services in order to achieve the necessary savings.

There are positive signs that the NHS is prepared to take the tough choices needed to deliver long-term change but the goal of improving quality and maintaining levels of service and jobs seems challenging

The ambition set out in the Five Year Framework of delivering the necessary savings while improving quality and sustaining levels of service and jobs looks increasingly optimistic

3.8 The Welsh Government is pressing health boards and trusts to deliver on their savings plans. The Five Year Framework sets out an ambition that the NHS deliver the necessary savings at the same time as improving quality and sustaining the level of services and jobs. In practice, that goal gives the NHS limited scope to act to reduce costs.

3.9 The Five Year Framework is sound in asserting that quality must be a priority despite the financial pressures. Delivering poorer-quality services, with worse outcomes or higher-adverse incidents and infections is not acceptable. It is also self-defeating as a reduction in quality potentially ends up creating extra demand to rectify mistakes as well as, potentially, clinical negligence claims. However, there is a trade-off between the pace and scale of quality improvement

and the investment required to deliver those improvements. It is therefore positive that across 2011-12, despite the financial pressures, the NHS made improvements across a range of quality areas, including reducing levels of hospital-acquired infections.

3.10 Overall NHS bodies have appeared to maintain levels of service, as measured by the length of time people wait for elective treatment. The proportion of patients waiting more than 26 weeks for treatment has stayed at a fairly constant six per cent over the past year (against a target of five per cent) and the number of patients waiting for more than 36 weeks has reduced from 5,077 in 2010-11 to 1,614 in 2011-12. In addition, NHS bodies managed to sustain performance in terms of the length of time people wait for treatment in accident and emergency with 89 per cent of patients waiting less than four hours in 2011-12 compared to 88 per cent in 2010-11.

3.11 Across 2011-12, the number of WTEs working in the NHS increased, but it is unlikely that such a position can be sustained. With pay accounting for a significant proportion of NHS spending, staff cost is the single-largest area of cost to the NHS and is the single-largest area of overspend. Despite a pay freeze and reported savings on staffing through workforce modernisation, net staffing costs have risen considerably ahead of plan. It is hard to see how the NHS can live within its means and meet the ambition of sustaining levels of jobs in future years. That said, reducing staffing costs does not necessarily mean making people redundant. But it may mean looking at reducing some staff hours, greater use of flexible working and redesigning work so that it can be managed by fewer people or by staff at lower grades.

3.12 As the NHS addresses the challenge of reducing its staffing costs, it will need to do so in a planned way in order to manage risks to service levels and quality. The risk is that, in the absence of a strategic approach, health boards and trusts adopt an ad hoc approach, through recruitment freezes and vacancy management, where the primary goal is to make short-term savings rather than take a whole-system approach to managing the impact on patients. Indeed, such approaches can even cost more where they lead to NHS bodies having to take on more expensive locum and agency staff to fill gaps. The Welsh Government has recently launched a new workforce framework, *Working Differently – Working Together*, which will be underpinned by local workforce planning. That framework recognises the need for a whole-systems approach. Notably, it does not repeat the Five Year Framework's ambition of maintaining job levels. It explicitly sets a goal of reducing management costs and also identifies the challenge of ensuring workforce costs are affordable.

3.13 NHS bodies are developing three-year service and financial plans to ensure that the identified financial challenge can be met. It will be important that these plans are robust and deliverable. In particular, the plans will need to link the financial and service delivery plans with robust workforce plans to manage the risks that changes in the workforce may have on levels of service and quality.

The NHS has struggled to deliver the required transformation of services in the past but there are signs that it is now prepared to take the tough choices needed to make the NHS financially sustainable and to improve the quality of services

3.14 The sustainable solution to the financial challenges facing the NHS is to transform the way that NHS services are delivered. As this report has shown, there is some doubt as to whether the local savings plans are delivering the scale of savings that are required to get the NHS through an unprecedented period of public funding constraint. The major potential for releasing savings and also, most importantly, improving care, are to be found in reshaping the pattern and methods of delivering health services.

3.15 Our report, *A Picture of Public Services 2011*, comments on the track record of the NHS in delivering reform of services and the difficulties it has faced in the past. Since we published our report, there have been several significant developments. In particular, the Welsh Government published *Together for Health: A Five Year Vision for the NHS in Wales* in November 2011. The vision reaffirms some of the key elements of reform that have previously been set out in Welsh Government visions for the NHS, including:

- a focus on keeping people out of hospital through health prevention;
- treating patients in community settings and in their own homes;
- developing centres of excellence for specialist care to concentrate expertise; and
- integrating health and social care services.

3.16 The key difference between the current drive for reform and previous efforts is the growing recognition that the status quo is simply unaffordable. *Together for Health* clearly identifies the need for 'a relentless quest for value for money'. As part of delivery, the Welsh Government will develop a new financial framework to support financial planning. The Welsh Government has committed to a review of the financial regime, which it intends will be wide-ranging and lead to improvements across the financial system in the NHS. Also, each NHS body will develop a budgeting system with greater clinical involvement in financial decision making. Such a system is an improvement. Clinical decisions and actions drive many of the costs in the NHS. Therefore, engaging clinicians in financial decision making and encouraging greater ownership of the financial challenges should help to drive forwards sustainable reform.

3.17 In moving forwards, the NHS also faces the challenge of finding the funding to support the service reconfiguration. With a real terms 36 per cent cut in capital funding over the current spending period, the NHS will need to find ways to use the assets it already owns in new ways to reflect new patterns of service delivery. It will also need to explore alternative methods to funding new facilities needed to deliver the reshaped services. Since 2007, the Welsh Government has had a moratorium on using the Private Finance Initiative in the NHS, so that is not available as an option to fund new facilities. However, the recently announced Wales Infrastructure Investment Plan provides a framework for future capital investment decisions and the Department will need to ensure that any new funding proposals align with the priorities set out in that Plan.

3.18 The NHS faces particular challenges as, unlike local government, NHS bodies are unable to borrow to fund capital developments and pay back the borrowing from revenue. In any case, the pressure on revenue is such that NHS bodies would struggle to find the revenue funding to pay back borrowing, although they could potentially use savings generated by the new ways of working. There is some funding available through the Welsh Government's Invest to Save programme, but it is relatively limited compared to the scale of the challenges. In 2010-11, NHS Invest to Save was around £7.5 million, £3 million of which related to a voluntary early exit scheme, and the Finance Minister recently announced £6.6 million for 2011-12.

3.19 There is also a revenue challenge in funding the new ways of delivering the services. In some instances in the past, changes have been made by introducing a new service to run in parallel with the existing service. In future, the squeeze on revenue funding may make this option unfeasible and NHS bodies will need to prepare for managing the risks associated with stopping an existing service and migrating to a new way of working. Clinical engagement and leadership will be essential in delivering such difficult changes and in helping patients to understand and adapt to the new approaches.

3.20 NHS organisations will be coming forwards with plans for reforming the way services are configured and delivered. The Welsh Government has set up a national clinical forum to review the plans. Once they are agreed, the major challenge then becomes delivering the necessary change and showing the leadership required to engage the public and staff in helping to put the NHS on a sustainable footing. Making the necessary system-wide changes will need widespread support from other sectors, notably, local government and the voluntary sectors, as well as support and engagement from the public, patients and their representatives. As we say in our report, *A Picture of Public Service 2011*, the NHS will need to use the opportunity afforded by the new political cycle following Assembly elections in 2011 and local government elections in 2012, to move forwards with the difficult changes that are needed.

Appendix 1 – Audit methods and technical notes

Methods

Data analysis: This report is primarily based on analysis of financial information from published budgets, and the monitoring return forms that the health bodies provide to the Welsh Government each month. It also draws on other financial data, including:

- Welsh Government data on the funding allocated to health bodies at the start of the year and the end of the year;
- health bodies' audited accounts; and
- HM Treasury's *Public Expenditure Statistical Analysis* (PESA).

Document review: In interpreting the financial data we have also drawn on published strategic documents specifically related to the NHS in Wales. These include the NHS Five Year Framework and *Together for Health: A Five Year Vision for the NHS in Wales*.

Technical notes

Health budgets: The overall figures used in this report relate to 'health revenue budgets' or 'health capital budgets'. This term refers to all of the revenue or capital funding identified in the Welsh Government's budget that is allocated to health. It therefore includes both the funding for NHS bodies and the central health funding for the Department. It does not include any of the departmental budget specifically allocated for social services or children's services.

Real terms: This report includes figures on the 'real terms' budget. 'Real terms' involves factoring inflation in to the analysis. For public sector budgets, it is accepted practice to use the UK Government Treasury's GDP deflator series, which sets out the rate of inflation in the past and forecasts the rate of inflation for future years. For this report, we have used the set of deflators issued by the Treasury in December 2011. The inflation figures for the years covered in this report are set out below.

2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
3.31	2.3	3.00	1.73	2.75	2.60	2.70	2.50	2.50

Funding gaps: This report includes an analysis of the funding gaps the NHS faces, based on forecasts of the cost pressures in the NHS. However, there is some uncertainty about those pressures. We have drawn on two main sources: the NHS Five Year Framework and the National Finance Agreement, which identify specific and overall cost pressures each year based on a mix of national and locally supplied data. Both forecasts cover a range of detailed elements, including pay and non-pay and take account of specific NHS inflationary indexes. To calculate funding gaps, we have used the NHS Delivery line from the health budget. We use this part of the budget because it covers the funding for the NHS services to which the cost pressures apply.

Health boards: Legally the health boards are known as local health boards. However, since reorganisation they have had dispensation from the Welsh Government to refer to themselves as health boards – this report does the same.

Appendix 2 – NHS bodies' 2011-12 financial performance

This appendix sets out more detail on individual NHS bodies' 2011-12 financial performance and can be read in parallel with Part 2 of the main report.

In 2011-12, there was an in-year funding gap in the order of £280 million to £380 million at the start of the year

Part 2 of the main report assesses the in-year NHS funding gap to be somewhere between £280 and £380 million based on Welsh Government data. At the start of the year, the individual NHS bodies estimated an in-year gap of £279 million, the lower end of our calculations. NHS bodies also had an underlying deficit from 2010-11 of £187 million. In order to bridge the in-year gap and eradicate the underlying deficit, NHS bodies identified a total funding gap of £466 million.

The NHS bodies put in place savings plans to help bridge the funding gap and their initial savings targets as per their months 1 to 3 monitoring returns are set out in Exhibit 1 below.

Exhibit 1 - NHS body 2011-12 initial savings targets

NHS body	Initial savings target (£ million)
Abertawe Bro Morgannwg	43
Aneurin Bevan	52
Betsi Cadwaladr	57
Cardiff and the Vale	53
Cwm Taf	26
Hywel Dda	43
Powys	13
Velindre NHS Trust	2
Public Health Wales NHS Trust	3
Welsh Ambulance NHS Trust	7
Total	**300**

NHS bodies reported savings of £285 million in 2011-12 but received additional funding of £157.4 million from the Welsh Government to address cost pressures and achieve break-even

During the financial year, as is usual, various adjustments to the allocation were made by the Department to reflect funding issued from centrally held programme budgets and revisions to estimates of certain capital costs and provisions.

In addition, the NHS bodies have reported the achievement of significant savings in the year as set out in Exhibit 2.

Exhibit 2 - NHS bodies reported savings

NHS body	Initial savings target (£ million)	Final savings targets (£ million)	Savings reported (£ million)
Abertawe Bro Morgannwg	43	43	37
Aneurin Bevan	52	52	49
Betsi Cadwaladr	57	58	45
Cardiff and the Vale	53	59	59
Cwm Taf	26	31	27
Hywel Dda	43	43	43
Powys	13	13	13
Velindre NHS Trust	2	2	2
Public Health Wales	3	3	3
Welsh Ambulance	7	8	8
Total	**300**	**312**	**285**

The estimated in-year funding gap of £279 million would therefore have been covered by reported savings of £285 million. This was a significant achievement but was not enough to cover the total funding gap which includes the underlying deficit. The reported savings have also not been audited and many may not be cash-releasing but represent efficiency gains or cost avoidance measures, rather than a true decrease in expenditure. It is a complex picture and notwithstanding the savings reported, it was clear during the financial year that health boards would require additional funding to achieve their financial targets.

The Welsh Government agreed that funding of £133 million would be allocated in October 2011, of which £103 million would be recurrent (ie, will be included in funding allocations for future years), to recognise the cost pressures on health bodies. It was agreed that central reserves would fund £93 million of this uplift – £63 million recurrently plus £30 million as part of a tapering package to Hywel Dda – with the remaining £40 million funded from the Department.

In addition, Cardiff and the Vale Health Board received additional funding of £12.25 million, with £12 million as repayable brokerage from 2012-13 and 2013-14 resource allocations equally. This support, together with additional planned savings of £2.5 million, enabled that health board to break-even. In return, the health board was required to establish and keep in place a dedicated 'turnaround' team, and to submit a profiled financial plan for months 9 to 12 by the end of November 2011 and a financial and savings plan for 2012-13 by the end of February 2012.

By the end of February 2012, it remained apparent to a number of health boards and the Department that even after the additional October funding, and the reported achievement of substantial savings, some health boards would still not be able to contain their net expenditure within their revised resource limits.

On 6 March 2012, the Minister for Health, Social Services and Children, wrote to the chairs of the health boards offering further financial support. This support would be provided as an 'advance' or 'draw forward' against a health board's 2012-13 resource allocation, uplifting the resource limit to a level which would allow health boards to meet their statutory financial targets. Three health boards took up the offer: Aneurin Bevan (£4.5 million), Cwm Taf (£4 million) and Powys (£3.9 million). As a result, they will not be able to make use of this facility again in 2012-13.

The Chief Executive of NHS Wales has commissioned external reviews of the financial management arrangements of each health board in receipt of this support. Work is also being done with Betsi Cadwaladr and Hywel Dda Health Boards to support their financial planning.

The additional October allocation to Cardiff and Vale, and March allocation to Aneurin Bevan, Cwm Taf and Powys Health Boards were made specifically to ensure that they achieved their financial targets.
To highlight this, the Auditor General has placed a substantive report (alongside his audit opinions) on the accounts of each of those health boards.

A summary of the additional funding received by each NHS body in the year is set out in Exhibit 3.

Exhibit 3 - Summary of additional funding received in 2011-12

Health board	October 2011 (recurrent uplift)	November 2011 (primarily to achieve financial target)	March 2012 (to achieve financial target)	Total funding
Abertawe Bro Morgannwg	£17 million	-	-	£17 million
Aneurin Bevan	£17 million	-	£4.5 million	£21.5 million
Betsi Cadwaladr	£17 million	-	-	£17 million
Cardiff and Vale	£17 million	£12 million	-	£29 million
Cwm Taf	£17 million	-	£4.0 million	£21 million
Hywel Dda	£33 million	-	-	£33 million
Powys	£15 million	-	£3.9 million	£18.9 million
Total	**£133 million**	**£12 million**	**£12.4 million**	**£157.4 million**
Central reserves	£93 million	-	-	£93 million
Department	£40 million	£12 million	£12.4 million	£64.4 million
Total	**£133 million**	**£12 million**	**£12.4 million**	**£157.4 million**

The Welsh Government has changed its approach to provide £63 million of this additional funding on a recurrent basis and use brokerage to reinforce a tougher message to NHS bodies

The health boards each reported their forecast out-turn for the year on a monthly basis to the Welsh Government. The pattern of forecasting is shown in Figure 16 in the main report and shows the large overspends forecast at the start of the year reducing at month 7 when the additional recurrent funding was allocated in October. Further reductions in forecast overspends can be seen at the year-end as the March funding is reflected.

The additional funding provided in November 2011 and March 2012 was provided as a ‘draw forward’ of future years’ funding and therefore future funding will be reduced by the same amount. This is a specific change in approach for the Department. The funding to assist health boards in achieving their financial targets will no longer be provided without conditions but instead recipients are required to pay it back, in effect by receiving a corresponding reduction in funding in future years. In addition, those receiving March funding will not be able to request brokerage next year.

RESTRICTED

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Darren Millar AM
Chair of the Public Accounts Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

8 July 2012

Dear Darren,

PROGRESS IN DELIVERING THE WELSH HOUSING QUALITY STANDARDS

Thank you for your letter of 12 June 2012 on the Public Accounts Committee of the National Assembly for Wales' inquiry into 'Progress in delivering the Welsh Housing Quality Standards'.

2. As you will be aware HRA reform in England was implemented as planned from 1 April 2012. This was the result of a number of years of work between DCLG, HM Treasury, and Local Authorities, and two public consultations. The initial costing of the reform in England was set out in the Spending Review policy costing document which can be found here http://cdn.hm-treasury.gov.uk/sr2010_policycostings.pdf.

3. I understand that in Wales, where housing policy is a devolved matter, the Welsh Government has also been undertaking a review of the Housing Revenue Account Subsidy (HRAS). Your letter asks a number of questions regarding the HRAS in Wales. Firstly you ask for an update on discussions with the Welsh Government. The UK Government is fully supportive of the process currently being undertaken by the Welsh Government and we are working together to identify a mutually acceptable settlement which will allow the reform of the system in Wales.

3. While these are difficult issues – I have been clear throughout this process that any solution must not have a negative impact on the UK Exchequer – discussions with the Welsh Government on the options for reform have been continually constructive. The Welsh Government are currently considering a number of issues arising from a recent meeting and further meetings with my officials are expected to take place once this consideration has concluded.

4. Your second question asks for views on the future of the HRAS system in Wales. This is primarily a matter for the Welsh Government. The reforms in England have been completed and I wrote to Jane Hutt on 7 June 2011 to agree with her suggestion that attempts should be made to reform the system in Wales along similar lines to the English reforms. The UK Government will continue to work with the Welsh Government to identify a fiscally neutral settlement that will enable this reform to proceed.

5. Finally, you ask for details of funding levels for council housing in Wales. This is a matter for the Welsh Government.

6. I am copying this letter to the Secretary of State for Wales and to Jane Hutt.

Best wishes

DANNY ALEXANDER

Dyfodol Cynaliadwy
Sustainable Futures

Cyfarwyddwr Cyffredinol • Director General

Llywodraeth Cymru
Welsh Government

Public Accounts Committee
PAC(4) 16-12 – Paper 3

Mr Darren Millar
Chair
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11 July 2012

Dear Mr. Millar

Thank you for your letter dated 22 March 2012 raising further questions following my evidence session at the PAC meeting on 20 March 2012.

