Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/2115/15

David Rees AM
Chair, Health and Social Care Committee

17 July 2015

Dear David,

Thank you for your letter dated 24 June 2015 in which you ask a series of questions in follow up to my appearance at your Committee on 17 June. Responses to each question can be found below.

A breakdown of the additional £6.8 million planned care performance and £6.8 million Health Board winter pressures allocations provided during 2014-15 (details of which were outlined in paragraph 8 of you written paper), by individual health board.

The breakdown of the additional winter pressures allocations by NHS organisation are detailed in the table below:

Local Health Board	WAST Winter pressures	Unscheduled Care Winter pressures	Winter pressures - lost planned care	Total
	£m	**£m**	**£m**	**£m**
Aneurin Bevan HB		0.5	0.4	0.9
AbertaweBM HB		3.4	0.4	3.8
Betsi Cadwaladr HB		0.0	3.0	3.0
Cardiff & Vale HB		0.0	1.1	1.1
Cwm Taf HB		2.9	0.5	3.5
Hywel Dda HB		0.0	0.9	0.9
Powys HB		0.0	0.4	0.4
WAST	8.0			8.0
Total	**8.0**	**6.8**	**6.8**	**21.6**

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0300 0603300
Llinell Ymholiadau Cymraeg 0300 0604400
Correspondence.Mark.Drakeford @wales.gsi.gov.uk

Details of the general make up of primary and secondary care budgets, to include information about:

- **the allocations made to primary and secondary care respectively in 2014-15;**

The table below details the revenue resource allocations provided to Local Health Boards in Wales for 2014-15.

2014-15 Revenue Resource Allocations	**£m**
General Medical Services	469.1
General Dental Services	143.7
Pharmaceutical Services	158.9
Hospital and Community Healthcare Services	4,856.5
	5,628.2

Basis of calculation – derived from the split of final resource limits to Health Boards for 2014-15 as per HSSG Finance records

The Committee should note that the "resource allocations" above will exclude other funding that is provided to LHBs or to external bodies for both primary and secondary related purposes that are controlled through central health budgets not delegated to NHS organisations. These will cover services that are reimbursed either on an actual cost basis, for example, ophthalmic services, projects funded through grants and budgets for education and training budgets of NHS staff.

It should also be noted that the HCHS allocation of £4,856.5 million includes funding for the provision of certain primary care services which are not subject to separate primary care resource allocations. Examples include primary care prescribed drugs and appliances.

- **the proportion of the 2014-15 overspend that was attributable to primary and secondary care respectively; and**

I do not recall this question being asked in committee, and it is not something that can be identified easily for the reasons stated above. In overall terms health boards are responsible for the provision of both primary and secondary care services. Performance is monitored and reported on an aggregate level and not separately across primary and secondary care headings.

Any calculation to split the above on a national level would require a level of apportionment locally and nationally; the splitting of central budgets and matching of information between allocations and the published accounts to try and identify the different the variances. I have not asked officials to make this retrospective calculation as the figures would have to be heavily caveated for the reasons stated above.

- **the increases/decreases for primary and secondary care budgets respectively for each of the last five years, particularly as a proportion of the overall departmental budget.**

The table below details the revenue resource allocations provided to Local Health Boards in Wales for 2010-11 to 2014-15 and the percentage increase over the five year period.

	2010-11	2011-12	2012-13	2013-14	2014-15	Percentage increase over the 5 years
	£m	£m	£m	£m	£m	%
Primary Care allocations	729	740	754	766	772	5.9%
Hospital and Community Health Services allocations	4,624	4,740	4,768	4,672	4,856	5.0%
Total	**5,353**	**5,480**	**5,522**	**5,438**	**5,628**	**5.2%**

**From 2011-12 the annual allocation for prescribing was transferred into the HCHS allocation, 2010-11 has been re-presented on a consistent basis to provide a comparative. Basis of calculation – derived from the split of final resource limits to Health Boards for each year as per HSSG Finance records*

Clarification of the date on which health boards in Wales were informed that overspends and brokerage funding provided at the end of 2013-14, before the commencement of the National Health Service Finance (Wales) Act 2014, would not need to be repaid.

