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Health Finances 2012-13 and beyond

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I have prepared this report for presentation to the National Assembly under the Government of Wales Act 1998 and 2006.

The Wales Audit Office study team that assisted me in preparing this report comprised Geraint Norman, Clare Stevens and Mark Jeffs 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 16 July 2013

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Summary

1 Wales Audit Office reports over recent years have identified the significant financial pressures faced by NHS Wales – comprising the Welsh Government's Department of Health and Social Services (the Department) and the 10 Welsh NHS bodies. Over recent years NHS Wales has faced tougher financial settlements than its counterparts in other parts of the UK. The Department is having to manage the increasingly significant gap between the amount of money that it requires in order to meet known demand and cost pressures and the actual funding it is allocated. With 'flat cash' settlements for the last two years, much of the 'low-hanging fruit' for making financial savings has already been identified and NHS Wales is facing a growing challenge to deliver cost reductions without impacting on patient experiences, safety and quality.

2 This report provides a detailed assessment of the financial position across NHS bodies in 2012-13. It also looks at performance in the delivery of services, focusing on those areas that the Department has identified as a priority. The report then goes on to consider the future short, medium and long-term financial and service challenges for NHS Wales. The audit methods we used to undertake this work are set out in Appendix 1.

3 This report covers the 2012-13 period, during which NHS bodies have worked within two sets of accounting rules, depending on whether they are a 'trust' or a 'local health board'. One of the key financial requirements for local 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 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 local health boards, any overspend within these thresholds is not deemed to be 'irregular' spend. The Department intends to introduce a more flexible financial regime from 2014-15 so that, rather than having an annual break-even target health boards will be required to break-even over a three-year period.

Despite a tough financial settlement, NHS bodies met their statutory financial targets in 2012-13 but some of the actions taken to break-even are not sustainable

4 In 2012-13, the Department's overall health and social services revenue budget was £6.1 billion[1]. The vast majority of the Department's budget is spent providing NHS services via the ten NHS bodies, through the core funding and funding for specific initiatives. The Department overspent against the budget by some £5 million (around 0.1 per cent). This overspend was mainly due to clinical negligence compensation payments being higher than expected. Nevertheless, the Department generally managed financial risks well across the year. The Department identified a number of cost pressures early on: the risk of overspends at NHS bodies and unfunded central programmes. It created a contingency at the outset, but recognised it was unlikely to be sufficient to cover the potential financial risks. The Department took some tough priority and risk-based decisions to reduce spending on central programmes in order to provide additional funding to support financial and service pressures at NHS bodies. Before allocating the funding, the Department undertook a review of the financial and service pressures at each NHS body and allocated funding on that basis. This approach was an improvement on the previous year when the Department allocated the same amount of additional funding to most local health boards.

5 We have some specific concerns about the Department's approach to providing NHS bodies with additional funding. As it has done in the past, the Department gave a clear message at the start of the year that there would be no additional funding for NHS bodies. The Department subsequently allocated additional funding totalling £92 million. We are concerned that this sends mixed messages and that, in practice, some NHS bodies are assuming as part of their annual financial planning that they will receive additional funding from the Department.

6 All NHS bodies met their statutory target to break-even in 2012-13. All but two were able to do so thanks to the additional funding from the Department. Two local health boards delivered relatively significant surpluses at the year-end which they were able to lend to two other local health boards that required additional funding.

7 While the £188 million savings reported by NHS bodies is significant, the level of reported savings is some £100 million less than in 2011-12. We have concerns that some of the savings may be overstated, in particular reported savings on staff do not reconcile with staffing numbers and expenditure as reported in NHS bodies' financial statements. There is evidence that local health boards are reliant on unsustainable one-off savings and technical accounting adjustments in order to break-even. Our audit work has identified that some NHS bodies reduced the number of planned procedures carried out on patients at the end of the year. While the reasons for the reduction are complex, our local work suggests that some NHS bodies reduced activity in order to help manage financial pressures.

8 In general, the financial planning process at NHS bodies can be improved. Although NHS bodies produced plans for 2012-13 that technically showed they had sufficient income and savings to cover expenditure, we do not consider that those plans were sufficiently robust. In particular, we found that often financial plans were simply rolled over from one year to the next. Many of the reported 'identified' savings had little or no detailed plans showing how those savings were to

1 Whist the funding in the budget is notionally split £5.9 billion for health-related services and £0.2 billion for social services, the Department takes an integrated approach to managing finances across health and social services.

be achieved. In reality, many were little more than an aspiration to make savings under a particular heading. There is considerable scope to improve the integration of financial, service and workforce planning across NHS Wales.

In the face of financial and service pressures in 2012-13, there have been some improvements in efficiency and quality but there has been a downturn in performance in some key areas

9 The period of financial constraint has coincided with significant pressures on NHS services in Wales, particularly in unscheduled care. Against this backdrop, we considered the performance of NHS Wales in delivering against its key priorities and targets (known as the Tier 1 priorities).

10 The data shows a clear improvement against efficiency targets, with people spending less time in hospital. Lower lengths of stay frees up capacity (staff and beds) to treat other patients, or to translate into efficiency savings. This improvement in length of stay is thanks in part to more people being admitted on the day of their treatment and rising levels of day surgery.

11 However, service performance on some key patient-focused areas has deteriorated. Waiting times for planned treatments have got significantly worse over the past three years, with around one in five patients now waiting more than six months to be treated. Performance in emergency care has deteriorated - emergency departments are increasingly stretched meaning patients are waiting longer to be treated or admitted than in the past three years. The Department's explanations for the deterioration in planned and emergency services have focused heavily on external factors: rising demand from older people, prevalence of illness, weather, and socio-economic issues. While these are clearly significant contributing factors, the Department needs to better understand the impact of factors such as finance and the reduction in bed numbers on the delivery of performance targets.

12 Other indicators of quality of care show some improvements. Performance in delivering some stroke services has improved (although some areas have seen a deterioration). Reported cases of healthcare-associated infections (Methicillin-Resistant Staphylococcus Aureus (MRSA) and C. difficile) have fallen but we have concerns that some incidents may not be reported, thereby understating the true position.

The Department and NHS bodies continue to face major service and financial challenges and are likely to struggle to sustain current levels of service and performance

13 The Department is undertaking a range of initiatives designed to help NHS bodies manage the financial pressures they face. In line with our recommendations, it is seeking to address the short-term focus of the financial regime by introducing new legislation. It is working with NHS bodies to develop three-year plans that link finance, service and workforce plans together. There remain some uncertainties, particularly in terms of how to fund upfront investment three-year plans. There also remain significant risks that NHS bodies build up unsustainable deficits in the early years that are not then recovered. Despite these risks, the move away from the annual focus, and the perverse behaviours it encourages, is to be welcomed.