The questions and my answers below follow the same numbering in your letter.

1. **Question**: Paragraphs 2.46 to 2.49 of the Auditor General's report states that the slower than expected pace of stock transfer in some local authorities has hampered the achievement of the WHQS. The report estimates that stock transfer has required financial support from the taxpayer of £476 million to date, including the £430 million cost to the UK Treasury of writing off local authorities' housing related debts. In light of this conclusion, what assessment has the Welsh Government made of the value for money of stock transfer as a policy tool, given the Auditor General's estimate that stock transfer has required financial support from the taxpayer of £476 million cost to date?

   Answer:

   At the start of the pre ballot process, local authorities undertake a stock condition survey and an options appraisal which considers the feasibility and value for money of each option available. The options appraisal identifies how a local authority can reach and maintain the Welsh Housing Quality Standard. The options appraisal is considered by full Council which votes on whether to pursue the transfer option.

   The options appraisal and Council decision form part of a local authority's application to Welsh Government for provisional approval to proceed to ballot.

   Following a positive result in a tenant ballot, the Welsh Government undertakes a full financial, value for money appraisal of the effect of transfer and presents a business case to HM Treasury. This seeks Treasury's support to agreeing to provide debt funding (this funding is not chargeable to existing Welsh Government budgets).

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Continued…

The financial effects of the proposed transfer on public expenditure are assessed with regard to its impact on the public sector borrowing requirement (PSBR). The analysis compares the PSBR cost of a local authority retaining the housing stock with the PSBR cost of transfer.

The financial appraisal is carried out on a case by case basis as the financial circumstances of individual local authorities vary considerably and 'one size does not fit all'. Careful consideration of the support required from tax payers has underpinned each decision.

2. **Question:** Paragraphs 2.24 to 2.28 of the report highlight that Landlords have business plans indicating that they intend to spend around £2.54 billion on work related to the WHQS between April 2011 and March 2017. However the report also finds that landlords have identified various areas of uncertainty that could affect their investment plans, for example assumptions about future income, required expenditure and organisational and contractor capacity (paragraph 2.29 and Appendix 3 of the report). How will the Welsh Government ensure that landlords actually commit to WHQS-related work the funds they have identified in their business plans (given some of the uncertainties identified in the Auditor General's report)?

Answer:

It is recognised in paragraph 2.29 of the report that not all the uncertainties identified should be regarded as significant, however the Welsh Government is supporting social landlords to mitigate risk in the following ways:

Business Planning
Local authorities submit annual business plans that relate to the ring fenced Housing Revenue Account (HRA). The business plans are subject to an annual review and the local authorities are also required to provide details of progress made against achieving WHQS.

LSVT associations are subject to a similar review process and have to demonstrate satisfactory progress in order to continue to receive Dowry Funding.

Traditional RSLs have to manage their business planning within the Welsh Government Regulatory Framework and Delivery Outcomes which applies to all housing associations registered and regulated by the Welsh Ministers under Part 1 of the Housing Act 1996. It sets out the regulatory framework that housing associations have to meet from 2 December 2011 and contains ten "Delivery outcomes" (standards of performance). The Welsh Government has described what the landlords need to do to meet the outcomes in terms of housing provision, governance and financial management.

Stock Condition Information
In order help landlords keep their business plans up to date, guidance has been issued regarding the commissioning of condition surveys of their stock at least every 5 years, or alternatively a 5-year rolling programme of surveys based on a representative sample of 20% of the stock each year.

Rent Policy
The Welsh Government has consulted upon a proposed new rent policy that would apply consistently to local authority and RSL landlords which would be fairer to tenants. Implementation of the new policy is expected by April 2013 to enable the policy proposals to be revised in light of consultation responses and any changes to the Housing Revenue Account Subsidy (HRAS) system. There are safeguards built into the new rent policy to ensure that no landlord's financial position would be untenable following implementation.

HRAS System
A review of HRAS has identified a need to negotiate a revised financial settlement on HRAS before reform in Wales can be determined and negotiations are also still continuing with HM Treasury to leave the HRAS system.

A new technical sub group, including representatives from all stock retention authorities, has been set up to develop options for reform once the outcome of HMT negotiations are known and the implications for local authorities are being looked at. An important aim of this work is to ensure that HRAS reform provides a better way forward than the continuance of the status quo.

Housing Benefit Reform
Welsh Government is also concerned about the Housing benefit (HB) rule changes and the potential impact on the future revenue flows of social landlords. Steps are being taken to mitigate the effects of these changes which would put more pressure on demand for social housing. A steering group is being set up by WG to address the issues raised by changes in HB rules.

Organisational Capacity
Although it is acknowledged that LSVT associations have complex work programmes to meet five year completion timeframes a mid year progress review which took place in September 2011 indicated that only one of the LSVT associations (Bron Afon) was reporting slippage to its programme as a result of exceptionally bad winter weather in 2010/11.

Contractor Capacity
A number of initiatives are funded by Welsh Government to provide practical support to contractors. The Supplier Development Service is an all Wales service that provides practical assistance to Welsh based SMEs in securing both public and private sector contracts.
Value Wales have worked closely with suppliers to develop the Supplier Qualification Information database (SQuID) to remove the barriers that procurement can pose.
I2i have developed the Can Do Toolkit to encourage purchasers to use their purchasing powers to support SMEs and enable job and training gains where procurement is used as a policy tool.

3. **Question:** Recommendation 4 of the Auditor General's report relates to the development of a clear framework to assess value for money (including the wider benefits achieved) from WHQS-related expenditure. The report also urges the Welsh Government to respond promptly to the recommendations of a Ministerial Task and Finish Group's March 2011 report on housing and regeneration sustainable community investment to better co-ordinate work to maximise the benefits of WHQS-related expenditure. Why hasn't the Welsh Government already made clear its plans in response to the recommendations of the Ministerial Task and Finish Group's March 2011 report on housing and regeneration sustainable community investment?

Answer:

The Welsh Government has accepted the recommendations of the Ministerial Task and Finish Group on Housing and Regeneration Sustainable Community Investment and welcomes the recommendation in the Auditor General's report that they should be taken forward. This is a complex area and we are looking to develop suitable approaches but we acknowledge the recommendations have not been addressed as quickly as we would have liked.

In the interim we have been working jointly with Value Wales to take forward the Community Benefits agenda in the housing and regeneration sectors. We have also provided continuing support for i2i this financial year and they are working to ensure awareness is raised of existing social clauses in procurement resources and to ensure social landlords are supported and encouraged to adopt good procurement practice promoted by Welsh Government.

4. **Question:** Paragraphs 2.68 to 2.83 of the Auditor General's report conclude that there is positive evidence of wider social, economic and environmental benefits from work to achieve the WHQS but some landlords have focused on this more strongly than others and there is no clear framework for measuring success. How does the Welsh Government intend to measure the wider benefits flowing from the projected £2.5 billion investment in WHQS-related work between April 2011 and March 2017?

Answer:

The Housing White paper has given a clear commitment to collaborative working with Value Wales to develop a clear framework for assessing value for money and ensuring the wider community benefits, including jobs and training opportunities, are embedded in public sector procurement practice.

Value Wales has developed a Community Benefits Measurement Tool which captures the value delivered in terms of workforce, training, supply chain, community activity and environmental benefits of capital investment contracts. I2i are working jointly with Value Wales to encourage the take up of the Welsh Communities Benefit Tool across all social landlords by holding joint seminars and providing bespoke advice to individual organisations. The resulting data will brought together by Value Wales and will support the assessment of the impact of this significant investment on the economy.

The Welsh Government is continuing to work with landlords to maximise the social and economic benefits associated with housing improvement programmes and will be looking at ways of improving the promotion and capture of wider benefits from the remaining WHQS-related work. I2i are currently developing a framework to measure and monitor added value from WHQS' which sits behind the Value Wales Community Benefits Tool and will capture the wider benefits that have been achieved outside of procurement.

Please let me know if we can provide any additional information that may be of assistance to deliberations of the committee.

Yours sincerely

Gareth Jones
Director General – Sustainable Futures.

National Audit Office

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

HC 192
SESSION 2012–13

29 JUNE 2012

Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland

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Healthcare across the UK: A comparison of the NHS in England, Scotland, Wales and Northern Ireland

Report by the Comptroller and Auditor General

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

Amyas Morse
Comptroller and Auditor General
National Audit Office

27 June 2012

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This report identifies key trends and variations in the delivery of healthcare across the four nations of the UK, and highlights where further examination may help determine those practices that could deliver better value for money.

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Additional documents can be found on our website at www.nao.org.uk/uk-healthcare-2012

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This report can be found on the National Audit Office website at www.nao.org.uk/uk-healthcare-2012

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Key facts

Set out below are data for all four nations for the indicators quoted in the Summary of the report. A more comprehensive set of indicators is discussed in the Summary and presented in the main body of the report.

	England	Scotland	Wales	Northern Ireland
Life expectancy at birth – men, 2008–2010, years	78.6	75.9	77.6	77.1
Life expectancy at birth – women, 2008–2010, years	82.6	80.4	81.8	81.5
Spending per person on health services, 2010-11, £	1,900	2,072	2,017	2,106[1]
Spending on health services as a percentage of total public spending, 2010-11, %	22.0	20.4	20.3	19.7[1]
Number of GPs (headcount) per 100,000 people, 2009	70	80	65	65
Average taxable income of GPs, 2009-10, £	109,400	89,500	93,500	91,400
Day cases as percentage of all hospital admissions, 2008-09	41.0	36.4	36.8	41.8
Average hospital length of stay (acute beds only), 2008-09, days	4.3	5.7	6.3	5.5
Number of emergency admissions per 100,000 people, 2009-10	9,994	9,917	11,471	–
(increase since 2000-01, %)	(28)	(9)	(3)	–
Reduction in MRSA infection rates per bed day, 2007-08 to 2010-11, %	67	62	38	43

NOTES

1 The Department of Health, Social Services and Public Safety (Northern Ireland) will be seeking to have the published data for health spending in 2010-11 re-stated. The Department considers that spending on health services per person was £1,975 in 2010-11 and that Northern Ireland devoted 18.5 per cent of public spending to health.

2 Notes on comparability are included in the main body of the report with full sources included in the detailed methodology, available at: www.nao.org.uk/uk-healthcare-2012

Summary

1 Since 1999, responsibility for health services has been devolved to the administrations in Scotland, Wales and Northern Ireland. The administrations have powers to choose how much money to spend on health services, what their policy priorities should be, and how services should be delivered, as the UK Government does for England. This report compares the four nations of the UK by setting out comparable data, where available, on health outcomes and spending, and on the delivery and performance of the health services.

2 The work for the report was carried out in collaboration with the Wales Audit Office and the Northern Ireland Audit Office, and we are grateful for the contribution they made. We are also grateful for the advice and assistance of Audit Scotland during the course of our work.

3 The report identifies the extent to which variances exist between the four nations and where further examination may help determine those practices that could deliver better value for money. To set any differences between the nations in context and to provide additional comparators for Scotland, Wales and Northern Ireland – in terms of similar population size and characteristics – we also report certain data for the nine English regions.

4 We did not investigate systematically the reasons behind any variations in performance, although we have carried out more detailed analysis in a number of areas. We also suggest possible explanations for some of the variations. Our methodology is summarised in Appendix One, with further details available at www.nao.org.uk/uk-healthcare-2012.

5 **Figure 1** overleaf sets out the indicators we would have liked to use to compare the health services of the four nations. However, much of the data collected by national statistics authorities are not directly comparable, with the data for some measures either not consistently collected across the nations or not available for certain years. We were therefore not able to use all our preferred indicators or to present them over a consistent time period. Where comparable data were not available we present alternative indicators for which data are consistently collected across the nations. While most of the figures we report have been previously published in comparable formats, we have not audited the data collection processes or validated the figures.

Figure 1
Indicators for comparing the health services

	Preferred indicators	Key data issues	Actual indicators reported
Health outcomes	Composite measure of population health.	Difficulty in measuring some aspects of health and weighting between the different elements.	Life expectancy. Mortality rates.
Health spending	Health spending per person by care setting (e.g. hospital, primary care).	No consistent approach to disaggregating spending data by care setting.	Total health spending per person.
	Percentage of public spending devoted to health.		Percentage of public spending devoted to health.
Cost and volume of health service resources	Unit costs of paying for staff and other resources.	Limited comparable data in some areas of non-staff costs.	Average GP and dentist income. Cost per prescription item.
	Number of resources per person.	No data on some staff, e.g. practice nurses.	Number of GPs, dentists and selected hospital staff per person.
Efficiency and productivity in the use of health service resources	Amount of activity (e.g. GP consultations, hospital admissions) produced by resources.	Limited activity data for primary and community care.	Survey data on the estimated number of patients seen by GPs. Combined measure of hospital activity per medical staff.
	Composite measure of productivity, i.e. indicator of total resources and total quality-adjusted activity.	Sensitivity to weighting the quality measures and the different units of inputs or outputs. Data not available for all four nations.	Data on the efficient use of hospital beds (day cases, lengths of stay).
Quality and effectiveness of healthcare	Measures of health gain attributable to the healthcare provided (e.g. change in quality of life).	Attribution of any health gain to health services. No comparable data currently available on some key measures of primary and hospital care quality (e.g. hospital readmissions and patient satisfaction).	Performance against Quality and Outcomes Framework indicators. Emergency admission rates. Hospital waiting times. Healthcare associated infection rates.

Source: National Audit Office

Health outcomes

6 There are significant differences in health outcomes across the UK. For example, in 2008–2010, average life expectancy at birth varied for men from 75.9 in Scotland to 78.6 in England, and for women from 80.4 in Scotland to 82.6 in England. Similar disparities were also evident in healthy life expectancy and in 'standardised mortality ratios', which take account of the make-up of each nation's population in terms of age and gender. However, such measures of outcomes largely reflect general standards of public health – and therefore the need for healthcare – rather than the performance and effectiveness of the health services.

Spending on health services

7 Spending on health services in the UK has more than doubled in cash terms in the last decade, growing from £53 billion in 2000-01 to £120 billion in 2010-11 (equivalent to an increase of around 80 per cent in real terms). The rate of increase has been broadly consistent across the four nations but levels of spending per person on health services continue to vary. Published data for 2010-11 showed that England had the lowest spending per person on health services (£1,900).

8 As well as reflecting how well health services are delivered, the variations in health outcomes and spending, between the nations and over time, are affected by differences in:

- the health needs of the nations' populations, which are affected by demographic, geographic and behavioural factors; and
- the priority given to health, compared with other devolved services.

Population health needs

9 Many factors affect population health needs and the demand for healthcare, including the level of ill-health, the age and socio-economic profile of the population, and behavioural factors, such as diet and smoking. No one nation had the greatest level of health need against all the individual indicators we examined. However, exploratory work, commissioned for this report, to calculate a consolidated measure of need combining a range of indicators suggested that there are substantial differences in average health need per person between the nations. On the basis of the data available, average need was estimated as highest in Northern Ireland and lowest in England.

Policy and funding priorities

10 Each nation has its own government department to develop and implement the health policy and priorities of its government. Health priorities have varied across the nations, and within nations, over time, although there has been overlap in key areas such as public health, waiting times and cancer services. Comparisons of outcomes and performance between the nations need to be viewed in the context of differences in priorities. For instance, nations that prioritise, and commit more funding to, public health campaigns may expect to see any impact on health outcomes only in the longer term.

11 The administrations in the four nations are free to choose how much of their overall budget to devote to health. Since 2005-06, the proportion spent on health by each of the four nations has remained fairly constant. England has consistently devoted the highest proportion of total public spending to health services (22.0 per cent in 2010-11), with Northern Ireland the lowest.

Health service delivery and performance

Organisation of health services

12 Except in Northern Ireland, where a single organisation purchases services for the whole population, the majority of health services are organised at a local level. In the last decade there has been notable divergence in policy and performance management between the nations, particularly in the use of competition between healthcare providers. Since devolution, the commissioners and providers of health services have been reintegrated in Scotland and Wales, thus removing the internal market. In contrast, the internal market remains in Northern Ireland and the role of competition has increased in England.

Cost and volume of health service resources

13 Staff costs account for around two-thirds of spending on health services. Most NHS hospital staff in the UK are employed through similar nationally negotiated contracts, so there is little difference in pay bands. There has been, however, more marked variation in the pay of dentists and in particular of GPs, who derive their earnings from the income of their practice. In 2009-10, the average taxable income of GPs ranged from £89,500 in Scotland to £109,400 in England. Some of this variation is likely to result from differences in the size of patient registers and the income practices receive for providing additional services.

14 In line with the rise in funding, levels of health service resources, such as staff and capital spending, have also increased over the last ten years. Scotland has consistently had the most GPs per person, with 80 GPs per 100,000 people in 2009 (measured by headcount) compared with 65 in both Wales and Northern Ireland. Based on the most recent data, for 2009, Scotland also had the highest number per person of medical hospital staff and of nursing, midwifery and health visiting staff. Northern Ireland had the most non-clinical hospital staff per person.

Efficiency and productivity in the use of health service resources

15 There are no routinely published, comparable indicators that measure all aspects of efficiency or productivity in the four nations in either primary or hospital care. We therefore looked at a number of individual measures relating to the efficient use of (a) the healthcare workforce (activity per staff member) and (b) hospital beds (day case rates and hospital lengths of stay). It should be stressed that these measures do not account for any differences in the complexity or quality of the care provided.

16 In the absence of routinely collected comparable data on the number of patients seen by GPs, we report findings from a 2009 survey. GPs in Wales estimated seeing more patients per week on average than their counterparts in the other nations, with GPs in Scotland seeing the fewest. Within hospitals, activity levels per medical staff member were highest in England and lowest in Scotland in 2008-09.

17 Northern Ireland treated the highest proportion of all hospital admissions as day cases in 2008-09 (41.8 per cent). In the same year, average hospital lengths of stay varied from 4.3 days in England to 6.3 days in Wales. Further analysis of two specific areas of hospital care – births and hip replacements – indicated that, even after adjusting for differences in patient characteristics and case-mix (such as the proportion of complicated procedures), there was significant variation in hospital lengths of stay within nations. This suggests that there is scope for improved efficiency.