I am sure that the committee will understand that the NHS outturn performance each year is not finalised until all final accounts, including the NHS summarised accounts, are laid by the Auditor General in the Assembly. This was in July 2014 for the financial year 2013/14. The new requirements of the NHS Finance (Wales) Act 2014 came into effect before the 2013/14 outturn was completed i.e. April 2014.

In my written statements in May and June 2014, covering the new planning arrangements introduced on the1st April, I made it clear that the new regime signaled a significant change in financial management arrangements. As part of the new arrangements, I was clear that we would not continue to provide additional funding to organisations which did not have robust plans in place and continued to incur deficits year on year, and this has commitment has been met since the introduction of the new regime.

In my written statement in June 2004, I outlined that I would only approve plans that could pass a rigorous process to ensure that we end any concept of a deficit culture. Only two plans, namely those of Cardiff and Vale and Cwm Taf University Health Board's, included the repayment of 2013/14 deficits in their plans, but in both cases the prepayment was planned for year three of their plans (2016/17). During the approval process, both boards were told by officials that the confirmation of the arrangements regarding non repayment of 2013/14 deficits would be confirmed later in year and that they should focus on delivery of their approved plan in the meantime. This had no impact on their 2014/15 plans because the repayments were not planned until year 3 of their respective plans.

In my written statement in June I also stated that I would be working with the Finance Minister over the summer to look at how the required funding outlined by the independent Nuffield Trust Report published in June could be funded. When the 2015/16 budget was announced (including the additional funds for 2014/15) at the end of September, my officials confirmed that the repayment of 2013/14 overspends would not be pursued via presentations made to Chairs and Chief Executives following the budget announcement. The content of the presentations and confirmation of the approach was also shared with auditors as soon as practical during a regular update meeting after the budget announcement.

While the non repayment intent was made clear from early Autumn, it should be noted that 2014/15 was the first year that the legislation and audit approach on the new regime was to be operated. My officials worked closely with the AGW staff on the practical application and interpretation of the legislation during the months leading up to the year end. Officials clearly set out the need to draw a line under the old regime during these discussions.

Following the work outlined above, the final clarification of the 2013/14 non repayment was requested to be put in writing by the auditors and health boards as part of the year end process so that it could be clearly set out in the published accounts. Officials did this on 5th May 2015 in a letter that stated that the 2013/14 deficits and brokerage would not need to be repaid but any deficits incurred under the new financial regime would need to be recovered.

The above has subsequently been covered in the underlying published health board and NHS summarised accounts to correctly reflect the agreed reporting requirements under the new financial regime and in my written statement covering 2014/15 outturn.

An update on work that the Welsh Government is undertaking on financial flows across health board boundaries.

The Welsh Government has been working with NHS Wales on financial flows across health board boundaries for some time but the principles have not been finalised due to the significant planned service changes that needed to be implemented.

The current financial flows mechanism was first reviewed two years ago by Directors of Finance with principles being put forward for consideration. It was agreed that this work needed to be reviewed by Chief Executives and others to reflect the proposed changes resulting from the changing patient flow arrangements that would arise through the South Wales programme and other reconfiguration plans.

This work is now being led by the NHS Collaborative Director Bob Hudson. It has been agreed that this work will be updated to the next meeting of Chief Executives in September where the new principles for income and financial flows can be considered for application starting in 2016/17.

What statistical techniques are used by Welsh Government and health boards to seek to predict winter pressures and is this reflected in general annual allocations made to health boards?

Changes in overall patterns of demand relating to the different seasons are well understood and largely predictable, for example every year there are more A&E attendances in the summer months than in the winter. The Welsh Government, LHBs and Public Health Wales regularly review and analyse trends over time to understand what drives overall demand, patterns of demand and the age of patients using services.