14 The Department has updated its direction in terms of service priorities. In particular, it has widened the focus, and number, of priority areas and targets. While a wider focus is welcome, there is a danger that increasing the number of targets places increasingly unrealistic expectations on NHS bodies. Performance in 2012-13 showed that, in effect, NHS bodies deprioritised waiting times in order to manage emergency pressures and meet financial targets. Expecting them to make up the lost ground and also to deliver on new priorities in an environment of unprecedented financial pressures is highly optimistic.

15 NHS bodies again face major financial and service challenges for 2013-14. The Department has been more rigorous this year in requiring detailed evidence that savings plans are robust. NHS bodies struggled to identify sufficient savings with a net funding gap (once identified savings have been taken into account) of £212 million as of April 2013.

16 The position over the medium to long term looks equally challenging unless there is a significant change in terms of funding or transformation of services. The projections for public spending across the UK show that austerity is likely to last until at least 2016-17 and possibly beyond. In that climate, the Welsh Government faces the difficult choice of whether to fund NHS bodies in line with cost and demand pressures or whether to continue to provide a year-on-year 'flat cash' settlement.

17 Some progress is being made with transformation and reconfiguration of services, but the pace of change is restricted by significant public and political opposition to some of the proposals. While the case for change is rightly focused on the clinical benefits, it is important that reconfiguration results in a financially sustainable NHS in Wales. At present, the detail on the costs and savings from reconfiguration is unclear. The scale of financial challenge may necessitate even more radical changes than have been proposed so far. Given the rate of progress, the scale of opposition to some proposals and the likelihood that some changes will require upfront investment, it is unlikely that reconfiguration will solve the short-term or medium-term financial pressures facing the NHS. However, service transformation and reconfiguration offers the best opportunity to put the NHS in Wales on a financially sustainable footing over the longer term.

Recommendations

18 Appendix 2 shows our recommendations from last year and the Department's response. Set out below are our recommendations following this year's review.

R1 The Department continues to send mixed messages over the availability of additional funding: insisting at the beginning of the financial year that no funding will be provided before later allocating additional funding. We understand the Department's desire to focus NHS bodies on their goal of living within their means. However, the historical provision of providing additional funding has contributed to an unhelpful culture where some NHS bodies are second guessing the position and assuming they will get additional funding. **To help develop a culture of greater financial transparency across NHS Wales, the Department should:**

- **develop a shared understanding and ownership by regularly reporting and discussing with NHS bodies the financial position of NHS Wales as a whole, including the central budgets managed by the Department;**
- **clearly articulate the position at the beginning of the financial year in respect of what flexibility the Department has to manage financial risks;**
- **during the year, keep NHS bodies updated in terms of any flexibility within the central budget and how it intends to use any surpluses; and**
- **work with and challenge NHS bodies to improve the consistency and transparency of financial reporting and forecasting particularly for cost improvement programmes.**

R2 Service reconfiguration and change offers the best chance of developing a lower-cost model that puts the Welsh NHS on a more financially sustainable footing. At present, the financial costs and benefits of transformation and reconfiguration are unclear. The Department is in the process of supporting and challenging NHS bodies as they develop integrated three-year workforce, service and financial plans. **In considering NHS bodies' three-year plans, the Department should:**

- **robustly challenge NHS bodies to develop an ambitious programme to reform the delivery and configuration of services, to include integrated service plans that set out in detail the costs (both revenue and capital expenditure) and expected financial benefits alongside patient quality and safety impacts; and**
- **test the sustainability of NHS bodies' plans for medium to long-term change against the Department's own assumptions for the medium to long-term prospects for NHS finances.**

R3	In order to manage financial and service pressures, it is clear that many NHS bodies have deprioritised delivery of their targets on waiting times for planned procedures. Given the financial constraints, some form of prioritisation of activity and goals could be seen as inevitable. But such prioritisation needs to be well thought through, transparent and the risks need to be managed. The extent to which such prioritisation is documented and publicised varies between NHS bodies. The Department has not deprioritised any areas and has tasked NHS bodies with delivering against an increasing number of Tier 1 priorities. **The Department and NHS bodies should work together to develop a robust framework for reviewing priorities and managing risks in those areas of service delivery that assume a lower priority, in particular to clarify:** • **whether it is realistic to continue to expect NHS Wales to improve performance against an ever-rising set of priorities given a real terms decline in resources;** • **the extent to which NHS bodies are free to determine their own local priorities/risk appetite in relation to deprioritising service delivery; and** • **the extent to which NHS bodies should publicise and engage the public in relation to prioritisations that impact on the level or quality of services.**
R4	Last year we recommended that the Department challenge NHS bodies to accelerate savings from workforce planning while managing the risks to service levels and quality. We found that there are still significant issues with workforce planning and the robustness of the workforce savings that NHS bodies claim to have delivered. **The Department should:** • **step up its challenge of NHS bodies' workforce plans, to ensure that they have robust and detailed workforce plans, which link directly to service plans and plans for workforce savings; and** • **provide detailed in-year challenge to test whether the workforce savings that NHS bodies report can be reconciled to the workforce plans and actual staffing levels.**
R5	Last year we recommended that the Department should support NHS bodies in sharing good practice on savings, but our local work suggests that there is little evidence of learning across NHS Wales either by sharing good practice on savings schemes that have worked well or using available costing data to identify and learn from existing practices. **The Department should support NHS bodies by helping to identify, gather and disseminate good practice, considering the use of case studies, seminars, training and a central access point for this information.**
R6	Last year we recommended that the Department work with NHS bodies to profile technical accounting adjustments and central savings across the year. This year, we found several NHS bodies are still making relatively large adjustments at the end of the year. This situation exposes the Department to significant financial risks at the year end, if those adjustments do not materialise. **We recommend that the Department steps up its challenge on NHS bodies to produce updated projections, including in-year balance sheet reviews, building on the good practice we found in at least one local health board.**

Part 1 - Despite a tough financial settlement, NHS bodies met their statutory financial targets in 2012-13 but some of the actions taken to break-even are not sustainable

1.1 This part of the report considers the financial position during 2012-13 of NHS Wales – comprising the Welsh Government Department of Health and Social Services[2] (the Department) and the ten NHS bodies across Wales. It sets out the scale of the financial challenges facing the NHS at the beginning of the year and the progress it has made to meet these challenges through the year.

The Department marginally exceeded its approved budget and took a risk-based approach to reducing spending on central programmes in order to provide additional funding to NHS bodies

Despite a tough financial settlement, the Department came very close to containing spending to within its approved budget

1.2 As our previous *Health Finances*[3] report identified, the NHS in Wales is facing the toughest financial challenge in the UK. Other parts of the UK have received small real terms increases to health revenue budgets, whereas the NHS in Wales has faced a real terms reduction since 2010-11. Such a sustained real terms reduction in health spending is unprecedented in UK history. As set out in Figure 1, data from the Office of National Statistics shows that in 2011-12, Wales had a lower health spend per head of population than Scotland, Northern Ireland and comparable regions in England. Our analysis set out in Figure 2, based on indicative budget allocations, suggests that health spending in Wales is likely to fall behind England by 2014-15. Analysis of more recent data confirms the trend in Figure 2, with health spending per head of population in Wales falling behind the other countries in the UK.