Quality and effectiveness of healthcare

18 We analysed data from the Quality and Outcomes Framework, an incentive scheme for GP practices, to assess aspects of the quality of primary care provided in four disease areas – coronary heart disease, stroke, hypertension, and diabetes. GP practices in Scotland and Northern Ireland generally scored better in 2010-11 than those in England and Wales. The variation between the nations was less than in the previous year.

19 The rate of emergency admissions, where patients require unplanned hospital treatment, is also an indicator of the quality of primary and community care. Emergency admissions per person were higher in all four nations in 2009-10 than in 2000-01, with the increase greatest in England (28 per cent). Wales had the highest rate of emergency admissions in 2009-10 (11,471 per 100,000 people). Comparable data were not available for Northern Ireland.

20 Reducing waiting times for accident and emergency services and elective hospital care has been a priority across the UK, and the length of time patients wait for key hospital procedures has fallen in all four nations since 2005-06. For six common procedures, waiting times in 2009-10 were shorter in Scotland and England than in Wales and Northern Ireland. However, the targets/performance standards used vary in how they are framed, which makes it difficult to compare performance. England was the only nation to achieve its accident and emergency performance standard in 2010-11. England and Scotland were the only nations to achieve their performance standards for elective hospital care in full in 2011.

21 There has been a considerable decrease in levels of key healthcare associated infections in all four nations in recent years. For instance, from 2007-08 to 2010-11, MRSA rates decreased by between 67 per cent in England and 38 per cent in Wales. There was also a reduction in the number of deaths caused by *Clostridium difficile* during the same period.

Concluding comments

22 The health departments in the four nations are charged with securing value for money for the significant amounts of public money that they spend. We publish this report at a time when health services across the UK are under increasing pressure to use resources more productively. Funding is becoming tighter and ageing populations, and advances in drugs and technology, contribute to continued growth in the demand for healthcare.

23 We found limited availability and consistency of data across the four nations, restricting the extent to which meaningful comparisons can be made between the health services of the UK. For this reason, and without a single overarching measure of performance, we cannot draw conclusions about which health service is achieving the best value for money. Where comparative data are available, we found that no one nation has been consistently more economic, efficient or effective across the indicators we considered.

24 The shared history and similarities between the four health services mean they offer a natural starting point to better understand the factors that affect value for money and the impact of divergent health policies and systems on performance. We consider there would be value in the four health departments carrying out further comparative work to evaluate the variation in, and understand the drivers of, value for money. To take this work forward, the health departments would need to:

- confirm that there is a desire at a national level to compare performance with a view to learning lessons and identifying good practice;
- agree the specific indicators that would provide the most insight;
- establish what data would be required to make comparisons and identify how to collect and collate these data proportionately and cost-effectively; and
- use the comparisons as a starting point to draw out key factors that drive performance and value for money.

25 To take account of the difference in population needs and patient characteristics, any systematic evaluation of variation needs to be based on consistently collected, patient-level data. For our work, we undertook exploratory analysis of two specific areas of hospital care across the four nations, showing that such comparative methodologies are possible where suitable data exists. Health departments would need, however, to undertake further work to:

- understand the differences in how existing routinely collected data are recorded and any bias this may introduce; and
- agree other areas of healthcare for which consistent, comparable patient-level data could be collected and made readily available.

Part One

Health outcomes and spending

1.1 This part of the report covers health outcomes and spending in the four nations of the UK. Any differences between the nations need to be set in the context of the make-up of their populations and their underlying health needs. Data on these factors are also set out in this part.

Health outcomes

1.2 Life expectancy, standardised mortality ratios and infant mortality rates are key measures of health outcomes. Life expectancy at birth varies significantly between the nations. Average life expectancy was between two and three years higher in England than in Scotland in 2008-2010, for men and women (**Figure 2**). There is similar variation between the nations in healthy life expectancy – the number of years a person can expect to spend in very good or good general health.

Figure 2
Life expectancy

	England	Scotland	Wales	Northern Ireland
Average life expectancy at birth, 2008–2010				
Men (Minimum – maximum[1])	78.6 (73.6 – 85.1)	75.9 (71.6 – 79.4)	77.6 (75.4 – 80.8)	77.1[2] (73.9 – 79.4)
Women (Minimum – maximum[1])	82.6 (79.1 – 89.8)	80.4 (78.0 – 82.7)	81.8 (79.7 – 83.9)	81.5[2] (79.8 – 83.2)
Average healthy life expectancy at birth, 2007–2009[3]				
Men	63.5	60.1	62.5[4]	60.5
Women	65.5	63.5[4]	62.8[4]	62.5

NOTES
1 Minimum and maximum average life expectancy are for local areas within each nation. The size of local areas vary; in larger areas extremes of life expectancy may be masked.
2 Life expectancy figures for Northern Ireland are provisional.
3 Defined as the number of years an individual can expect to spend in very good or good general health; based on survey data on self-reported health. The figures are not comparable with data previously published by the Office for National Statistics which were based on a different scale for self-reported health.
4 Not statistically significantly different from the position for England at the 95 per cent confidence level.

Source: Office for National Statistics. Full sources included in the detailed methodology, available at www.nao.org.uk/uk-healthcare-2012

1.3 There was also considerable variation in life expectancy at birth across the English regions. Average life expectancy, for men and women, was highest in the South East (79.7 and 83.5 years respectively) and lowest in the North West (77.0 and 81.1 years). At local area level across the UK, average life expectancy at birth varied by 13.5 years for men (85.1 years in Kensington and Chelsea in London compared with 71.6 years in Glasgow City) and by 11.8 years for women (89.8 years compared with 78.0 years for the same areas).

1.4 Differences in mortality rates across the four nations remain evident after adjusting for some of the variation in population demographics. 'Standardised mortality ratios' account for differences in the age and gender of the populations, with scores over 100 (the UK average) indicating more deaths than expected. In 2008, the standardised mortality ratio in Scotland was 117, higher than in the rest of the UK (Northern Ireland: 107; Wales: 103; and England: 98).[1] These relative differences in standardised mortality ratios have remained more or less unchanged since 2000.

1.5 Infant mortality rates (children dying before the age of one, per thousand live births) have fallen in England, Scotland and Wales since 2000, with the rate of decline greatest in Scotland (**Figure 3** overleaf). Infant mortality rates were 35 per cent lower in Scotland than in Northern Ireland in 2010 (3.7 compared with 5.7 deaths per thousand births). Across the English regions, the South West had the lowest infant mortality rate (3.2 deaths per thousand births), with the West Midlands the highest (5.5 deaths per thousand births).

Spending on health services

1.6 Total spending on the NHS[2] across the UK has more than doubled in cash terms in the last decade, growing from £53 billion in 2000-01 to £120 billion in 2010-11 (equivalent to an increase of around 80 per cent in real terms). Per person spending on health services increased at a similar rate over this period (**Figure 4** on page 15).

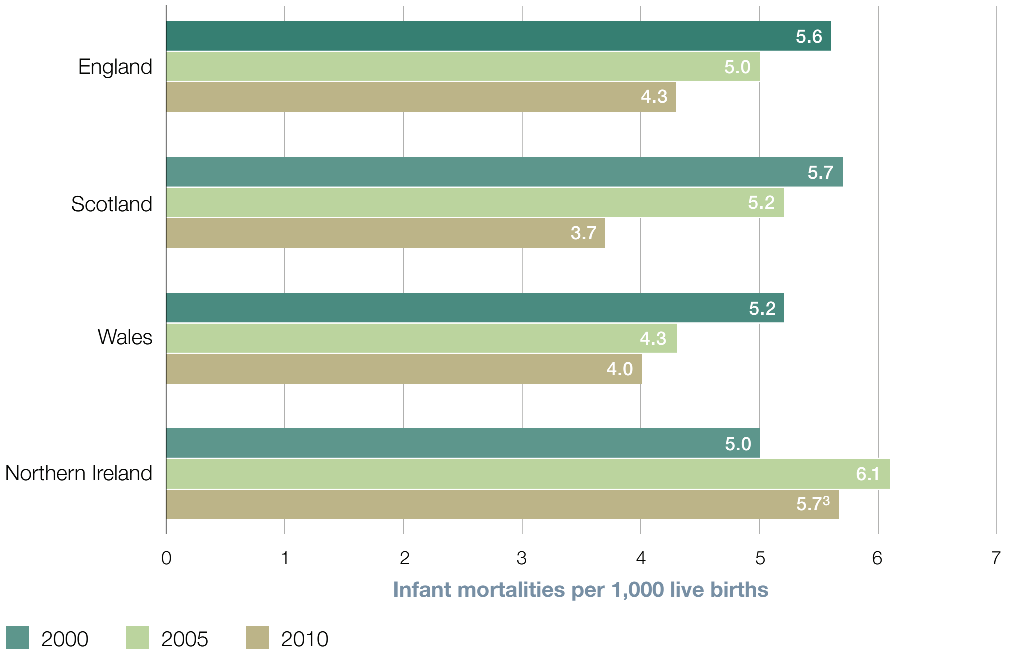
1.7 Looking forward, according to government spending plans, Wales is predicting the lowest increase per person over the four years to 2014-15 – remaining almost constant in cash terms and equating to an average annual fall of 2.3 per cent in real terms. In comparison, real terms spending is expected to fall by, on average, 0.6 per cent per year in Scotland and by 0.4 per cent per year in Northern Ireland, and to remain the same in England per year, between 2010-11 and 2014-15.

1 The data for England and Wales cover residents of those nations only; the data for Scotland and Northern Ireland cover both residents and non-residents. Source: Office for National Statistics.

2 For simplicity, in this report we use the term NHS for all four nations, although health services in Northern Ireland are provided under the organisational name Health and Social Care.

Figure 3

Infant mortalities per 1,000 live births,[1,2] 2000, 2005 and 2010



NOTES

1 As the number of births in Northern Ireland is relatively small, the mortality rates are more susceptible to random variation and so can be volatile year-on-year. At the 95 per cent confidence level, the differences between Northern Ireland rates for 2000, 2005 and 2010 are not significant; however, the rate in 2010 was significantly higher in comparison to England, Scotland and Wales.

2 Figures are not directly comparable as England and Wales data do not include non-residents whereas Northern Ireland and Scotland data include non-residents.

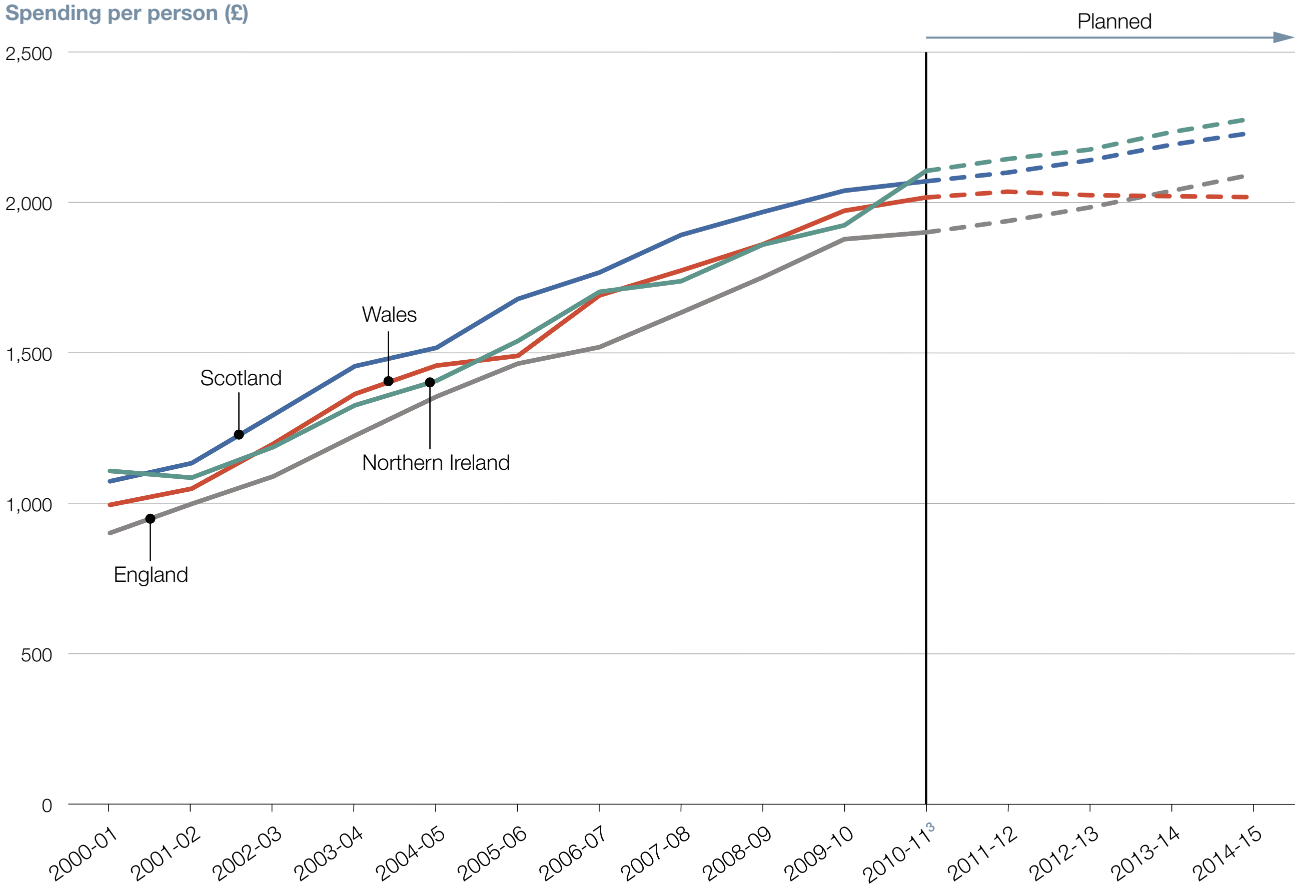
3 Data for Northern Ireland for 2010 are provisional.

Source: Office for National Statistics; Statistics for Wales

1.8 Published data for 2010-11 showed that England had the lowest spending per person on health services (£1,900) (**Figure 5** on page 16). The variation in spending per person was greater across the English regions than between the nations, with spending in London 16 per cent above the average in England (and 29 per cent higher than in the South East of England). Factors likely to affect the level of spending per person include staff pay and the concentration of teaching and specialist hospitals in particular areas.

1.9 As we were finalising this report, the Department of Health, Social Services and Public Safety (Northern Ireland) informed us that it considered that the published data for Northern Ireland on spending on health services in 2010-11 were incorrect. The Department considers that spending on health services was lower than that reported due to an error in disaggregating spending between health services and personal social services. Applying the Department's revised figure for spending on health services in 2010-11 would mean that spending per person was £1,975 and that Northern Ireland devoted 18.5 per cent of public spending to health. The Department will be seeking to have the published data for health spending in 2010-11 re-stated.

Figure 4
Actual and planned spending on health services per person,[1,2] 2000-01 to 2014-15



NOTES

1 Spending figures for 2000-01 to 2005-06 are not strictly comparable with those for 2006-07 to 2010-11.

2 Existing spending based on total identifiable expenditure on health; the trend in planned spending is derived from government NHS spending plans.

3 The Department of Health, Social Services and Public Safety (Northern Ireland) will be seeking to have the published data for health spending in 2010-11 re-stated. The Department considers that spending on health services per person was £1,975 in 2010-11.

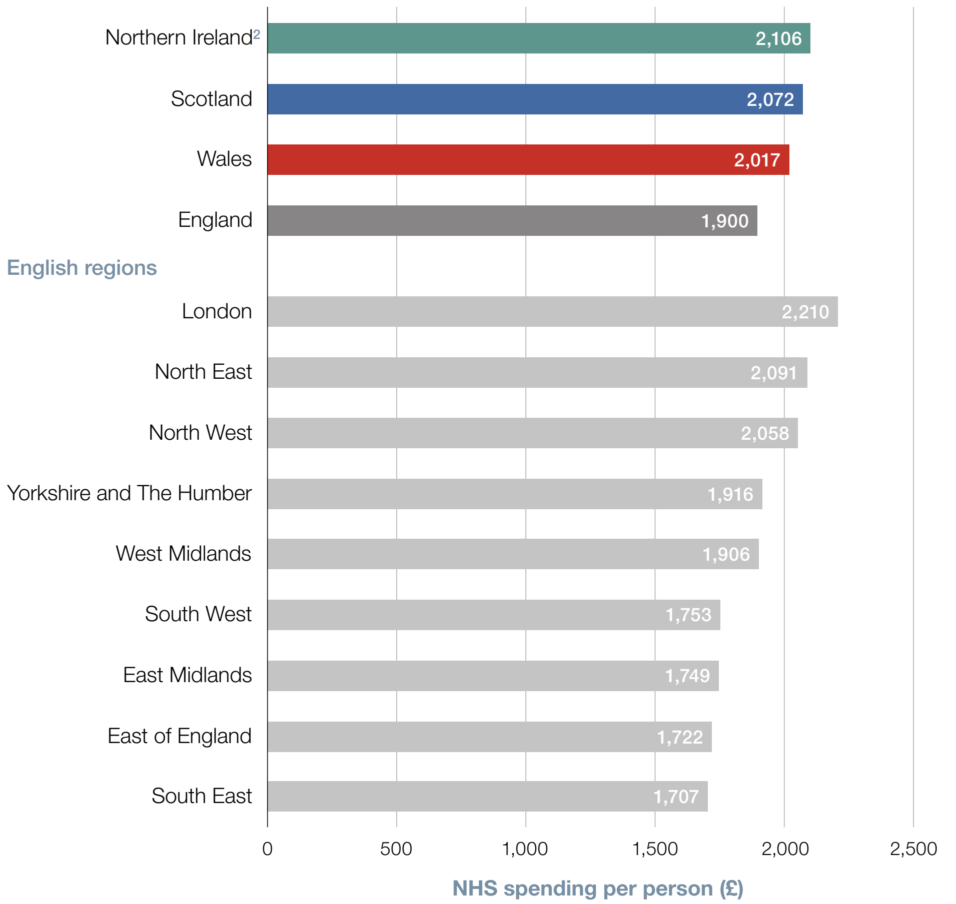
Source: HM Treasury; Scottish Government; Wales Audit Office analysis of Welsh Government data; Northern Ireland Executive

1.10 The amount of money spent on health services, and the variation between the nations and over time, is affected by differences in:

- the health needs of the nations' populations, partly reflecting demographic and behavioural factors (paragraphs 1.11 to 1.13);
- the priority given to health compared with other services, such as education and transport (paragraphs 1.14 to 1.20); and
- how health services are delivered, including the cost of purchasing resources and their productivity (Part Two of this report).