While seasonal pressures are understood, these can never be accurately predicted on a day to day basis too far in advance. Evidence shows that within each season there can be significant variation in daily demand and pressure caused by changes in the weather. This has disproportionate impact in Wales given its age profile, in particular the high proportion of elderly people. The other major factor that leads to changes in demand, particularly in the winter, is the prevalence of infectious disease which has a significant impact of unscheduled care services and is again related to age.

The NHS develop specific plans for winter which include demand predictions and contingencies for the weather with an extra £40 million allocated for winter pressures in 2014/15. The annual allocation to health boards reflects demand and expenditure throughout the year.

Clarification of when the Auditor General's office was made aware that NHS organisations would not be required to repay 2013-14 brokerage and overspends, in light of the statement in the Auditor General's Report NHS Wales: Overview of Financial and Service Performance 2013-14 that "the Department will not only require repayment of any 2013-14 brokerage funding in 2014-15, but also repayment of any 'deficit' by those NHS bodies not meeting their financial targets".

As the Committee will appreciate there are regular meetings between auditors and my officials. As stated earlier, I have been advised that some discussions on intent would have been discussed throughout 2014/15 but this became more formal post the budget announcement in September and through to the year end. I understand that the AGW's report was published on 14th October and the confirmation discussions post the budget announcement may not have been in time to firm up any references made in the AGW's report particularly when the first application of the legislation and its implications were being discussed up to the publication of the 2014/15 accounts.

What data is collected to demonstrate the increase in complexity of patient cases and its impact on the capacity of health services in Wales? The Committee would particularly welcome month-by-month figures of length of stay and hospital bed capacity, if available, for each of the last five years.

The Patient Episode Database for Wales (PEDW) captures various data on hospital admissions that can be used, both individually and collectively, to identify increases in patient complexity. The following are typical examples of data items which are routinely analysed by Welsh Government and NHS providers to demonstrate changes in the presenting caseload.

- Patient Diagnoses – captures primary diagnosis and presenting comorbidities via ICD10 coding;
- Operative Procedure – captures any operative procedure(s) and intervention(s) performed using the OPCS4 coding classification;
- Patient Age – for example to analyse the impact of an ageing population on hospital stays;
- Duration of Hospital Stay – used to identify changes in variation to the distribution of hospital stays linked to age and case mix;
- Mortality Outcomes – for example to monitor the impact on palliative care resources from changes in the number of deaths;
- Healthcare Resource Groups – uses standard groupings of clinically similar treatments with common levels of healthcare resource;
- Admission Dates – used to analyse changes in seasonal variation in association with other factors.

Further data to demonstrate case complexity changes are available from a range of datasets and collections. For example, this includes access data from Accident & Emergency and call data from Ambulance services.

The attached spreadsheet includes tables and charts showing five year trends for average length of stay (ALOS). The elective (main surgical specialties) ALOS chart for Wales shows a reduction of approximately 0.4 days over the five years. This is particularly significant given that daycase rates have increased by 9% over the same period, which in isolation would serve to increase the ALOS. Conversely, emergency ALOS has increased by approximately 0.2 days over the period as reductions in efficiency have been neutralised by the impact of an ageing population. The effect of diverting previously admitted (short stay) patients to assessment units is also a factor in the increasing ALOS outcomes. The emergency ALOS chart also highlights the seasonal variation of hospital stays, in particular the winter and post winter peaks.

Hospital bed capacity is also provided in the attached, although data prior to 2013 is only available quarterly. This shows that between 2010/11 and 2014/15 there was a reduction of 1,088 in the numbers of beds available across Wales, a 9% decrease. The increase in day surgery and emergence of assessment units and other admission avoidance initiatives have contributed significantly to a reduced demand for beds.

Best wishes

Mark Drakeford AC.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services