1.3 In 2012-13, there was a small (0.4 per cent) cash terms reduction in the health elements of the Department's revenue budget which, at the start of the financial year was £5.85 billion compared with £5.87 billion the previous year. By the end of the 2012-13 financial year, the budget had been increased by some £0.057 billion (one per cent of the budget), comprising:

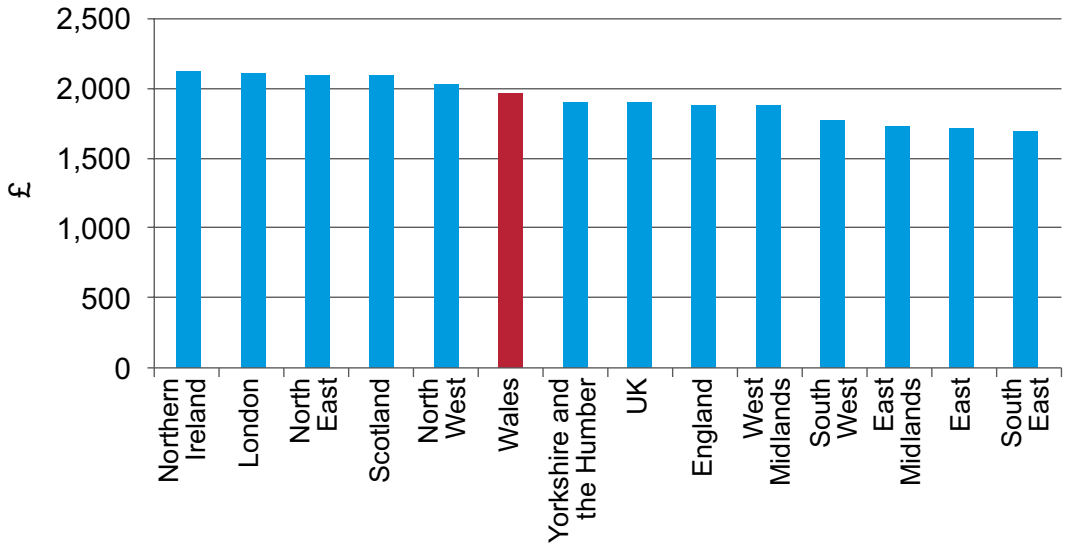
- **a** £35 million transfer from capital to revenue;
- **b** £12 million to reduce orthopaedic waiting times; and
- **c** £10 million from bids from the invest-to-save fund[4].

2 Although we refer to the Department for Health and Social Services, for our analysis of NHS budgets and spending we have excluded all non-health elements.

3 Further information can be found in our 2012 Health Finances report at www.wao.gov.uk/assets/englishdocuments/NHS_Finances_167A2012_English_2.pdf

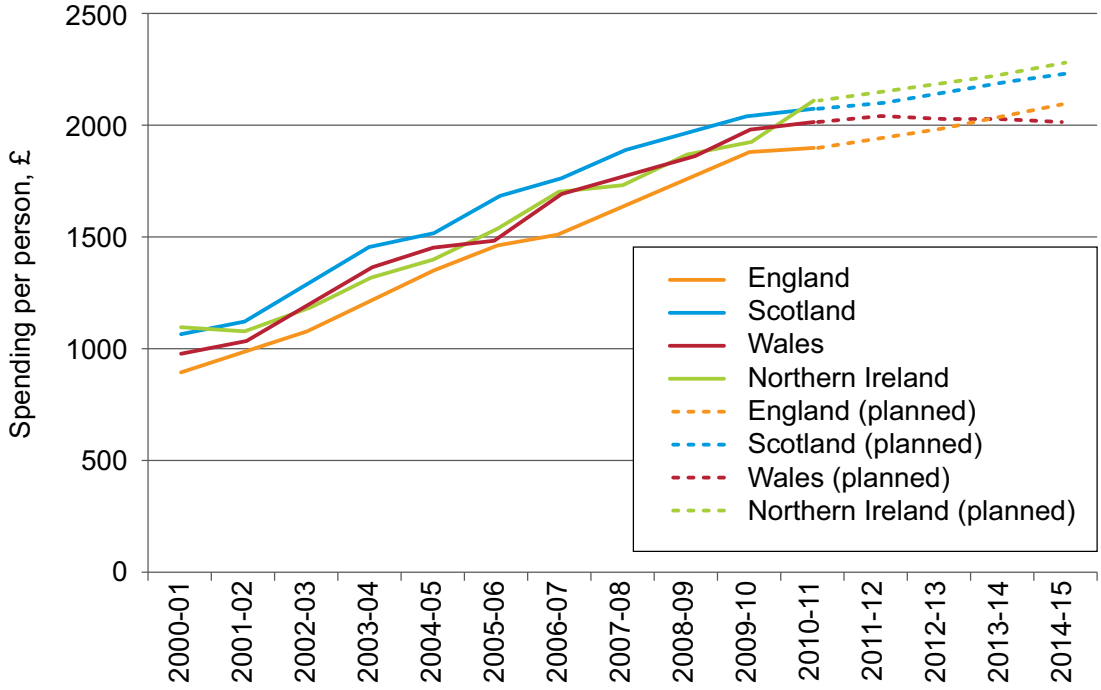
4 The invest-to-save fund provides funding for initiatives that involve upfront costs in order to release spending. Projects must pay back the initial investment. The £10 million here is net of savings that have been repaid.

Figure 1 - UK public expenditure on health services per head of population 2011-12



Source: Office for National Statistics, Country Regional Analysis, October 2012.

Figure 2 - Projections of health spending based on budget plans following the 2010 Spending Review



Source: National Audit Office, Healthcare across the UK (June 2012)

1.4 During the year, the Department made a planned draw of £12 million from central reserves as part of an ongoing commitment to funding waiting times for orthopaedics. Given that this funding was part of a three-year commitment announced in 2011, in our view it should have been incorporated into the Department's budget. By the year end, the Department overspent on its approved budget by £5 million (around 0.1 per cent of the budget). The Department reports that this was mainly due to the increased cost of clinical negligence compensation. This overspend was covered by underspends elsewhere within the Welsh Government. Consequently, unlike previous years, the Department did not need to make any unplanned call on the Welsh Government's central reserves.