Figure 5

Spending on health services per person, by nation and English region,[1] 2010-11



NOTES

1 Figures are for total identifiable spending on health rather than NHS allocations.

2 The Department of Health, Social Services and Public Safety (Northern Ireland) will be seeking to have the published data for health spending in 2010-11 re-stated. The Department considers that spending on health services per person was £1,975 in 2010-11.

Source: HM Treasury

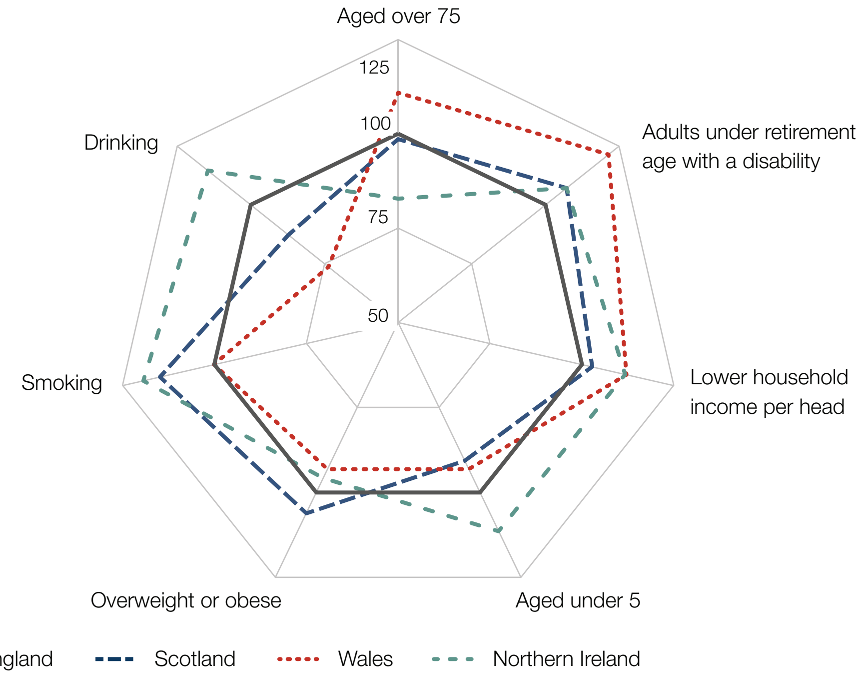
Population health needs

1.11 Many factors affect population health needs and the demand for healthcare. These factors, which are to some extent interrelated, include:

- the level of ill-health and the incidence of disease and chronic conditions;
- the age and socio-economic profile of the population;
- access to services determined by, for example, the number of people living in rural areas; and
- behavioural factors such as diet, levels of physical activity, alcohol consumption and the number of people who smoke.

1.12 Comparable data are not available on all the factors that affect health needs. Based on selected indicators where comparable data are available, we found no one nation consistently had the greatest health needs against all the measures. As illustrated in **Figure 6** – where scores further from the centre of the diagram represent higher need – the position is mixed with, for instance, a higher proportion of older people in Wales and higher levels of smoking in Northern Ireland and Scotland.

Figure 6
Population and behavioural indicators associated with increased health needs[1,2]



NOTES

1 The UK average is set at 100 with scores over 100 representing likely need above this UK average. Over four-fifths of the UK's population live in England so its scores are close to the UK average.

2 Across the indicators different years (from 2008 to 2011) are used, due to limitations in data availability.

Indicators

Aged over 75 and *Aged under 5* – proportion of population aged under five or 75 and over, mid-2010 estimation.

Adults under retirement age with a disability – based on men (women) aged 16 to 64 (59) with a disability, 2008-09.

Household income per head – gross domestic household income per person, 2009, with scores furthest from the centre representing lower income. Figures are provisional.

Overweight or obese – proportion of adults with a body mass index classed as 'overweight or obese', 2008. Data for Northern Ireland are for 2010-11. Data for Wales are measured by a different process.

Smoking – proportion of adults self-defined as a current smoker, 2008. Source figures are rounded to nearest percentage point.

Drinking – proportion of men (women) with maximum daily alcohol consumption of more than eight (six) units at least once in the last week among adults aged 16 and over, 2008.

Source: Office for National Statistics; Department for Work and Pensions; Department of Health, Social Services and Public Safety (Northern Ireland)

1.13 We commissioned an exploratory exercise to estimate relative health needs at local level across the four nations.[3] Combining data on a range of factors associated with variations in health needs, including measures of population age, levels of disability and wealth, the analysis suggested that there was substantial difference in health needs between the nations. On the basis of the data available, Northern Ireland was estimated as having the highest average need per person with England the lowest (**Figure 7**). The local areas with the highest and lowest needs were both in England, which accounted for the majority of the areas. Local areas vary in size and in larger areas, in particular, extremes of need may be masked.

Figure 7
Estimation of relative health need per person[1]

	England	Scotland	Wales	Northern Ireland
Average need[2]	0.91	0.98	1.07	1.11
Minimum–maximum need[3,4]	0.63–1.27	0.80–1.16	0.92–1.24	1.00–1.26

NOTES
1 The figures are relative scores with higher numbers representing higher estimated health needs per person based on data from 2007-08 to 2009-10. Absolute figures are nominal.
2 Population weighted mean average; UK average 0.93.
3 Minimum and maximum relative need for local health areas within each nation for the period in question (152 primary care trusts in England, 14 heath boards in Scotland, 7 health boards in Wales, and 4 health and social care boards in Northern Ireland).
4 The size of local health areas vary (see Figure 9); due to less aggregation, smaller areas are more likely to have extremes of need.

Source: Deloitte analysis for National Audit Office

Policy and funding priorities

1.14 In 1999, responsibility for certain services, including health, was devolved to Scotland, Wales and Northern Ireland.[4] Each nation has its own government department to develop and implement the health policy and priorities of its government. The *Health and Social Care Directorates* in Scotland, the *Department of Health, Social Services and Children* in Wales, and the *Department of Health, Social Services and Public Safety* in Northern Ireland are each accountable to the elected body in their nation. The *Department of Health* in England is accountable to the UK Parliament.

3 Further information on this methodology is available at: www.nao.org.uk/uk-healthcare-2012.
4 The Northern Ireland Assembly has, however, been suspended for long periods, including from October 2002 to May 2007. During these times the UK Parliament regained full responsibility for devolved matters, including health.

Health policy priorities

1.15 Health priorities vary across the nations at any one time and within nations over time, although there is overlap in key areas. Public health, waiting times, cancer services and mental health have regularly been priorities in all nations in the last ten years. Comparisons of performance and outcomes between the nations need to be viewed in the context of these variations in priorities. For instance, nations that make public health campaigns a priority, and commit more funding to them, can expect to see the impact on health outcomes only in the longer term.

Funding priorities

1.16 Scotland, Wales and Northern Ireland receive block grants from HM Treasury to fund public services.[5] The amount of money provided by HM Treasury is primarily based on historical levels of funding, with annual changes calculated using the 'Barnett Formula', rather than on the basis of current population needs. For public services covered by the Barnett Formula, where there is an increase or decrease in the funding for the relevant government department in England, the three other nations receive the same absolute increase or decrease in per person funding.

1.17 So, for example, if funding for health services in England increases by £100 per person, the devolved administrations receive an additional £100 per person through the Barnett Formula. The devolved administrations are not, however, obliged to spend the increase in funding on the same purpose as that which triggered the additional payment and are free to allocate money according to their chosen priorities.

1.18 The administrations in the four nations are free to choose what proportion of their overall budget to devote to health. Since 2005-06, the proportion spent on health by each nation has remained relatively constant at between 18 and 22 per cent of all public spending.[6] Over the last five years, Northern Ireland has had the most variability in health spending from one year to the next. England has consistently had the largest proportion of public spending devoted to health (22.0 per cent in 2010-11) with Northern Ireland the lowest (**Figure 8** overleaf).

1.19 In addition to funding allocated by the administrations, the NHS can generate income by charging patients, including for prescriptions, dentistry and private practice work. The nations have different charging policies. Only patients in England now pay for prescriptions, although in practice around 90 per cent of prescriptions are free as hospital inpatients, people under 16 or over 59, and those meeting certain other eligibility criteria do not have to pay. In 2010-11, prescription charges raised £450 million for the NHS in England.

5 Additional funding comes from local revenues and taxes, the European Commission and borrowing by local authorities and other public bodies.

6 Total public spending in each nation includes spending on some areas that the devolved nations do not control, such as welfare benefits.

Figure 8
Public spending on health services, 2010-11

	England	Scotland	Wales	Northern Ireland[1]
Spending on public services				
Total spending per person (£)	8,634	10,165	9,947	10,668
Spending on health services				
Percentage of public spending (%)	**22.0**	**20.4**	**20.3**	**19.7**
Total spending (£m)	99,249	10,821	6,065	3,790
Spending per person (£)	1,900	2,072	2,017	2,106
Relative spending on health compared to England	100	109	106	111

NOTE

1 The Department of Health, Social Services and Public Safety (Northern Ireland) will be seeking to have the published data for health spending in 2010-11 re-stated. The Department considers that spending on health services in 2010-11 was £3,554 million (£1,975 per person, 104 relative to England = 100) and that Northern Ireland devoted 18.5 per cent of public spending to health.

Source: HM Treasury

1.20 Also in 2010-11, private practice patients treated within NHS hospitals in England generated income of £428 million (0.8 per cent of hospital revenues, compared with 0.4 per cent in Wales and an estimated 0.1 per cent in Scotland and Northern Ireland).[7] A different scheme for dental charges is used in Scotland and Northern Ireland to that in England (where income totalled £617 million in 2010-11) and Wales, and comparable data are not available.

7 Updated from R Harker, *NHS funding and expenditure*, House of Commons Library, April 2012. Hospital revenues exclude income from non-patient care activities.

Part Two

Delivery and performance of health services

2.1 This part of the report covers aspects of the delivery and performance of health services across the four nations of the UK, specifically:

- the organisation of health services;
- the cost and volume of health service resources;
- efficiency and productivity in the use of health service resources; and
- the quality and effectiveness of the healthcare provided.

Organisation of health services

2.2 Across the UK, primary care is predominantly provided by independent NHS contractors, such as GP and dental practices. There are also a variety of providers of specialist secondary services, such as acute and mental health hospitals and ambulance services. The organisation of health services in the four nations is shown in Appendix Two. Except in Northern Ireland, the majority of services are organised at a local (sub-national) level. These local health areas vary in terms of the size of population they cover (**Figure 9**).

Figure 9
Local health areas

	England[1]	Scotland	Wales	Northern Ireland[2]
Total population in 2010, million (% of UK population)	**52.2** (83.9)	**5.2** (8.4)	**3.0** (4.8)	**1.8** (2.9)
Number of local health areas	**151 primary care trusts**	**14 health boards**	**7 health boards**	**1 health and social care board**
Average population covered	350,000	370,000	430,000	1.8 million
Smallest – largest population covered	91,000 – 1.3 million	20,000 – 1.2 million	135,000 – 689,000	n/a

NOTES

1 Under the Health and Social Care Act 2012, primary care trusts in England will be replaced by clinical commissioning groups from April 2013. There are expected to be 212 such groups.

2 In Northern Ireland, health services are commissioned at a national level by a single organisation.

Source: Office for National Statistics; General Register Office for Scotland; Public Health Wales

2.3 While the structures put in place when the NHS was created in 1948 were similar across the UK, there are now some notable differences caused by:

- the nations' autonomy over some aspects of delivery before 1999, including the integration of health and social care in Northern Ireland in 1974; and
- more substantial policy and performance management divergence since devolution in 1999, in particular in the use of competition between healthcare providers and payment-by-activity reimbursement frameworks.

Competition in health services

2.4 The use of competition between healthcare providers, and choice for patients, varies considerably across the UK, reflecting differences in the predominant political ethos of each nation's governments. During the 1990s, separate organisations were given responsibility for planning and purchasing (commissioning) and providing health services across the UK, thereby creating an 'internal market'. This contractual relationship replaced the previous arrangements whereby health authorities both commissioned health services and managed the hospitals that provided the services.

2.5 Since devolution, the governments in Scotland and Wales have reintegrated the commissioners and providers of health services so that the health boards plan and deliver services. The internal market was removed in 2004 in Scotland and in 2009 in Wales, but remains in Northern Ireland.

2.6 In England the role of competition has increased in the last decade with, for instance, the private sector having a greater role in providing NHS-funded healthcare. In addition, some hospital trusts in England have been granted greater autonomy through foundation trust status. This gives them more managerial and financial freedom, and makes them directly accountable to the UK Parliament.

Payment frameworks

2.7 Since 2004, all four nations have used a voluntary incentive scheme known as the 'Quality and Outcomes Framework' to pay GP practices according to how well they care for their patients. The Framework currently comprises 146 process, activity and outcome measures.

2.8 Around a quarter of GP practice income across the UK is provided through the Quality and Outcomes Framework. The remainder is based on the size and weighted needs of each practice's patient register. For example, a practice with a large elderly population will get more funding than a practice with a small, younger population, who are assumed to have lower health needs.

2.9 Hospital and other secondary healthcare providers in Scotland, Wales and Northern Ireland are primarily funded through allocations, which are not directly linked to the cost of specific units of care. Since 2003, England has used an alternative funding framework, known as 'Payment by Results', whereby hospitals are reimbursed based on a national price for a given unit of activity. Payment by Results currently provides over half of the income of an average hospital in England. The remainder comes from locally negotiated block contracts with commissioners and other activities such as teaching, training and research.

Cost and volume of health service resources

2.10 As spending has risen, health service inputs, including the number of staff, have also increased over the last ten years, although the timing and scale of these increases have varied. Staff costs are estimated to account for around two-thirds of spending on health services. The health departments in the four nations can influence the economy with which resources are purchased in both primary and hospital care by, for example, setting national workforce contracts.

2.11 This section of the report sets out data on:

- the income and number of GPs and dentists;
- the pay and number of hospital staff; and
- non-staff costs.

No comparable data are available on some key areas such as vacancy rates, which may indicate staff shortages, and the 'market forces factor', which measures external cost pressures that affect pay rates.

Income and number of GPs and dentists

2.12 Most providers of primary care are independent contractors, with staff paid from the practice income. There is substantial variation between the nations in the pay levels of dentists and particularly of GPs. In 2009-10, GPs in England received the highest average taxable income of £109,400, 22 per cent higher than GPs in Scotland, who had the lowest reported income (**Figure 10** overleaf). Some of the variations in pay may be explained by the higher funding received by practices with, for instance: larger patient registers (Scotland has the fewest patients per GP); higher external cost pressures arising from local employment conditions; and contracts for providing additional services. The variations could also be due, in part, to the effect of part-time working, which may vary between the nations.

Figure 10

Average (mean) taxable income of GPs and dentists, 2009-10

	GPs[1,2] (£)	Dentists[2,3] (£)
England	109,400	85,300
Scotland	89,500	79,300
Wales	93,500	77,600
Northern Ireland	91,400	86,500

NOTES

1 Refers to contractor GPs on General Medical Services (GMS) and Personal Medical Serivces (PMS) contracts in England and Scotland and GMS contracts in Wales and Northern Ireland (where PMS contracts do not exist).

2 Figures relate to NHS and private, full and part-time work.

3 The data for dentists are for those who have carried out NHS work in 2009-10. Dentists who spend more than 75 per cent of dental time on NHS dentistry have average (mean) taxable incomes in England and Wales of £89,200, in Scotland of £85,600 and in Northern Ireland of £66,400. The contractual arrangements for dentists vary between the nations so income data are not directly comparable.

Source: The Health and Social Care Information Centre

2.13 Across the UK the number of GPs per person increased between 2004 and 2009. The rate of increase varied between the nations, with a higher rise in England (10 per cent) than in Scotland and Wales (5 per cent) and Northern Ireland (3 per cent).[8] These figures are based on headcount and do not account for differences in, and changes to, levels of part-time working.

2.14 Scotland had the highest number of GPs per person in both 2004 and 2009. This may be explained, in part, by its rurality, with more GPs required in areas of lower population density to ensure similar proximity to services. In 2009, the number of GPs per person in Scotland (measured by headcount) was 23 per cent higher than in Wales and Northern Ireland (80 compared with 65 per 100,000 people). The range between the English regions and the four nations is similar (**Figure 11**). In 2010, Scotland had more dentists than the other nations – 55 per 100,000 people – compared with 49 in Northern Ireland, 44 in Wales and 42 in England.[9]

Pay and number of hospital staff

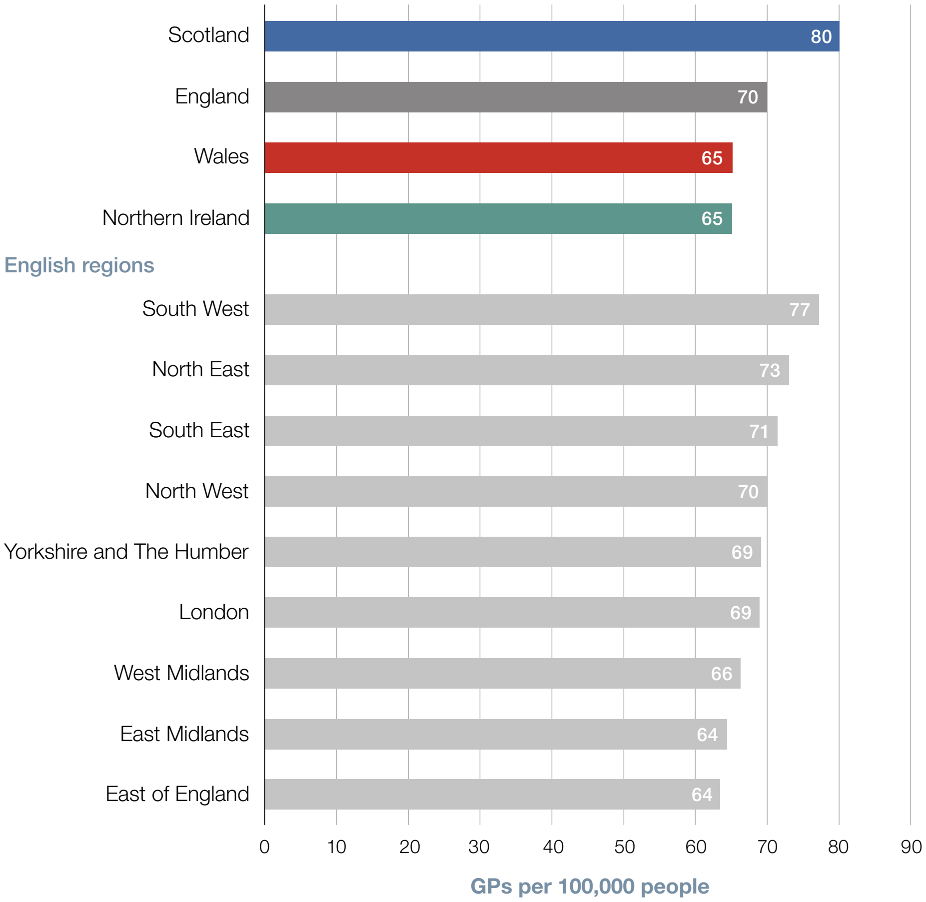
2.15 Most NHS hospital staff in the UK are employed through similar nationally negotiated contracts and, as a result, pay bands are similar in all four nations. No comparable data are published on the distribution of staff across these pay bands. In England, foundation trust hospitals are able to modify staff contracts and pay rates, although there is limited evidence of this autonomy being used to date.