The Department took an appropriate risk-based approach to making savings from centrally managed budgets to fund the increased cost pressures at NHS bodies following a mid-year review, but this sends mixed messages about the availability and allocation of additional funding

1.5 At the beginning of 2012-13, the Department was aware that there was a significant risk that NHS bodies would require additional funding. In March 2012, NHS bodies reported that they had not identified sufficient savings to bridge the £315 million gross funding gap for 2012-13. The Chief Executive of the NHS and the Department's Director of Finance met with each NHS body to discuss the position with a view to ensuring NHS bodies had robust plans to meet their statutory break-even target. In May 2012, all NHS bodies submitted plans to the Department that reported sufficient planned savings to cover forecast expenditure, with the exception of Hywel Dda Local Health Board where there was a remaining funding gap of £12.8 million. The Department recognised that there was a significant risk that the NHS bodies would overspend by between £30 million and £95 million, adopting a planning assumption of £50 million as the most likely deficit.

1.6 At the beginning of the year, the Department set aside a contingency of £49.4 million. The contingency was made up of £31 million from within central budgets and a further £18.4 million coming from the repayment of brokerage – funding drawn forward by NHS bodies from 2012-13 in 2011-12 and now requiring repayment – which was provided to some local health boards last year. The contingency was therefore initially sufficient to cover the identified risk of a £50 million overspend across the NHS bodies.

1.7 However, the Department faced a further funding challenge due to some £49 million of unfunded commitments within its own central services budget. This position had arisen in part because of existing commitments to programmes where demand and costs were rising, such as some primary care services and clinical negligence. There were also some unfunded commitments from the Welsh Government's manifesto and programme for government. The Department reviewed each unfunded commitment and identified the scope to reduce or delay spending on those commitments in 2012-13 by £11.7 million. This left a funding gap in the order of £37 million which the Department needed to bridge (paragraph 1.10).

1.8 The Department monitored the position of every NHS body at the end of each month. In July 2012, the Department announced £9 million of additional allocations to manage unscheduled care pressures and set aside a further £1 million for unscheduled care initiatives. In their monthly monitoring returns, NHS bodies set out a best, most-likely and worst-case scenario in terms of their end of year position. With the 'most likely' deficit across NHS bodies exceeding

the Department's planning assumption of £50 million, the Department undertook a detailed 'mid-year review' in September 2012. That review involved an assessment of the financial and service delivery challenges and performance, including detailed discussions with each NHS body.

1.9 Following the review, the Department agreed to provide an additional £82 million in total to the NHS bodies. As set out in Figure 3, the amounts allocated to the NHS bodies do not directly correspond to the level of financial risk that they were reporting to the Department. The Department's risk assessment went wider than the financial risk; it also included risks to delivery against other performance targets and priorities. Consequently, three local health boards received more funding than was required to cover their reported likely deficits. Overall, the process for allocating this additional funding was an improvement on that adopted last year, where most NHS bodies received the same amount regardless of their financial position. Nonetheless, the Department could be more explicit about the criteria against which it assesses and balances risks, so that NHS bodies can have a clearer idea of the underpinning rationale.

Figure 3 - Deficits at the mid-year review (September 2012) and the additional funding provided by the Department in December 2012

Local health board	Forecast year end deficit (£ million)	Additional funding provided (£ million)
Abertawe Bro Morgannwg ULHB	13.5	10.0
Aneurin Bevan LHB	0	10.0
Betsi Cadwaladr ULHB	19.0	15.0
Cardiff and Vale ULHB	20.0	25.0
Cwm Taf LHB	10.0	10.0
Hywel Dda LHB	3.1	8.0
Powys TLHB	4.0	4.0
Total	**69.6**	**82.0**

Note

The 'forecast year end deficit' is the 'most likely' deficit reported by NHS bodies in the Monthly Monitoring Return for September 2012. Further details on the position of NHS bodies in September 2012 can be found in our update paper for the Public Accounts Committee at www.wao.gov.uk/assets/englishdocuments/574A2012_Health_Finances_Update_Report_FINAL.pdf

Source: Wales Audit Office analysis of Welsh Government data

1.10 The Department was able to provide the additional funding to NHS bodies and meet the unfunded commitments (paragraph 1.7) in part by reducing spending on non-priority areas within its central budget. In May 2012, the Department undertook a review which included an assessment of the likely impact of making such reductions and ranked the risks as low, medium or high. The Department decided to go ahead with £32.3 million of low and medium-risk spending reductions. In November 2012, the Department identified a further £9.7 million of savings and underspends against central budgets. Later in the year, the Department identified additional savings and/or underspends worth around £1.6 million. Some of the key areas where the Department reduced its spending included:

- **a** £4.5 million from training the NHS workforce (2.4 per cent of budget);
- **b** £1.9 million from health protection and immunisation (16 per cent of budget);
- **c** £2.0 million from health promotion (31 per cent of budget);
- **d** £1.2 million from emergency preparedness (20 per cent of budget);
- **e** £3.9 million from health research and development (8.9 per cent of budget); and
- **f** £0.5 million from hospice support (7.1 per cent of budget).

1.11 We have not examined the individual assessments and decisions but the principle of identifying priorities and risks before deciding where to cut spending is sound. There is a potential risk that a short term reduction in areas like training and prevention could have longer term cost implications. The Department is undertaking a review to establish whether further reductions in some of these areas can be made without impacting on the quality of services and whether additional investment in some areas could lead to savings over the medium to long term.

1.12 The Department also made a £35 million capital to revenue transfer in the year. In essence, it gave £35 million of its capital[5] budget in exchange for £35 million of revenue budget through the Welsh Government's budgetary processes. By doing so, it increased its revenue expenditure budget but decreased its capital expenditure budget. Such a transfer provided a short-term solution to managing the pressure on the revenue budget but the use of capital to revenue transfers is not sustainable in the medium and longer term.

1.13 Figure 4 shows that the total savings, alongside the £35 million capital to revenue transfer, were sufficient to enable the Department to cover the unfunded central commitments and additional funding to NHS bodies to enable them to meet their financial break-even targets. However, the savings were not sufficient to cover the additional increase in clinical negligence compensation.

5 Capital funding is for spending on NHS assets including property, vehicles, ICT, plant and medical equipment.

Figure 4 - Cost pressures on the Department's revenue budget and in-year savings 2012-13

Cost pressures	
NHS bodies' additional funding	£82 million
Unscheduled care pressures	£10 million
Unfunded central commitments	£37 million
Additional clinical negligence compensation	£8.5 million
Total cost pressures	**£137.5 million**
Funding	
Department's contingency	£31 million
Repayment of brokerage	£18.4 million
Capital to revenue transfer	£35 million
Reported savings and underspends in central health and social services budgets	£48.1 million
Total funding	**£132.5 million**
Net overspend	**£5 million**

Source: Wales Audit Office analysis of Welsh Government data

1.14 We have concerns that the Department's approach to the allocation of additional funding each year continues to give mixed messages to NHS bodies. The Department informed NHS bodies that that they would not receive any additional funding. On the one hand, this approach clearly encourages some NHS bodies to take the tough decisions and actions needed to break-even. However, some NHS bodies' financial planning for 2012-13 included, from the outset, an assumption that they would receive additional funding from the Department. In the event, the local health boards did indeed receive additional funding despite being told that they would not.

All NHS bodies met their break-even target in 2012-13 through a mix of savings and additional funding but many of the actions taken are not sustainable and improvements are required to financial planning and reporting

Delivery of substantial savings in 2012-13 helped all NHS bodies meet their break-even targets, but continued reliance on additional funding, one-off technical accounting adjustments and activity reduction is not sustainable

1.15 It is commendable that all NHS bodies achieved break-even in 2012-13 given the significant ongoing financial pressures. In March 2012, NHS bodies estimated the funding gap across Wales at some £315 million, which was subsequently revised to £330 million. The funding gap is made up of £193 million in-year cost pressures such as pay and energy inflation and £137 million to address an 'underlying deficit': funding issues rolled-over from the previous financial year.[6] Our work at NHS bodies has looked at how each organisation bridged their own element of that funding gap and the sustainability of their approach. A detailed analysis of financial performance by NHS body in 2012-13 is set out in Appendix 2.

1.16 Figure 5 shows that NHS bodies reported that over half of the 2012-13 funding gap (57 per cent) was bridged by in-year savings of £188 million. The remaining gap was bridged by additional funding (29 per cent) from the Department of £92 million and other actions including technical accounting adjustments and other savings estimated at £49 million (15 per cent). As shown in Appendix 2, two NHS bodies received year end brokerage from the surpluses and brokerage provided by other NHS bodies totalling £6.5 million. By the end of the financial year, the reported underlying deficit had risen from £137 million to £166 million.

Figure 5 - How NHS bodies achieved break-even in 2012-13

	£'000	% of final funding gap
Funding gap for 2012-13	(330,510)	100%
Reported savings for 2012-13	187,619	57%
Department's additional funding 2012-13	92,000	28%
Other NHS surpluses used for year end brokerage	373	-
Other (cost containment, cost avoidance and technical accounting gains)	50,952	15%
Net surplus	**434**	

Source: Wales Audit Office analysis of Welsh Government and NHS bodies' data

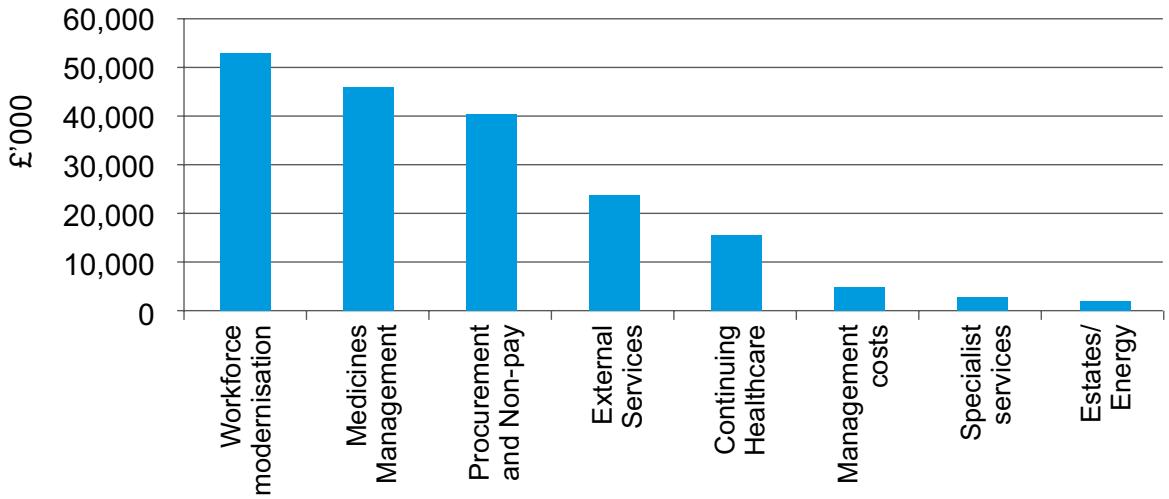
6 In 2011-12, NHS bodies bridged £137 million of their funding gap through additional non-recurrent income, one-off savings and accounting adjustments. As a result, £137 million of costs were not permanently removed, as is required to sustainably bridge the funding gaps. Therefore, in 2012-13 NHS bodies needed to address this underlying deficit of £137 million in addition to the in-year cost pressures, in order to deliver a sustainable break-even position.

NHS bodies reported delivery of £188 million of savings in 2012-13 but we have some concerns over their accuracy and sustainability

1.17 NHS bodies have delivered a range of cost savings over recent years but they are clearly finding it tougher to deliver savings, with the reported £188 million of savings in 2012-13 almost £100 million less than in 2011-12. Nevertheless, the reported savings still represent around 3.5 per cent of the total revenue budget. Figure 6 sets out the savings in 2012-13 as reported by NHS bodies to the Department in the 'monthly monitoring returns'.

1.18 Workforce modernisation is the largest area of reported savings. NHS bodies reported savings of £57.5 million in 2012-13 on workforce modernisation and management costs combined, with £44.2 million of these savings purporting to be as a result of reducing staff numbers. However, the reported savings are difficult to reconcile with other expenditure and staffing data. The audited 2012-13 financial statements show that staff and director costs have actually risen by £43.2 million (1.5 per cent) across Wales in the year and staff numbers have stayed constant. At the beginning of the year, NHS bodies forecasted total pay expenditure of

Figure 6 - Savings reported by NHS bodies as achieved in 2012-13



Source: Wales Audit Office analysis of Welsh Government data

£2.864 billion for the year but actually spent £2.975 billion – over £110 million more than they forecast. One area where NHS bodies have made progress is in spending £7.5 million less on agency staff in 2012-13 than in 2011-12. Last year we noted in particular the difficulties of achieving cash-releasing workforce savings and recommended that the Welsh Government provide challenge to NHS bodies to help; however, this appears to remain a significant issue.

1.19 The second-largest area of reported savings is in medicines management[7]. NHS bodies report savings of £45.8 million in the year. The audited financial statements show that costs in this area (prescribing and drugs) have reduced by £11.2 million. It is unclear what the remainder of these reported savings are. We are currently undertaking a programme of work looking at aspects of medicines management. Our work to date is showing that there are opportunities to make savings on the costs of primary care prescribing without impacting on the quality of patient care.

1.20 The third savings area to highlight is continuing healthcare[8]. This is a significant cost pressure for NHS bodies and will continue to be in the future. NHS bodies reported savings of £15.5 million in 2012-13 but actual costs have increased by £10.5 million compared to 2011-12. Again it is unclear what these reported savings actually represent.