8 The Health and Social Care Information Centre.

9 Office for National Statistics; Information Services Division Scotland; Northern Ireland Neighbourhood Information Service.

Figure 11

Number of GPs per 100,000 people,[1] by nation and English region, 2009



NOTE

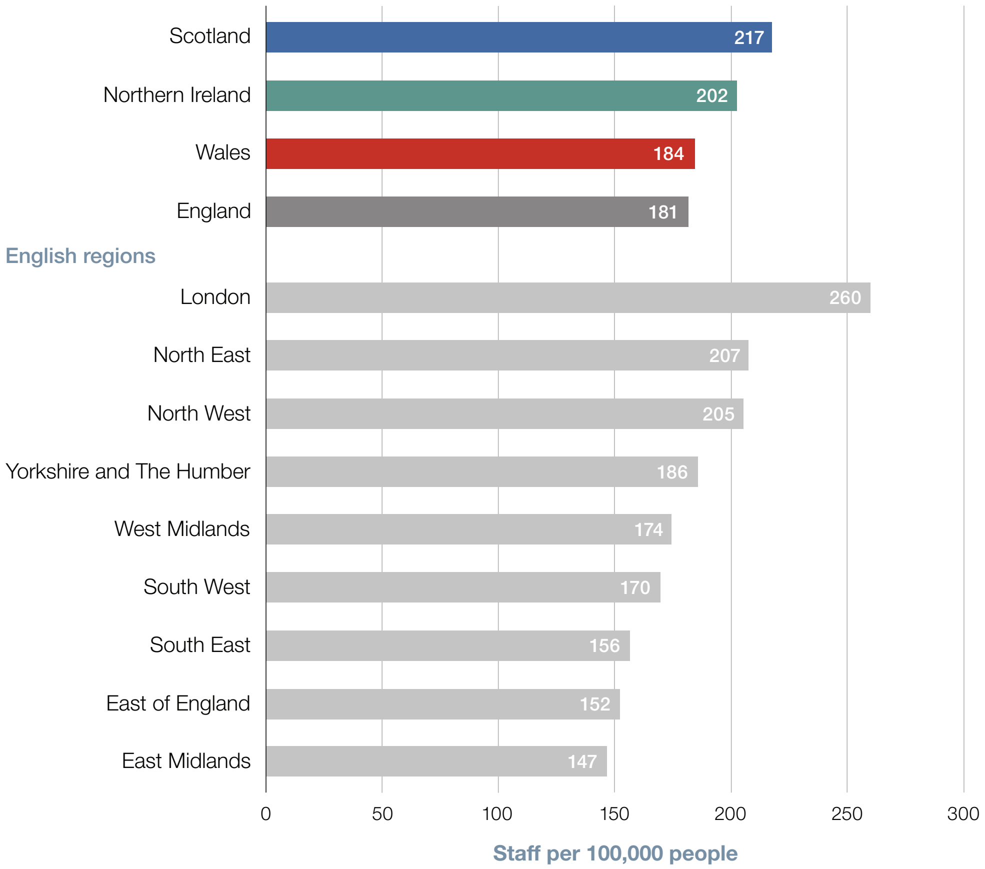
1 Staff numbers are headcount and do not account for the effect of part-time working which may vary across the nations and regions. However, the figures exclude retainees (often GPs working part-time after, for example, returning from maternity leave), locums, GPs in training, and those working only in out-of-hours services.

Source: The Health and Social Care Information Centre; Office for National Statistics

2.16 The number of medical hospital staff per 100,000 people increased substantially in each nation in the decade to 2009, although the available data cannot be used to compare the nations over time. This is because the data are not strictly consistent over time due to changes in how staff are categorised. In 2009, the number of medical hospital staff was 20 per cent higher in Scotland than in England (217 compared with 181 staff per 100,000 people). There was a greater range between the English regions, with 260 staff per 100,000 people in London, 77 per cent higher than the 147 staff in the East Midlands. One of the factors likely to affect the number of staff is the concentration of teaching and specialist hospitals in particular areas (**Figure 12**).

Figure 12

Number of medical hospital staff per 100,000 people,[1,2,3] by nation and English region,[4] 2009



NOTES

1 The NHS Hospital and Community Health Service staff numbers quoted are for directly employed full-time equivalent and include some hospital dental staff, accounting for between 2 per cent (England) and 6 per cent (Scotland) of total medical hospital staff.

2 Staff classification can vary between nations and therefore caution should be applied when making comparisons.

3 Figures exclude staff in independent sector providers of NHS care, staff in NHS hospitals who are employed by non-NHS organisations, and bank staff; levels of these staff will vary by nation and region.

4 Data for the English regions, which aggregate to an average of 186 staff per 100,000 people, are not fully comparable with the national figures.

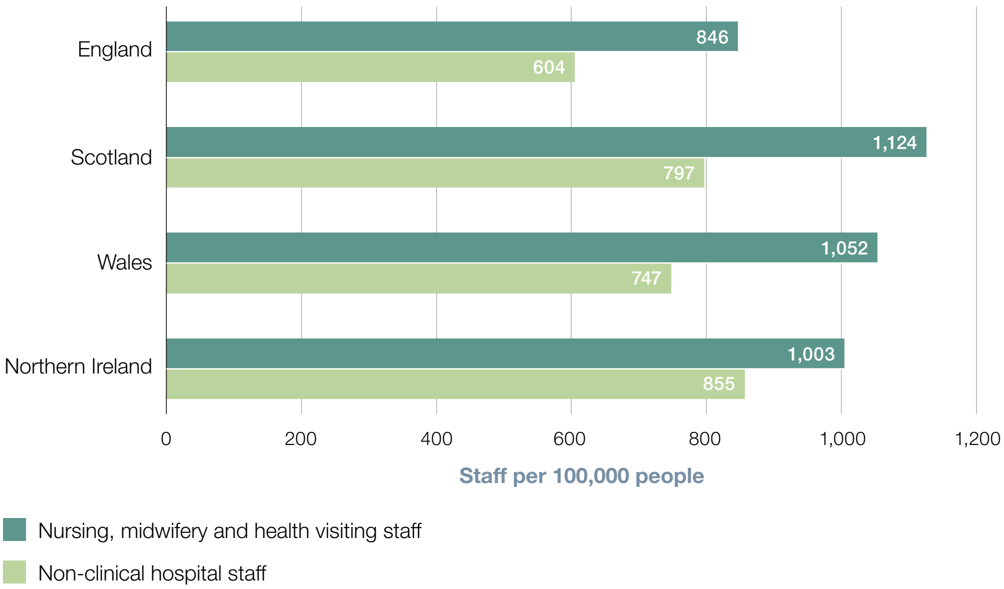
Source: Office for National Statistics; The Health and Social Care Information Centre

2.17 As a result of changes in the way that data are collected, figures for the number of nursing, midwifery and health visiting staff are not comparable between 1999 and 2009. Comparing the nations, Scotland had the highest number of nursing, midwifery and health visiting staff per 100,000 people in both 1999 and 2009, and England the lowest. In 2009, there were 33 per cent more of these staff in Scotland than in England (1,124 compared with 846 staff per 100,000 people) (**Figure 13**).

2.18 Data for the number of non-clinical hospital workers, such as NHS managers and administrative staff, are also not comparable over time. Comparing the nations, the number of non-clinical staff in Northern Ireland in 2009 was 42 per cent higher than in England (855 compared with 604 staff per 100,000 people) (Figure 13).

Figure 13

Number of nursing, midwifery and health visiting staff and non-clinical hospital staff per 100,000 people,[1, 2, 3] 2009



NOTES

1 The NHS Hospital and Community Health Service staff numbers quoted are for directly employed full-time equivalent. Staff classification can vary between nations and therefore caution should be applied when making comparisons.

2 Non-clinical staff includes senior management, administrative, estates, domestic and catering, general payments and staff with other miscellaneous occupations.

3 Figures exclude staff in independent sector providers of NHS care, staff in NHS hospitals who are employed by non-NHS organisations, and bank staff; levels of these staff will vary by nation.

Source: Office for National Statistics

Non-staff costs

2.19 Non-staff costs are estimated to account for around one third of NHS spending in the UK. Comparable data on such costs are limited, but information is available on capital spending – on land, buildings and equipment – which represents around 5 per cent of spending. Levels of capital spending vary considerably from one year to the next. However, between 2003-04 and 2010-11, Northern Ireland had the highest aggregate levels of capital spending at £98 per person, compared with £84 in Scotland, £80 in Wales, and £70 in England.[10]

2.20 Limited comparable information is available on the cost of purchasing drugs and healthcare consumables, such as syringes and other medical supplies. Data on the cost of prescription items in 2009 indicate that the cost of purchasing drugs varied considerably between the nations. The cost per item was £3.70 higher in Northern Ireland than in Wales, where £8.61 per item was the cheapest across the nations (**Figure 14**). The variations in cost may be caused, in part, by differences in the drugs prescribed. However, when we examined the costs of a group of commonly prescribed drugs, the cost per item still varied between the nations, with the cost lowest in Wales.[11]

2.21 The number of prescription items per person in Wales in 2009 was the highest at 22.5 items per person, almost six prescription items more than in Scotland. Some of the variation may be due to differences in prescribing practices with the average number of doses per prescription item potentially differing between the nations (Figure 14).

Figure 14
Prescription items: number per person and cost per item, 2009

	Average number of prescription items per person[1]	Average cost per prescription item[2] (£)
England	17.1	9.64
Scotland	16.6	11.28
Wales	22.5	8.61
Northern Ireland	18.9	12.31

NOTES

1 Figures relate to NHS prescription items dispensed by community pharmacies, appliance contractors (appliance suppliers in Scotland and in Northern Ireland) and dispensing doctors, and prescriptions submitted by prescribing doctors for items personally administered, known as stock orders in Scotland and Northern Ireland.

2 Refers to net ingredient cost: the cost of medicines before any discounts and does not include any dispensing costs or fees. This is known as gross ingredient cost in Scotland and ingredient cost in Northern Ireland.

Source: Office for National Statistics

10 HM Treasury.

11 Data not available for Northern Ireland.

Efficiency and productivity in the use of health service resources

2.22 There are currently no routinely published, comparable measures of efficiency or productivity for the four nations for either primary or hospital care. The Office for National Statistics does publish a measure of healthcare productivity for the UK. This is defined as the ratio of the volume of resources going into the health services (inputs) and the quantity of healthcare provided (outputs) adjusted for some aspects of quality. The measure covered only England when it was first published but now includes data for the whole of the UK, although the data for Scotland, Wales and Northern Ireland are less complete than for England.[12] Using this measure suggests that productivity has remained almost constant with an average annual decrease of 0.1 per cent between 2000 and 2009.[13]

2.23 The Office for National Statistics productivity measure is not disaggregated by nation or region so comparisons of performance cannot be made. Therefore, without a comparable aggregate measure, we had to assess efficiency within primary and hospital care in the four nations by presenting data on specific aspects of performance. It should be stressed that such measures do not take account of the complexity or quality of the healthcare provided.

2.24 This section of the report sets out data on:

- whether staff are utilised efficiently; and
- using hospital beds more efficiently.

The measures of efficiency presented do not cover certain aspects of healthcare, such as community care, since no comparable activity data are available in these areas. England and Northern Ireland produce a measure of hospital efficiency (known as a 'reference cost index'), based on the costs of producing certain units of care. However, these are not comparable and do not cover all of the health services provided.

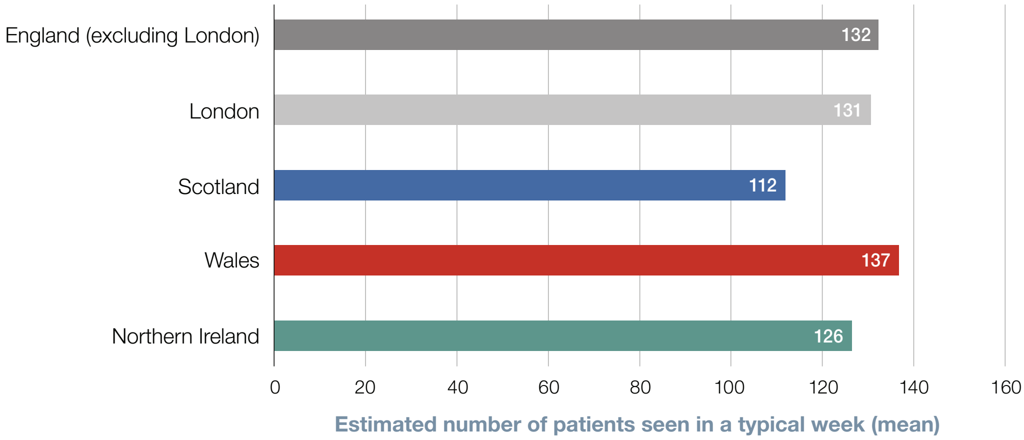
Utilising staff efficiently

2.25 A measure of efficiency within primary care is the number of patients seen by GPs. In the absence of routinely collected comparable data, we report findings from a 2009 survey. GPs in Wales typically spent an estimated 70 per cent of their time on face-to-face contacts with patients, compared with 68 per cent in England, 67 per cent in Northern Ireland and 65 per cent in Scotland.[14] Although GPs in Wales also reported that they worked slightly fewer hours than their counterparts in the other nations, overall they estimated seeing more patients per week on average (137), with GPs in Scotland seeing the fewest (112) (**Figure 15** overleaf). These differences in activity may, at least partly, reflect the differences in the number of GPs per person (as shown in Figure 11). The survey did not take account of the complexity or quality of the consultations.

12 For example, the quality adjustments are based on data only from England.
13 Office for National Statistics, *Public service output, inputs and productivity: healthcare*, March 2011.
14 Commonwealth Fund survey based on 1,062 responses from GPs in the UK, with 576 in England (including 186 in London), 197 in Scotland, 158 in Wales and 131 in Northern Ireland.

Figure 15

Estimated number of patients seen per GP in a typical week,[1,2] 2009



NOTES

1 Staff numbers are headcount and do not account for the effect of part-time working which may vary across the nations.

2 Data for London were collected separately to the rest of England and, therefore, London appears separately.

Source: Aston Business School

2.26 We also reviewed efficiency within hospitals using a measure of activity per medical staff member. Activity levels were calculated by combining the number of outpatient, inpatient and day case admissions based on the estimated average costs for each type of activity. This measure, which does not take account of the complexity or quality of care or differences in the grade-mix of staff, suggests that levels of activity per staff in 2008-09 were highest in England and lowest in Scotland (**Figure 16**).

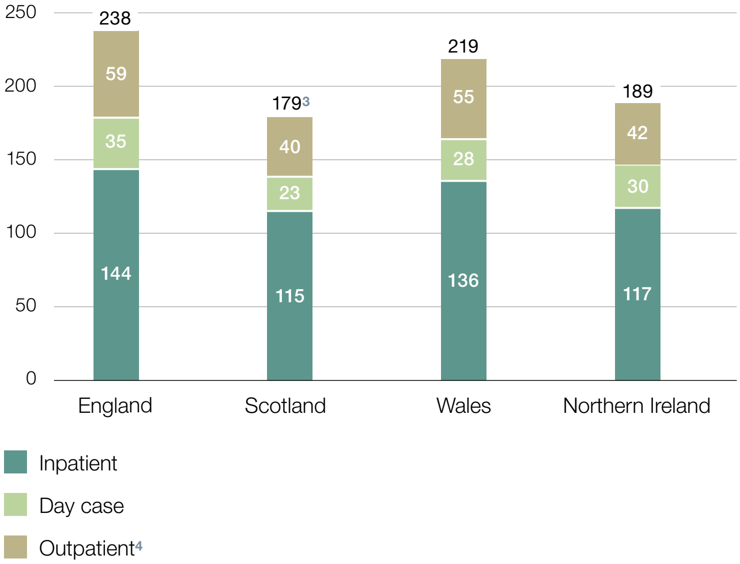
Using hospital beds more efficiently

2.27 As well as securing greater efficiency by increasing activity levels per staff member, the NHS can make more efficient use of hospital beds. For example, hospitals can reduce lengths of stay and conduct more activity as day cases, provided there is no clinical reason to keep a patient in hospital.

Figure 16

Hospital activity per medical staff,[1,2] 2008-09

Cost-weighted activity per hospital medical staff member (£000s)



NOTES

1 Cost-weighted activity index, covering Hospital and Community Health Services including hospital inpatient, day case and outpatient episodes. Weighting based on estimated average cost for inpatient, day case and outpatient activity published in 2008-09 English reference cost data.

2 Detailed notes on the comparability of medical staff numbers are included in Figure 12. Figures include activity from, but exclude staff in, independent and private sector providers of NHS care. Levels of independent and private sector involvement vary by nation (estimated at around 1 to 2 per cent of hospital services in England in 2008-09), with higher involvement likely to inflate performance against this measure.