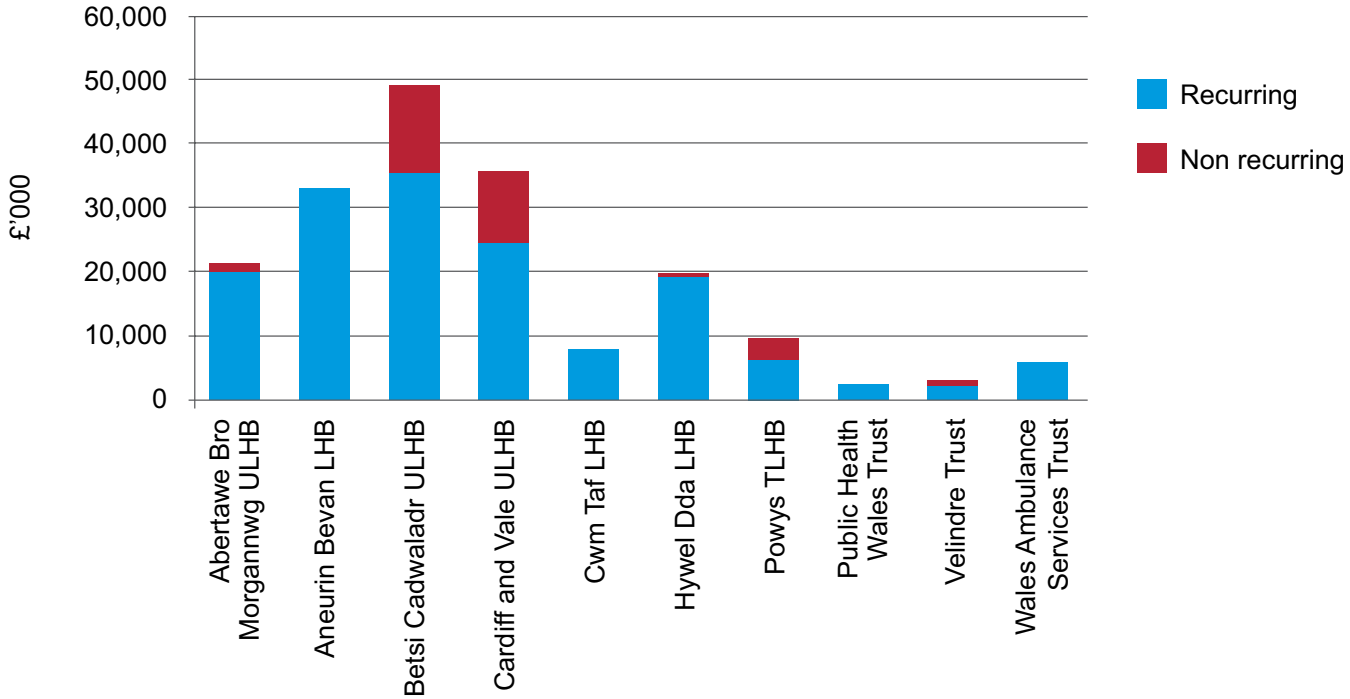
1.21 It may be that a large part of the reported savings are actually 'cost containment' or 'cost avoidance', rather than cash-releasing savings. In the environment of flat cash budget settlements, avoiding costs such as inflationary increases in the price of medicines will help NHS bodies to bridge their funding gaps. However, there needs to be caution with cost avoidance as it can be easy to overstate the scale of savings, for example, by including costs avoided by deciding not to purchase an item as a saving.

1.22 Overall, NHS bodies report that 17 per cent of their savings are non-recurrent ie, are one-offs that will not continue to be saved in future years. This is a larger proportion of total savings than in 2011-12 where only 12 per cent of savings were identified as non-recurrent. Figure 7 shows that some NHS bodies are far more reliant on non-recurring savings than others.

7 Medicines management encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care.

8 Continuing healthcare is the package of care that is arranged for patients and is funded solely by the NHS for individuals who are not in hospital who have complex, ongoing healthcare needs.

Figure 7 - Recurring and non-recurring cost savings by NHS body in 2012-13



Source: Wales Audit Office analysis of Welsh Government data

Other actions were undertaken to reduce the funding gap by £51 million but many were not sustainable

1.23 NHS bodies undertook a range of other actions in order to deliver some £51 million of 'savings' including:

- **a** one-off technical accounting adjustments;
- **b** cost avoidance/containment schemes; and
- **c** additional income.

1.24 The use of legitimate one-off technical accounting adjustments does not relate to activity performance or actual cost savings, but instead how items are valued and accounted for in the financial statements. We estimate that one-off technical accounting adjustments were in excess of £20 million in 2012-13. Examples include changing the way estimates and provisions of future liabilities are calculated. In order to fairly state the financial statements, NHS bodies should be reviewing the basis of their calculation each year so this is good practice. This year NHS bodies' reviews generally reduced estimates of liabilities and costs, thereby freeing up resource to support the break-even position. However, there will inevitably be times when costs may need to be increased. These gains are in accordance with the accounting standards but are not sustainable.

1.25 NHS bodies reduced their planned elective[9] activity in the last quarter of 2012-13, as set out in Figures 8 and 9. The reasons behind this reduction are complex. Officials told us that elective procedures had to be cancelled because of unprecedented emergency pressures on services, resulting in beds being occupied by emergency patients. In addition, the numbers of beds have reduced over the past few years, providing local health boards with less headroom to handle such emergency pressures without impacting on elective care. We recognise that there have been emergency pressures, particularly in the first half of 2012-13, but the data on emergency demand and bed use does not fully explain the significant drop in elective activity. We are concerned that financial pressures is also a factor behind the reduction in elective activity, in that:

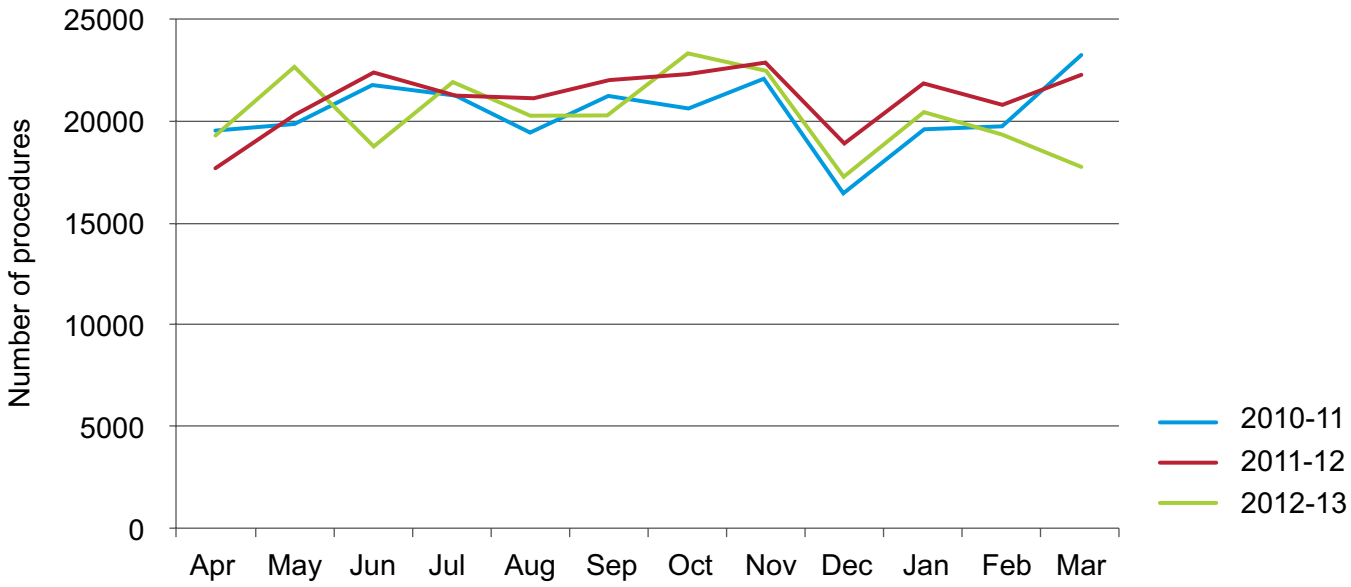
a some NHS bodies decided to significantly cut spending on waiting list initiatives, which involve paying hospital consultants premium rates for additional elective work; and

b some NHS bodies have told us that they took decisions to reduce elective activity in non-priority areas, based on clinical need, in order to reduce costs.

1.26 While reducing activity may have resulted in some savings, these are likely to be unsustainable. Reducing spending on waiting list initiatives is only sustainable if NHS bodies are able to significantly improve productivity in order to manage recurrent demand through activity paid at normal rates. Savings from cancelling or not scheduling elective activity are in most cases likely to have been marginal and represent a false economy. If activity is stopped or reduced, staff have to be redeployed and 'real' savings would only come from variable costs such as cleaning, prostheses and energy use. In addition, there is also an impact on patients who have to wait longer for treatment and for some their health may deteriorate with the delay in treatment and this could result in further costly procedures in the future. Reducing activity in this way is poor value for money and not an efficient and sustainable approach to making financial savings.

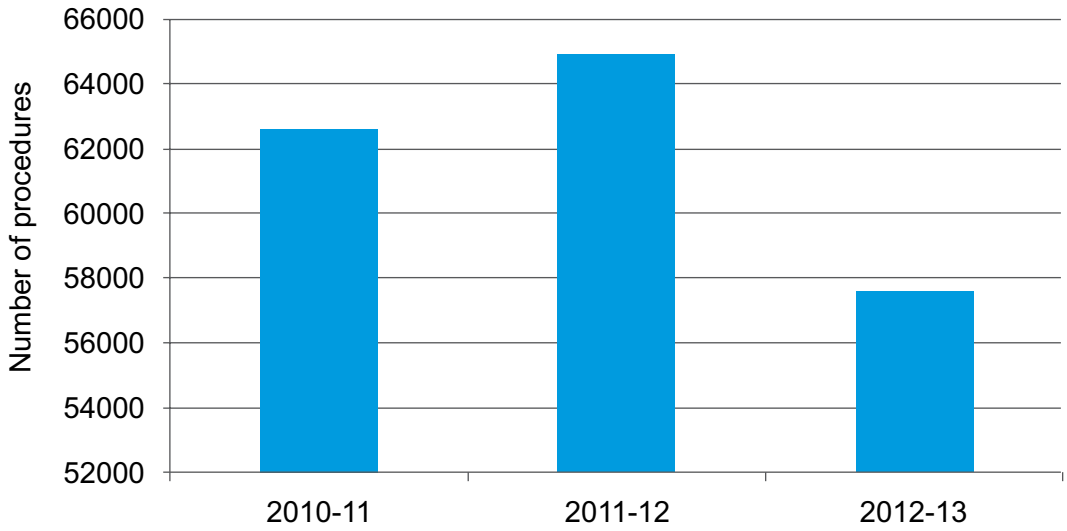
9 Elective procedures are planned procedures that are scheduled in advance as they are not a medical emergency.

Figure 8 - Number of elective procedures



Source: Wales Audit Office analysis of Welsh Government data

Figure 9 - Number of elective procedures in final quarter



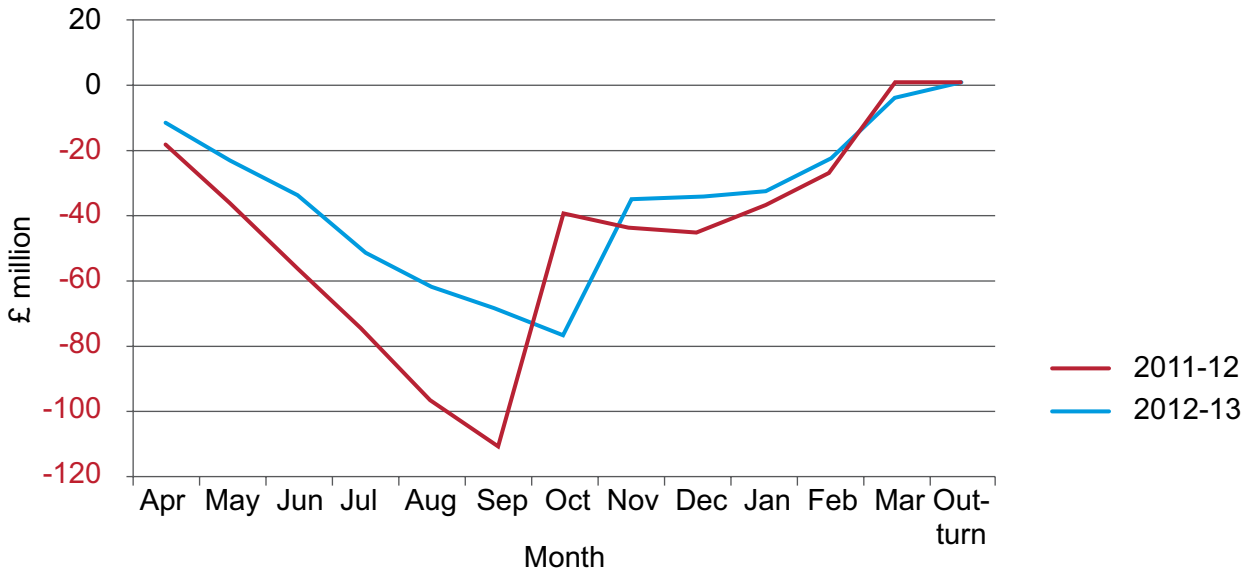
Source: Wales Audit Office analysis of Welsh Government data

NHS bodies did not have realistic savings plans at the beginning of 2012-13 to bridge the financial gap and improvements are required to the delivery of service plans and the monitoring and reporting of financial savings

The processes for setting budgets and identifying savings require improvement to ensure that plans are realistic, focused on longer-term goals and better consider quality of patient care and safety

1.27 Our work at NHS bodies has identified that although the process for budget setting and identification of savings for 2012-13 varied across NHS bodies, there are some common themes and improvements which should be considered to help make improvements in these areas. Our overriding concern is that the process of identifying savings to bridge financial gaps still functions very much as an annual affair driven by the statutory break-even requirement. Figure 10, which shows the NHS Wales financial position through 2011-12 and 2012-13, clearly illustrates the short-term pattern of overspends that are brought back by a combination of additional funding and late, sometimes unsustainable, savings in the final few months.