3 Total activity differs from the sum of the three constituent activities due to rounding.

4 Outpatient activity excludes non-consultant led services, the levels of which will vary between the nations.

Source: Office for National Statistics; Department of Health (England); The Health and Social Care Information Centre; Information Services Division Scotland; Statistics for Wales; Department of Health, Social Services and Public Safety (Northern Ireland)

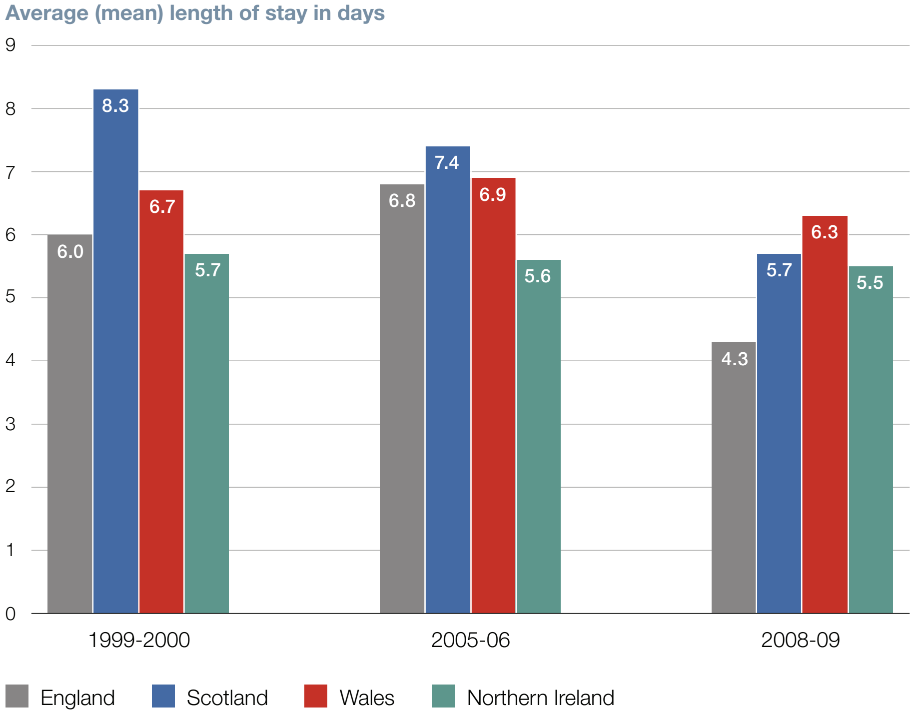
Reducing hospital lengths of stay

2.28 Reducing the length of time patients stay in hospital can reduce the cost per treatment as well as improving the quality of experience for patients. Lengths of stay are, however, influenced by the availability of community and social care (for which no comparable data are currently available), as well as by hospital performance. Patients are more likely to have their discharge delayed in areas where appropriate support services are not available.

2.29 Average lengths of stay have varied across the UK in the last decade. As a result of changes in the way that data are collected, figures are not comparable between years. Comparing the nations, Northern Ireland had the lowest average length of stay for acute hospital care in the first two years we examined. England had the lowest average length of stay in 2008-09, at 4.3 days compared with 6.3 days in Wales, which had the highest (**Figure 17**).

Figure 17

Average hospital lengths of stay,[1] 1999-2000, 2005-06[2] and 2008-09



NOTES

1 The definitions used for these data changed between years and so data are not directly comparable over time. For instance, 1999-2000 data are for non-psychiatric specialties whereas 2008-09 data are for acute specialties excluding mental illness, learning disability, maternity and geriatric care.

2 For 2005-06, Wales and Scotland data relate to acute specialties only, and Northern Ireland data cover the calendar year 2006 and exclude mental health and learning disability programmes of care. England data are for all specialties.

Source: Office for National Statistics

2.30 To investigate the scope for reducing lengths of stay, we used patient-level data to analyse two specific areas of hospital care – births and hip replacements. Our analysis indicated that, for these two areas of care, Wales generally had lower lengths of stay (shortest for hip replacements, second shortest for births). As well as differences between the nations, there was also substantial variation at hospital or health area level within each nation (**Figure 18** overleaf).

2.31 The variations in length of stay could not be wholly explained by differences in patient characteristics (such as age and socio-economic status) or case-mix (such as the proportion of complicated procedures). For both births and hip replacements, even after adjusting for these factors, all four nations had hospitals (or health areas) with significantly higher lengths of stay compared with their national average. While some of the variation in length of stay may be due to other factors that were not accounted for, such as the accessibility of post-hospital care, the results do suggest varying performance and, therefore, scope for improved efficiency.

2.32 We also investigated what factors might be associated with lower lengths of stay. The analysis suggested that hospitals (or health areas) providing higher quality care had, on average, shorter hospital stays. For instance, hospitals with lower lengths of stay tended to have lower death rates and higher patient satisfaction scores.[15]

Conducting more activity as day cases

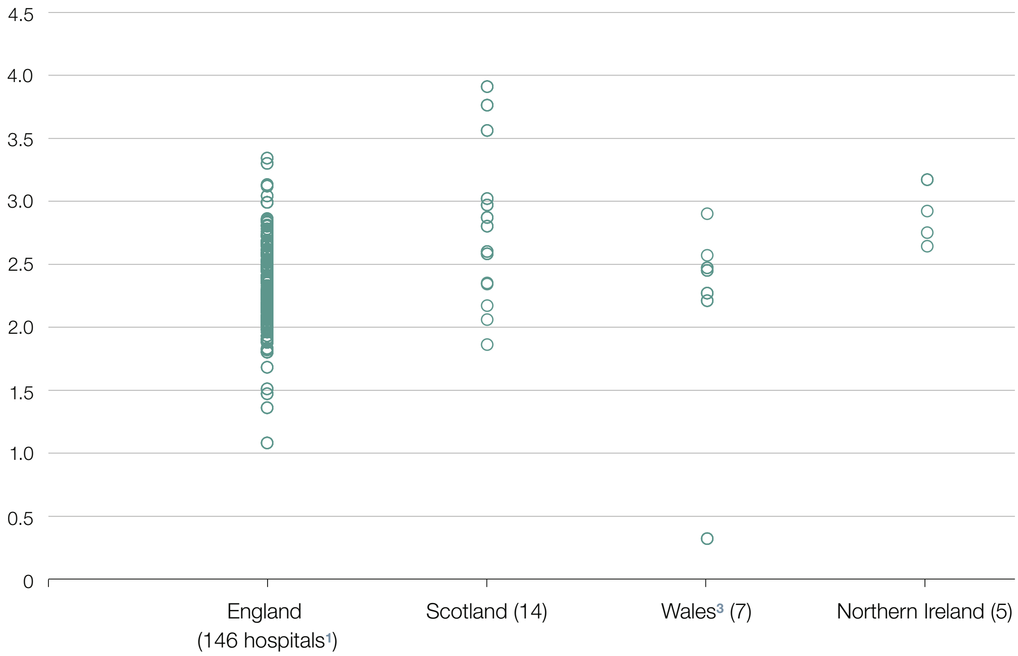
2.33 Day cases are planned treatments or operations where the patient occupies a hospital bed for part of the day but returns home on the day of admission. Our preferred approach would have been to compare the nations on the basis of day cases as a proportion of elective (i.e. non-emergency) admissions, but the data currently available are not comparable due to differences in definitions. Examining each individual nation's performance over time showed that the proportion of elective admissions conducted as day cases increased in all nations between 2005-06 and 2009-10.

2.34 Comparable data are available on day cases as a proportion of all acute hospital admissions. In 2008-09, Northern Ireland treated the highest proportion of these admissions as day cases (41.8 per cent) (**Figure 19** on page 35). It should be noted, however, that some healthcare provided as day cases could be delivered more efficiently in outpatient, primary or community care settings; however, no comparable data are available on the transfer of activity from one care setting to another.

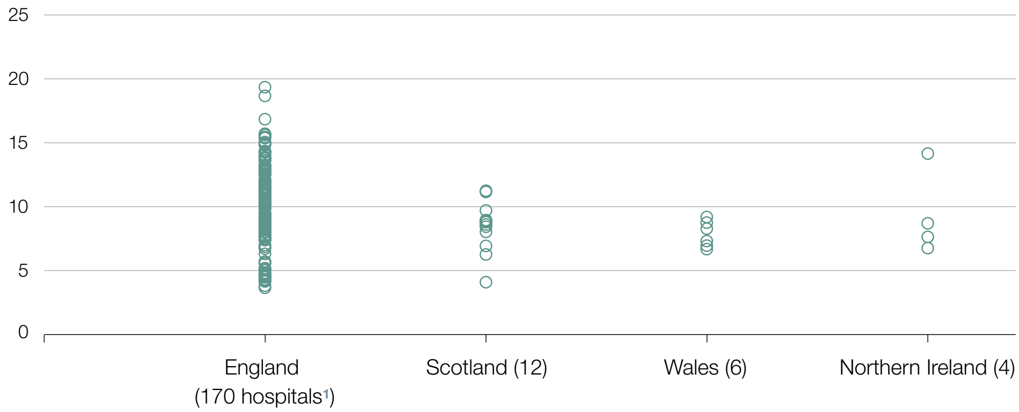
15 The association with patient satisfaction was tested for England only and measured using patient reported outcome measures (PROMs) available at: www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1583

Figure 18
Average length of stay for births and hip replacements, by hospital or health area[1] within each nation,[2] 2009-10

Births – mean length of stay, days



Hip replacements – mean length of stay, days



NOTES

1 Each dot represents a hospital trust, health board or health and social care trust; where more than one hospital have the same performance they may appear as a single dot. Trusts and boards with fewer than 100 cases have been excluded.

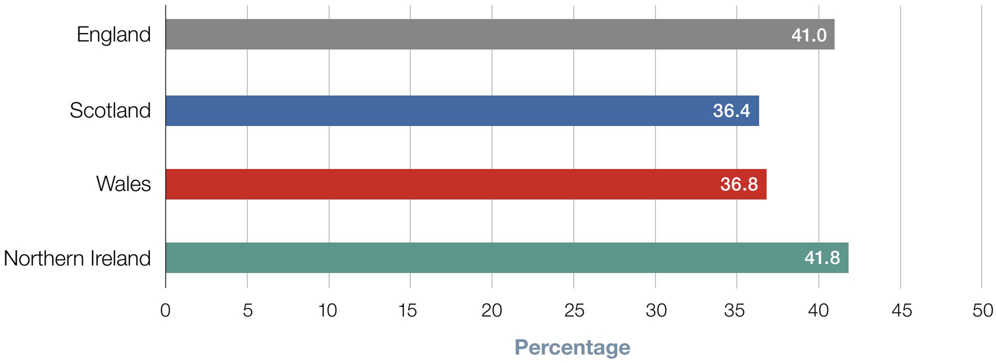
2 Figures are not adjusted for differences in patient characteristics (e.g. age and proximity to health services after discharge) or case-mix (e.g. complexity of procedure including, for births, mode of delivery).

3 The outlier for the Welsh births data is due to the health board not having a district general hospital (so more patients are transferred out, reducing their length of stay) and, to some extent, being small (so more random variation).

Source: Analysis of data provided by The Health and Social Care Information Centre; Information Services Division Scotland; Statistics for Wales; Department of Health, Social Services and Public Safety (Northern Ireland)

Figure 19

Day cases as a proportion of all acute hospital admissions,[1,2] 2008-09



NOTES

1 Hospital admissions exclude outpatient attendances.

2 Independent and private sector provision of NHS care is not included; the levels of such provision vary by nation (estimated at around 1 to 2 per cent of hospital services in England in 2008-09).

Source: Office for National Statistics

Reducing bed numbers

2.35 By conducting more activity as day cases or reducing lengths of stay while maintaining bed occupancy levels, the NHS can reduce the number of beds required to provide the same level of health services and thereby improve efficiency. Across all four nations, bed occupancy rates were similar and did not vary greatly between 2000-01 and 2009-10. Rates were highest in England, at 85 per cent in 2009-10, and similar in the other nations (82 per cent in Northern Ireland, 81 per cent in Wales, and 80 per cent in Scotland).[16]

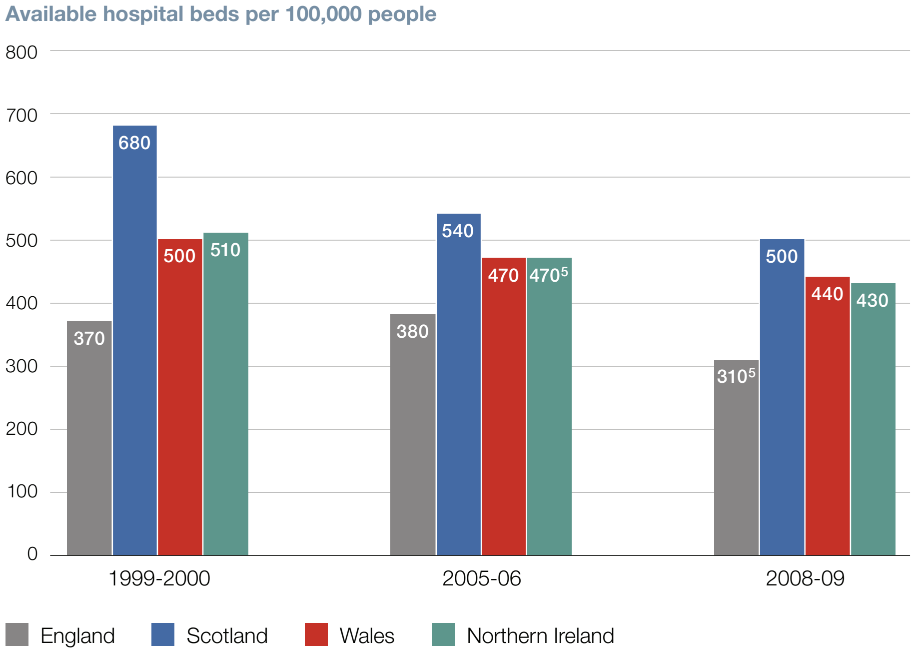
2.36 Due to changes in the way that data are collected, figures for the number of available hospital beds are not comparable between years. Comparing the nations, Scotland has consistently had the highest number of beds per 100,000 people (500 in 2008-09) and England the fewest (310) (**Figure 20** overleaf). This may be partly due to the relatively high number of beds for elderly patients in Scotland, compared with elsewhere in the UK. There was less variation between the English regions – a difference of 154 beds per 100,000 people between the North East (409) and the South East (255).[17]

16 Data are for all specialties. Source: Department of Health (England); Information Services Division Scotland; Statistics for Wales; Department of Health, Social Services and Public Safety (Northern Ireland).

17 Department of Health (England).

Figure 20

Available hospital beds[1] per 100,000 people,[2,3,4] 1999-2000, 2005-06 and 2008-09



NOTES

1 Average daily available beds in which wards are open overnight. Excludes day beds.

2 Figures rounded to the nearest 10 beds per 100,000 people.

3 The definitions used for these data changed between years and so data are not directly comparable over time.

4 Independent and private sector provision of NHS care is not included; the levels of such provision vary by nation (estimated at around 1 to 2 per cent of hospital services in England in 2008-09).

5 Excludes cots for healthy new-born babies, except for Northern Ireland in 2005-06 and England in 2008-09.

Source: Office for National Statistics

Local area efficiency

2.37 To inform our understanding of differences in the overall efficiency of local health areas,[18] we commissioned some exploratory analysis to investigate whether areas spent more or less than expected. For instance, areas performing better against the indicators of efficiency described above may be more likely to have lower than expected costs.

2.38 The analysis was developed from an existing methodology[19] and compared actual spending with the expected costs of local services based on indicators of need (see paragraph 1.13). It also included an adjustment for variations in some aspects of quality, including mortality rates, Quality and Outcomes Framework indicators, and hospital lengths of stay. Our analysis was, however, limited to some extent by the lack of consistent data at a local level across the four nations.

2.39 Although no clear causal relationships could be derived from this initial work, we did identify associations that would merit further exploration. In particular, the results suggested an association between lower-than-expected costs and:

- larger population sizes within the local health area;
- fewer GPs per person;
- a higher proportion of junior (sub-consultant level) doctors in relation to total doctor numbers; and
- higher levels of staff education and training in primary care.

Quality and effectiveness of healthcare

2.40 Comparable data on the quality and effectiveness of healthcare are patchy. This section of the report therefore sets out data on particular aspects of quality, specifically:

- for primary care, reported performance against the Quality and Outcomes Framework and the level of emergency admissions; and
- for hospital care, waiting times and healthcare associated infection rates.

No comparable data are currently available for other key measures of quality and effectiveness, such as GP waiting times, hospital readmission rates, patient satisfaction, and health inequalities.

18 The analysis is based on figures for the existing local health areas during the period analysed, 2007-08 to 2009-10 (152 in England, 14 in Scotland, 7 in Wales and 4 in Northern Ireland).
19 S Martin and P C Smith, *A comparison of English primary care trusts,* The Health Foundation, 2010. We extended this methodology to include data from 2007-08 to 2009-10, and to cover all four nations.

Quality of primary care

2.41 Drawing on data from the Quality and Outcomes Framework (paragraph 2.7), we examined the quality of primary care across four disease areas – coronary heart disease, stroke, hypertension and diabetes.[20] Our analysis showed the following:

- GP practices in Scotland and Northern Ireland generally scored better across the 28 indicators we analysed, outperforming England across all four disease areas. GPs in Wales did not, on average, perform consistently differently from their counterparts in England.
- The quality of primary care, across these disease areas, generally improved in all four nations between 2009-10 and 2010-11. The variation between the nations decreased, with England and Wales getting closer to the performance of Scotland and Northern Ireland.
- The extent of exception reporting – whereby a GP practice can exclude a patient from their scores – varies across the nations and is highest in Scotland. Exception reporting is designed to prevent GP practices being penalised where, for example, patients do not attend for a review or a medication cannot be prescribed due to a contraindication.[21] Taking account of exception reporting, GP practices in Northern Ireland still performed better than in England. However, the performance of GP practices in Scotland was no longer consistently higher.

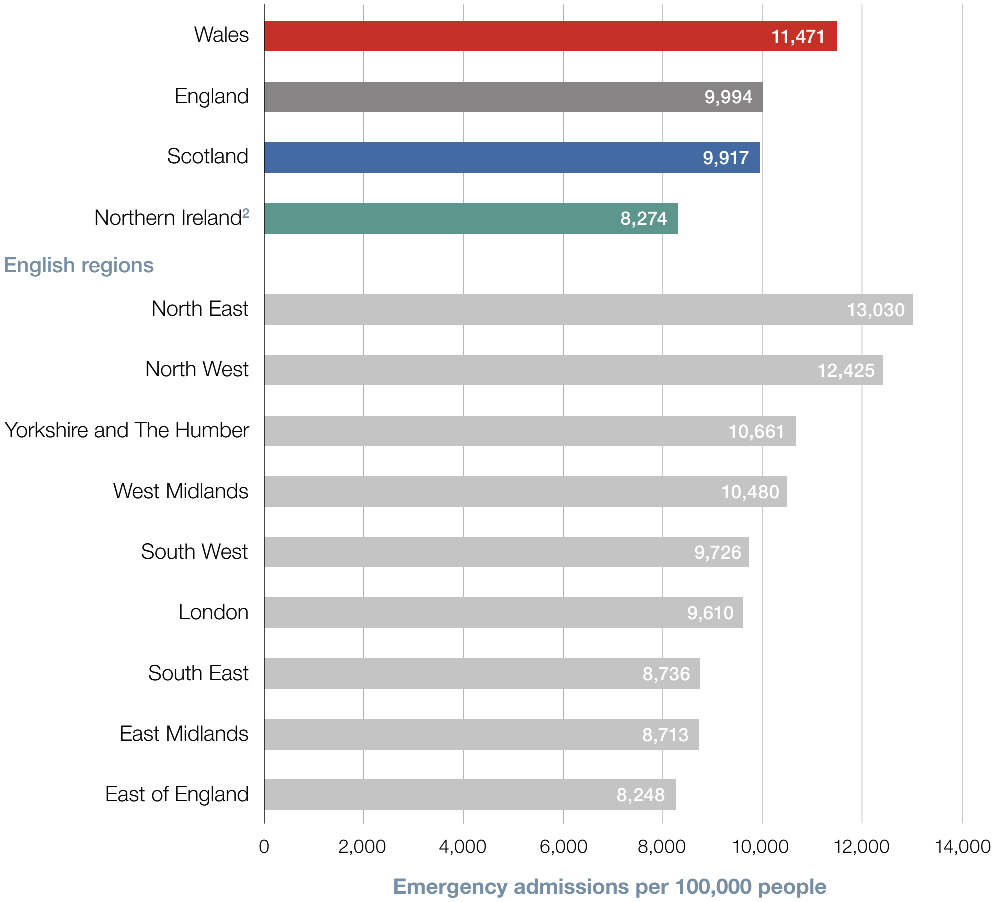
2.42 The rate of emergency admissions, where patients require unplanned hospital treatment, is also used as an indicator of the quality and effectiveness of primary care. Not all emergency admissions are avoidable. However, people with higher quality (and better access to) community, primary and social care are less likely to have unplanned hospital admissions as they can receive appropriate and timely care in the community.

2.43 The number of emergency admissions per 100,000 people has increased in all four nations. Between 2000-01 and 2009-10, the rate of increase was greatest in England – 28 per cent, compared with 9 per cent in Scotland and 3 per cent in Wales. No data were available for Northern Ireland for 2000-01 but emergency admissions increased by 2 per cent between 2005-06 and 2009-10.[22]

2.44 In 2009-10 the rate of emergency admissions was highest in Wales, at 11,471 per 100,000 people (**Figure 21**). This may be explained, in part, by differences in population demographics. Wales has a higher proportion of older people, who are more likely to be admitted as an emergency. The variation in the rate of emergency admissions was greater between the English regions (58 per cent) than between the nations (39 per cent).

20 More detailed findings are available at: www.nao.org.uk/uk-healthcare-2012
21 Contraindication defined as a patient condition or factor that serves as a reason to withhold a medication.
22 The Health and Social Care Information Centre; Information Services Division Scotland; NHS Wales Informatics Service; Department of Health, Social Services and Public Safety (Northern Ireland).

Figure 21
Emergency admissions per 100,000 people,[1] by nation and English region, 2009-10



NOTES

1 The data are taken from different publications; neither the consistency of the collection processes nor the comparability of the figures between nations have been checked.

2 Northern Ireland data only include emergency admittances from acute care (and not from GP, hospital transfer, or outpatient clinic) and so is not fully comparable with the other three nations.

Source: The Health and Social Care Information Centre; Information Services Division Scotland; NHS Wales Informatics Service; Department of Health, Social Services and Public Safety (Northern Ireland)

2.45 We carried out more detailed analysis of two specific areas of primary and community care: breast cancer screening and immunisation and vaccination programmes. For breast cancer screening, no one nation performed consistently better across the range of measures we analysed. England had, in general, poorer performance. This was due particularly to lower performance in London where a more transient population is likely to hinder the take-up of screening programmes.

2.46 In 2010-11, the take-up of flu vaccinations and children's immunisations was highest in Northern Ireland and Scotland. Performance was similar in all four nations for the third area we examined – HPV vaccinations. Across the UK, we found that areas with higher numbers of GPs per person tended to have better uptake of flu vaccination among people older than 65. This suggests a possible benefit of having more primary care resources.

Quality of hospital care

Waiting times

2.47 Analysis across 11 common hospital procedures by the UK Comparative Waiting Times Group (established by the statistics authorities in the four nations) found that the length of time patients wait, from the initial decision to admit to admission for the procedure, has reduced in all four nations since 2005-06. This is against a background of increasing numbers of procedures being carried out. For the six most common of these procedures, performance against the two measures used (the time within which 50 per cent, and 90 per cent, of patients were admitted) was better in Scotland and England than in Wales and Northern Ireland in 2009-10 (**Figure 22**).

2.48 All four nations aim to reduce the proportion of patients waiting over a set maximum time in accident and emergency departments and for elective (i.e. non-emergency) procedures. The accident and emergency targets/performance standards are broadly consistent, with all nations aiming for patients to be seen, admitted, transferred or discharged within four hours. England was the only nation to achieve its accident and emergency performance standard in 2010-11 (**Figure 23** on page 42).

2.49 The waiting time targets/performance standards for elective procedures vary in terms of the time limit for referral to treatment and the required level of achievement. This makes it difficult to compare the nations' performance. England and Scotland were the only nations to achieve their elective performance standards in full in 2011 (Figure 23).

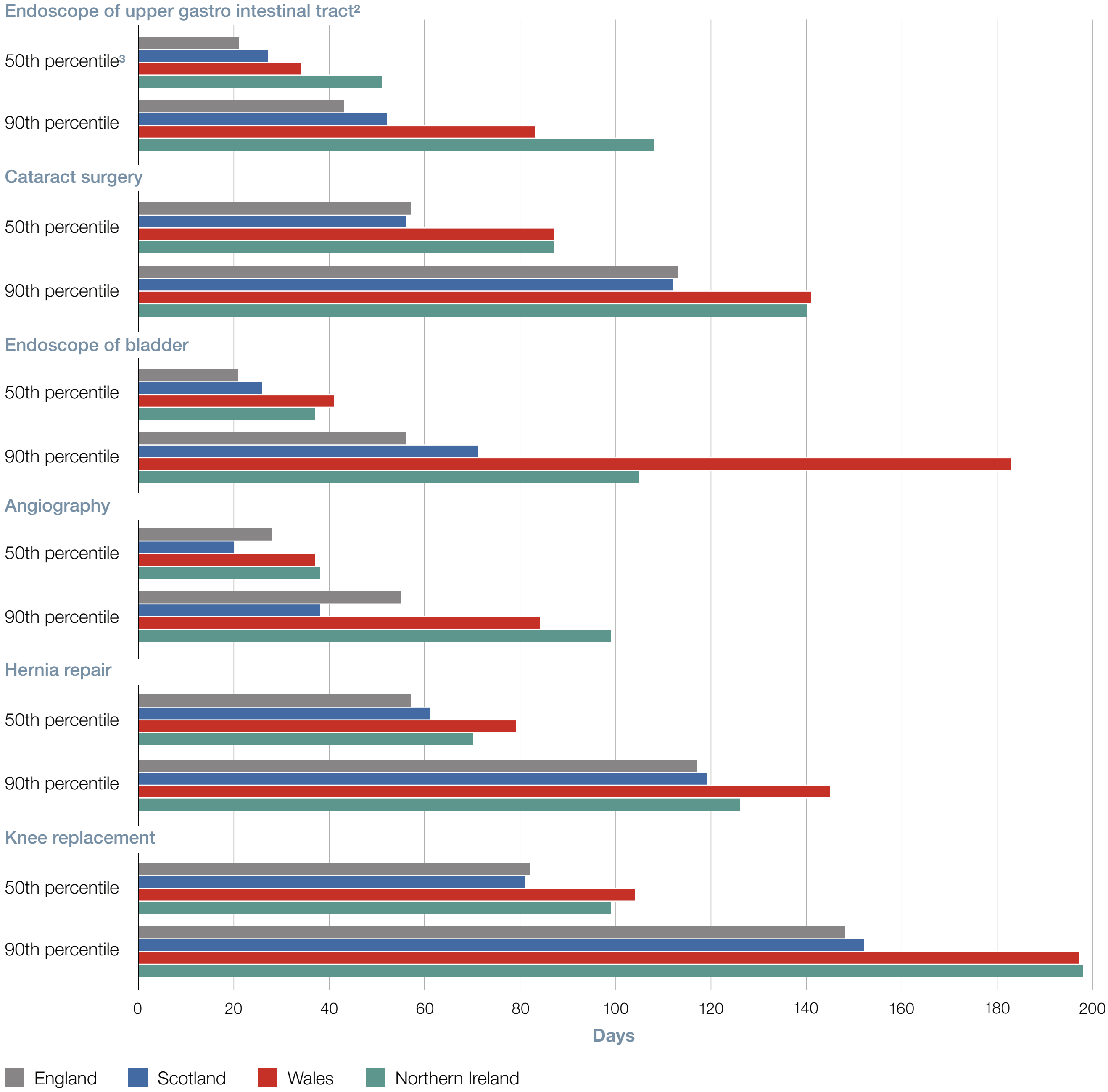
Rates of healthcare associated infections

2.50 The proportion of patients in hospital, including those in intensive care, with a healthcare associated infection decreased in England, Scotland and Wales between 2005-06 and 2011 (data are yet to be published for Northern Ireland). The surveys suggested that there were statistically significant reductions, of around a third, in both Scotland and Wales. The lowest rates of infection were in Wales (4.3 per cent of patients with a healthcare associated infection) (**Figure 24** on page 43).

2.51 There have been reductions in two key healthcare associated infections in recent years. MRSA infection rates decreased significantly in all four nations between 2007-08 and 2010-11, ranging from 67 per cent in England to 38 per cent in Wales. There was also a decrease in all nations in the number of deaths with the underlying cause recorded as *Clostridium difficile* in the same period; however, the reduction was not statistically significant in Wales (Figure 24).

Figure 22

Time waited for selected hospital procedures,[1] 2009-10



NOTES

1 Data relate solely to NHS activity in NHS hospitals. The levels of independent and private provision of NHS care vary by nation (estimated at around 1 to 2 per cent of hospital services in England in 2009-10). Data are based on country of treatment rather than country of residence, and include only patients who have been treated electively and were classified as either waiting list or booked.

2 The procedures are listed in order of number provided within the year with the highest first.

3 The 50th percentile relates to the time in days within which 50 per cent of patients were admitted. The 90th percentile relates to the time within which 90 per cent of patients were admitted.

Source: Office for National Statistics

Figure 23

Performance against waiting time targets/performance standards, 2011

Nation	Target/performance standard	Performance[1] (%)	Target/performance standard achieved?
Accident and emergency (from arrival to admission, transfer or discharge)			
England	95% of patients spend less than four hours	97.4	Yes
Scotland	98% of patients spend less than four hours[2]	96.4[2]	No
Wales	95% of patients spend less than four hours	88.1	No
Northern Ireland	95% of patients spend less than four hours	82.0	No
Elective procedures (from referral)			
England	90% of patients receive inpatient treatment within 18 weeks	90.5	Yes
England	95% of patients receive first outpatient appointment or diagnostic service within 18 weeks	97.3	Yes
Scotland	90% of patients treated within 18 weeks	92.0[3]	Yes
Wales	95% (100%) of patients waiting less than 26 (36) weeks for treatment[4]	91.4 (98.0)[4]	No
Northern Ireland	50% (100%) of patients waiting less than 9 (21) weeks to receive first outpatient appointment[4]	52.2 (80.1)[4]	Partly
Northern Ireland	50% (100%) of patients waiting less than 13 (36) weeks to receive inpatient treatment[4]	57.2 (91.1)[4]	Partly

NOTES

1 Accident and emergency data are for April 2010 to March 2011. Time periods for elective achievement data vary (January to December 2011 for England; December 2011 for Scotland, Wales and Northern Ireland).

2 The accident and emergency waiting times in Scotland are measured up to the decision to admit a patient, whereas the period between decision to admit and admission is included for the other three nations.

3 Scotland elective data are for December 2011, in line with expected date for meeting the standard.

4 In Wales and Northern Ireland, the elective waiting times targets (and reported performance) are for all patients awaiting treatment during that time period, whereas for the England and Scotland they are for patients who have received treatment during that time period. Data for Wales and Northern Ireland are for December 2011.

Source: Department of Health (England); Information Services Division Scotland; Scottish Government; Statistics for Wales; Department of Health, Social Services and Public Safety (Northern Ireland)

Figure 24
Healthcare associated infection rates

	England (%)	Scotland (%)	Wales (%)	Northern Ireland (%)
Prevalence in acute hospitals (all infections)				
Percentage of patients with a healthcare associated infection, 2011 (95% confidence intervals)	6.4 (4.7 – 8.7)	4.9 (4.5 – 5.4)	4.3 (3.8 – 4.8)	-[1]
Reduction since 2005-06	22[2]	33[3]	33	-[1]
Prevalence in intensive care units (all infections)				
Percentage of intensive care patients with a healthcare associated infection, 2011	23.4	25.3	12.8	-[1]
Reduction since 2005-06	4	7	54	-[1]
MRSA infection rates[4]				
Reduction in MRSA rates per bed day, from 2007-08 to 2010-11	67	62	38	43[5]
Deaths with underlying cause recorded as *Clostridium difficile*				
Reduction in *Clostridium difficile* deaths, from 2008 to 2010	59	74	9[2]	53

NOTES

1 Data have yet to be published for Northern Ireland.

2 Unlike Scotland and Wales, the reduction for England was not statistically significant at the 95 per cent confidence level.

3 The reduction for Scotland includes a revision to account for differences in patient exclusion criteria and infection definitions between the two surveys; the unadjusted decrease was 48 per cent. No adjustments are made for the other reductions presented.

4 Different definitions are used for MRSA rates across the four nations and, as a result, we only report changes over time.

5 MRSA annual rates in Northern Ireland are calculated as an unweighted average across the four quarters within the year.

Source: Health Protection Agency; Hospital Infection Society; Health Protection Scotland; General Register Office for Scotland; Public Health Wales; Welsh Government; HSC Public Health Agency; Northern Ireland Statistics and Research Agency; Office for National Statistics

Appendix One

Methodology

The main elements of our fieldwork, conducted between September 2011 and May 2012, are set out below. A more detailed methodology is published online at www.nao.org.uk/uk-healthcare-2012.

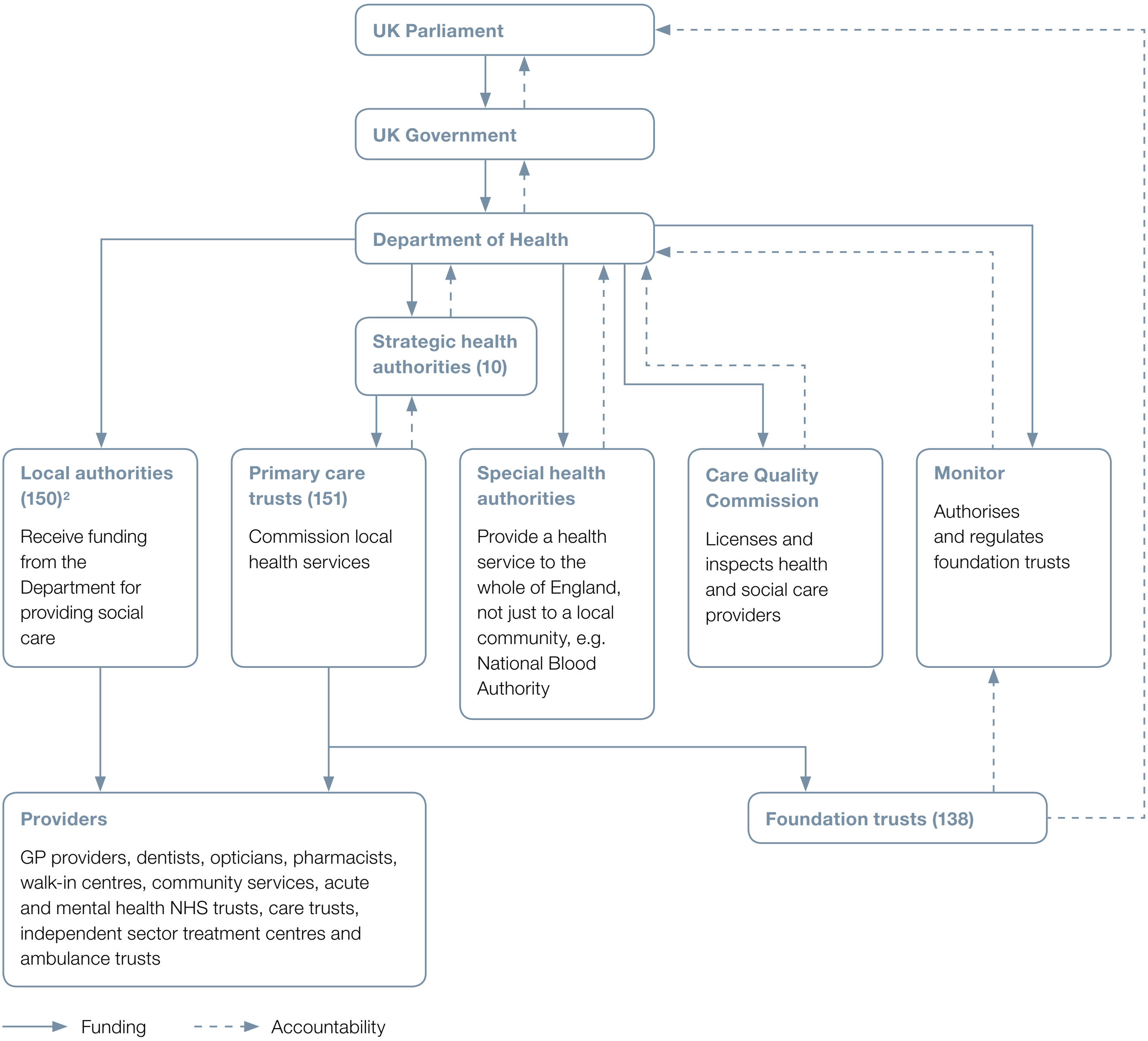
Method	Purpose
Review of literature on UK health comparisons. Key sources of documents included the Office for National Statistics, the Nuffield Trust, the Health Foundation and the King's Fund.	To understand: • the differences in the UK's health structures; • what comparisons are possible; and • known issues on data comparability.
Secondary data collection. We collated and analysed key data on costs, inputs, activity, quality and outcomes across the four nations and, where possible, the English regions. When available, we collected data for 2000, 2005 and 2010 or the nearest years.	To identify key differences and trends across the UK health services. We included data for the English regions to provide additional comparisons.
In-depth analysis of specialties – primary and community care. We examined delivery structures and performance for two specialties: breast cancer screening and vaccination and immunisation programmes. We collected organisational information from the departments of health and conducted desk-based research on performance.	To gain greater understanding of the causes of variation in performance, including the effect of different performance management regimes and organisational structures.
In-depth analysis of specialties – acute care. We analysed patient-level data for two hospital specialties (hip replacements and obstetrics) to create a hospital-level measure of efficiency based on length of stay and adjusted for patient case-mix. We then looked to see if there were any associations between performance, in terms of efficiency, and organisational factors.	To gain further insight into the extent, and drivers, of differences in efficiency.
Analysis of practice-level GP data. We used a sample of indicators, based on data from the Quality and Outcomes Framework, categorised into: simple, complex, intermediate outcome, and treatment.	To set out the variation, across the UK nations and English regions, in some aspects of primary care quality.
Cost efficiency analysis at local area level. We commissioned exploratory analysis to compare the estimated need at a local level to actual spending, adjusted for some aspects of quality.	To understand the extent of variation in need at local area level and factors associated with higher-than-expected spending.

Appendix Two

Organisation of health services

Organisation of health services

England[1]



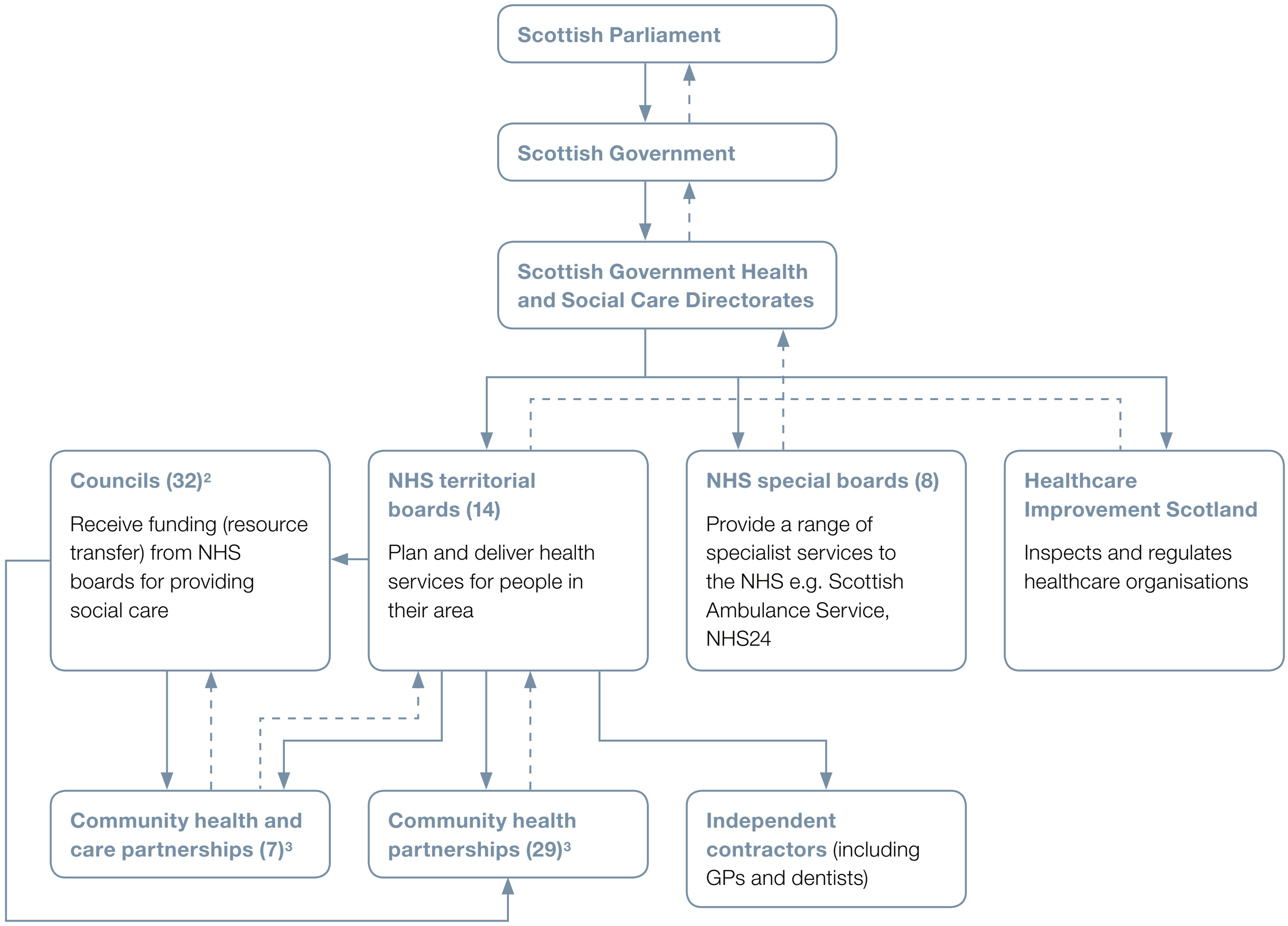
NOTES

1 The NHS in England is being restructured under the Health and Social Care Act 2012. Strategic health authorities and primary care trusts will be abolished from April 2013, and replaced by the NHS Commissioning Board and clinical commissioning groups.

2 The main source of funding for adult social services is the Department for Communities and Local Government.

Source: National Audit Office

Scotland[1]



NOTES

1 The Scottish Government recently announced plans to integrate adult health and social care services.

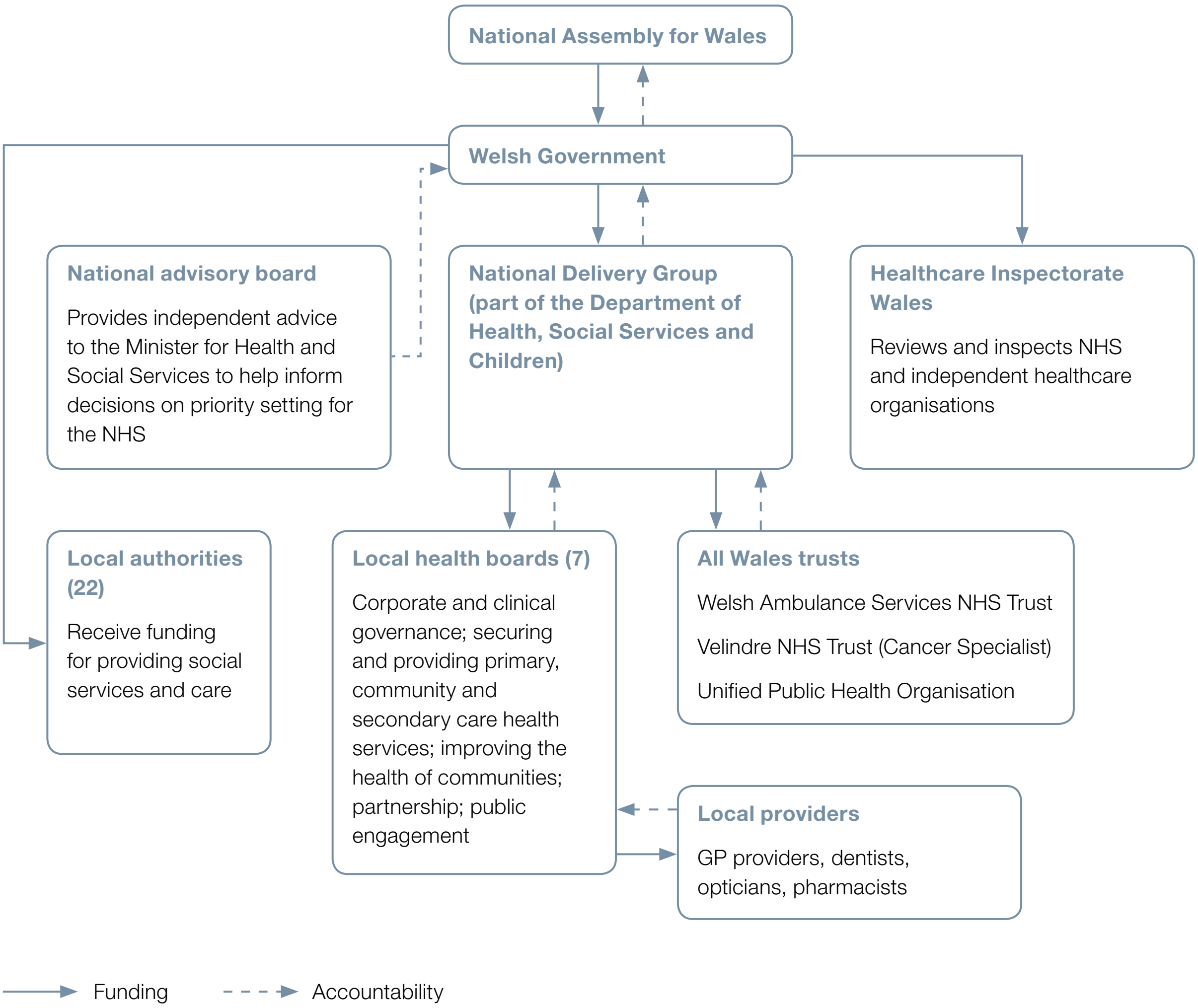
2 The main source of funding for councils is the Scottish Government Communities and Local Government Directorates.

3 The number of community health partnerships and community health and care partnerships is subject to change. These figures are as at November 2010, from 'Community health partnerships', Audit Scotland, June 2011.

Source: Audit Scotland

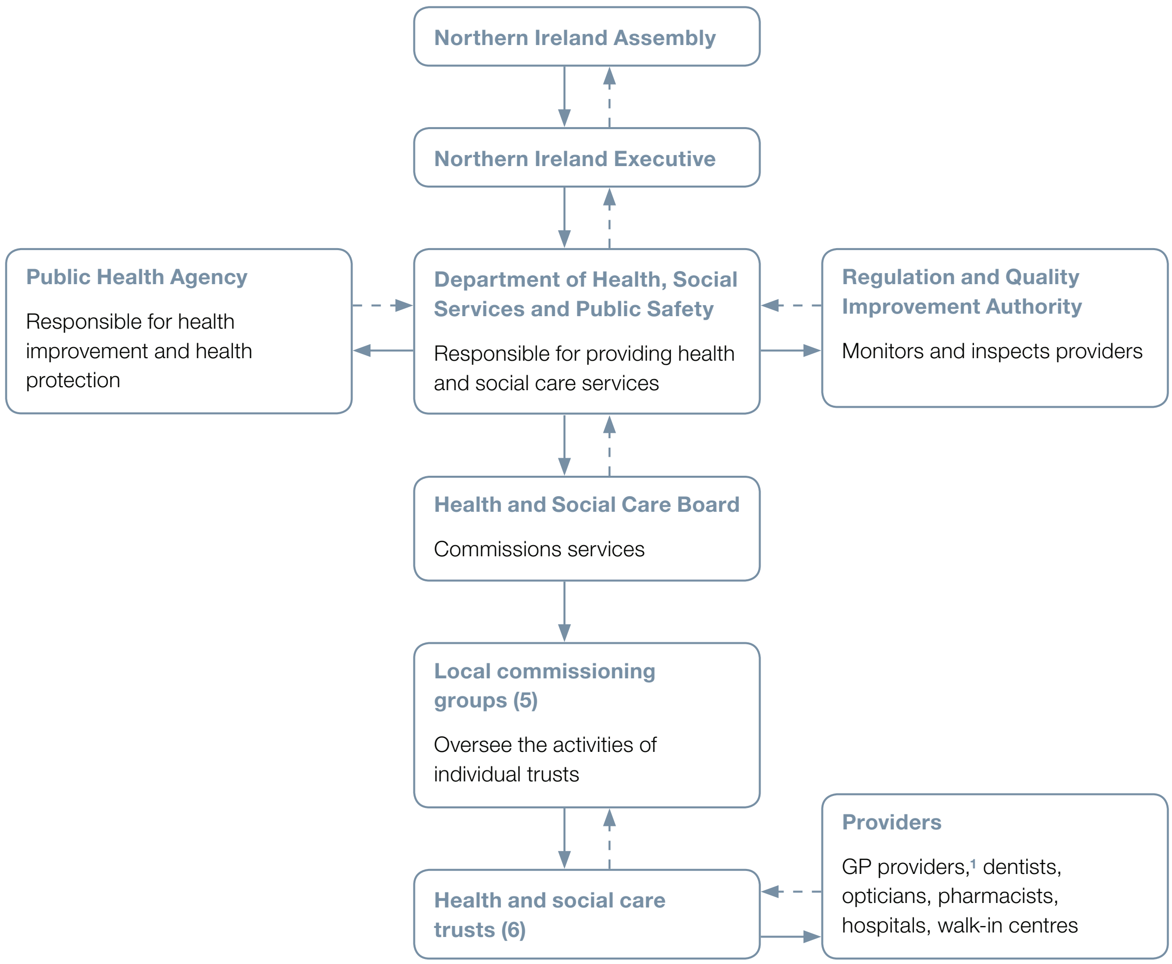
Organisation of health services *continued*

Wales



Source: Wales Audit Office

Northern Ireland



NOTE

1 GPs in Northern Ireland are contracted directly by the Health and Social Care Board and so they receive funding from, and are directly accountable to, the Board rather than the Health and social care trusts.

Source: Northern Ireland Audit Office

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Public Accounts Committee

Meeting Venue:	**Committee Room 3 - Senedd**
Meeting date:	**Tuesday, 10 July 2012**
Meeting time:	**09:00 - 11:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Concise Minutes:

Assembly Members:	**Darren Millar (Chair)** **Mohammad Asghar (Oscar) AM** **Mike Hedges** **Julie Morgan** **Gwyn R Price** **Jenny Rathbone** **Aled Roberts** **Lindsay Whittle**
Witnesses:	**Dame Gillian Morgan, Permanent Secretary, Welsh Government** **James Price, Director General BETS** **Arwel Thomas, Head of Coroporate Governance** **David Richards, Welsh Government**
Committee Staff:	**Tom Jackson (Clerk)** **Daniel Collier (Deputy Clerk)**

1. Consideration of draft report 'Grants Management in Wales'

1.1 The Committee noted that it had agreed at its last meeting, on 3 July 2012, to begin this meeting in private.

1.2 The Committee commented on and agreed amendments to its draft report 'Grants Management in Wales'.

2. Consideration of draft report 'Progress in delivering the Welsh Housing Quality Standard'

2.1 The Committee commented on its draft report 'Progress in delivering the Welsh Housing Quality Standard' and agreed to consider further at its meeting on 17 July 2012.

3. Preparation for evidence from Welsh Government on The Welsh Government's acquisition and action to dispose of the former River Lodge Hotel, Llangollen

3.1 The Committee discussed their intended handling of the subsequent evidence session (item 5) on the Wales Audit office report 'The Welsh Government's acquisition and action to dispose of the former River Lodge Hotel, Llangollen'.

4. Introductions, apologies and substitutions

4.1 The Chair welcomed Members and members of the public.

5. The Welsh Government's acquisition and action to dispose of the former River Lodge Hotel, Llangollen - Evidence from the Welsh Government

5.1 The Chair welcomed Dame Gillian Morgan, Permanent Secretary, Welsh Government; James Price, Director General, Business, Enterprise, Technology and Science; Arwel Thomas, Deputy Director, Corporate Governance and Assurance Division; and David Richards, Director of Governance.

5.2 The Committee questioned the witnesses.

Action points:

In response to questions, the Welsh Government agreed to provide:

- Details on whether senior Welsh Government managers above regional level would have been present for briefings of the former Minister for Enterprise, Innovation and Networks regarding proposals to purchase the River Lodge Hotel.
- A note on whether a deadline has been set to dispose of the former River Lodge Hotel site.
- A note on the process for evaluating bids for use of the site, including details on any conditions on the construction of a footbridge on the site.
- Further details on the Welsh Government's Property Leadership Team.
- Details on how Welsh Government officials in North Wales handled concerns raised by a local Assembly Member in a letter to the Minister regarding the acquisition of the River Lodge Hotel.

6. Papers to note

7. Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

Transcript

HM Treasury, 1 Horse Guards Road, London, SW1A 2HQ

Darren Millar AM
Chair of the Public Accounts Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

21 May 2012

Dear Darren,

PUBLIC ACCOUNTS COMMITTEE OF NATIONAL ASSEMBLY FOR WALES - HOUSING

I am writing in response to your invitation to give evidence at your inquiry on the basis of the Wales Audit Office's report 'Progress in delivering the Welsh Housing Quality Standards.' I apologise for the delay responding to your original letter.

The Statement of Funding Policy (2.7) says that "UK Ministers may, if invited, attend the Scottish Parliament, and the Welsh and Northern Irish Assemblies to explain the budget allocation." In general, Treasury ministers therefore appear in front of devolved committees after one off fiscal events such as the Spending Review. As housing is a devolved matter I feel it more appropriate in this case for the committee to take evidence from those with direct responsibility for housing policy in Wales. However, I would be happy to provide written evidence to the committee if there are any specific matters relating to United Kingdom Government housing policy.

Best wishes

DANNY ALEXANDER