Figure 10 - NHS Wales' surplus/deficit across 2011-12 and 2012-13



Source: Wales Audit Office analysis of Welsh Government data

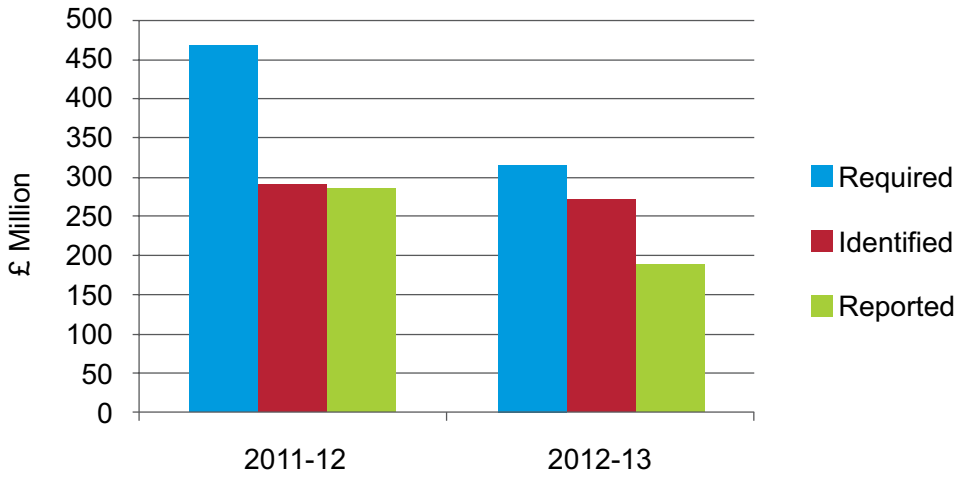
1.28 We have identified that the plans submitted by NHS bodies to the Department in May 2012 purporting to show a break-even position were not robust (paragraph 1.5). We found that many of the planned savings in their plans had little or no detail behind them showing how those savings would actually be achieved. In our view, none of the local health boards and only one of the NHS trusts actually had robust plans in place to ensure their expenditure was matched by income and funding at that point in time.

1.29 In general, NHS bodies' approach to identifying savings remains focused on the short-term. Many NHS bodies did not present their 2012-13 savings plans for their Board approval before 1 April 2012 and some plans were presented well into the financial year. A consequence of these delays is that savings delivery is far below target early in the year, but increases substantially in the final few months. This pattern reflects a short-term cycle focused on reaching the year end and then 'going back to the drawing board' to identify new savings for the next financial year.

1.30 The process for setting 2012-13 budgets in NHS bodies was in the main driven from the previous year's position, rolled forward and updated for expected changes and assumptions including cost pressure data provided by the Department. None of the NHS bodies fully considered service and workforce plans and activity data to help reset budgets from a 'zero base'. Our work at NHS bodies also identified that some NHS bodies could not evidence that they had clear links between savings, workforce and service plans. We found that some NHS bodies' savings plans formally consider risks to quality and safety, whereas others rely on less-formal challenge of plans by clinicians and/or managers to take account of impacts on services. Linked to this, the identification of savings in the majority of NHS bodies followed a simplistic process and at a number of bodies the same flat percentage savings were required from each directorate.

1.31 Figure 11 compares required and identified savings at month 1 (April) against actual savings reported by NHS bodies for 2011-12 and 2012-13 and shows that the savings plans for 2012-13 were more optimistic than in 2011-12.

Figure 11 - Total NHS savings 2011-12 to 2012-13



Source: Wales Audit Office analysis of Welsh Government data

1.32 An overly optimistic approach to identifying savings plans also appears to be corroborated by evidence that some budget holders in the NHS bodies refuse to sign up to their delegated budgets and/or savings plans. Budget holders often view elements of their budgets/savings plans to be outside their control and/or unrealistic, and so do not see why they should be held accountable. Having said that, in spite of these concerns, it is clear that NHS budget holders are working extremely hard to identify and deliver savings and there is some good practice at NHS bodies in engaging and supporting budget holders – some NHS bodies delivered 'finance workshops' in a timely and consistent manner to engage and advise staff who will be charged with delivering savings.

1.33 Our previous *Health Finances* report recommended that the Welsh Government encourage NHS bodies to share good practice on savings. Our audit work in NHS bodies found little evidence that they share and consider each other's successful savings schemes to identify how they might make savings of their own. This lack of learning is a significant lost opportunity. Similarly, we found that NHS bodies made limited use of cost information such as the All Wales Benchmarking Summary to identify key improvement areas and learn from the leaders in each area. There are, however, pockets of good practice – our local work identified two NHS bodies sharing productivity and benchmarking data with each other in order to help identify efficiencies.

1.34 Programme management and monitoring of progress on savings plans in NHS bodies is variable. There is evidence of central management of some form in NHS bodies but it needs to be strengthened to improve support of staff, sharing of good practice and coordination, including ensuring there are no duplicate savings areas identified in different directorates which has occurred at some NHS bodies.

In-year reporting has been strengthened but requires improvement in some key areas

1.35 The Department has strengthened the monthly monitoring returns process in recent years and it is a good means to ensure detailed and timely reporting of NHS bodies' in-year financial position and year end forecast. It provides the Department with a timely NHS-wide picture, which it can react swiftly to if required. Monthly monitoring returns set out a best, most-likely and worst-case scenario and savings are flagged up where they are viewed to be high risk. Nevertheless, it is essential that savings plans are clearly and realistically reported to ensure a proper understanding of the position so the most appropriate action can be taken by both NHS bodies and the Department.

1.36 Our work at NHS bodies indicates that there is now greater consistency between reporting to NHS bodies' Boards and to the Department and there is evidence of robust monthly reporting processes, with NHS bodies making timely submissions to the Department of the detailed information required in the monthly monitoring returns. However, there is scope for improving reporting in the following areas:

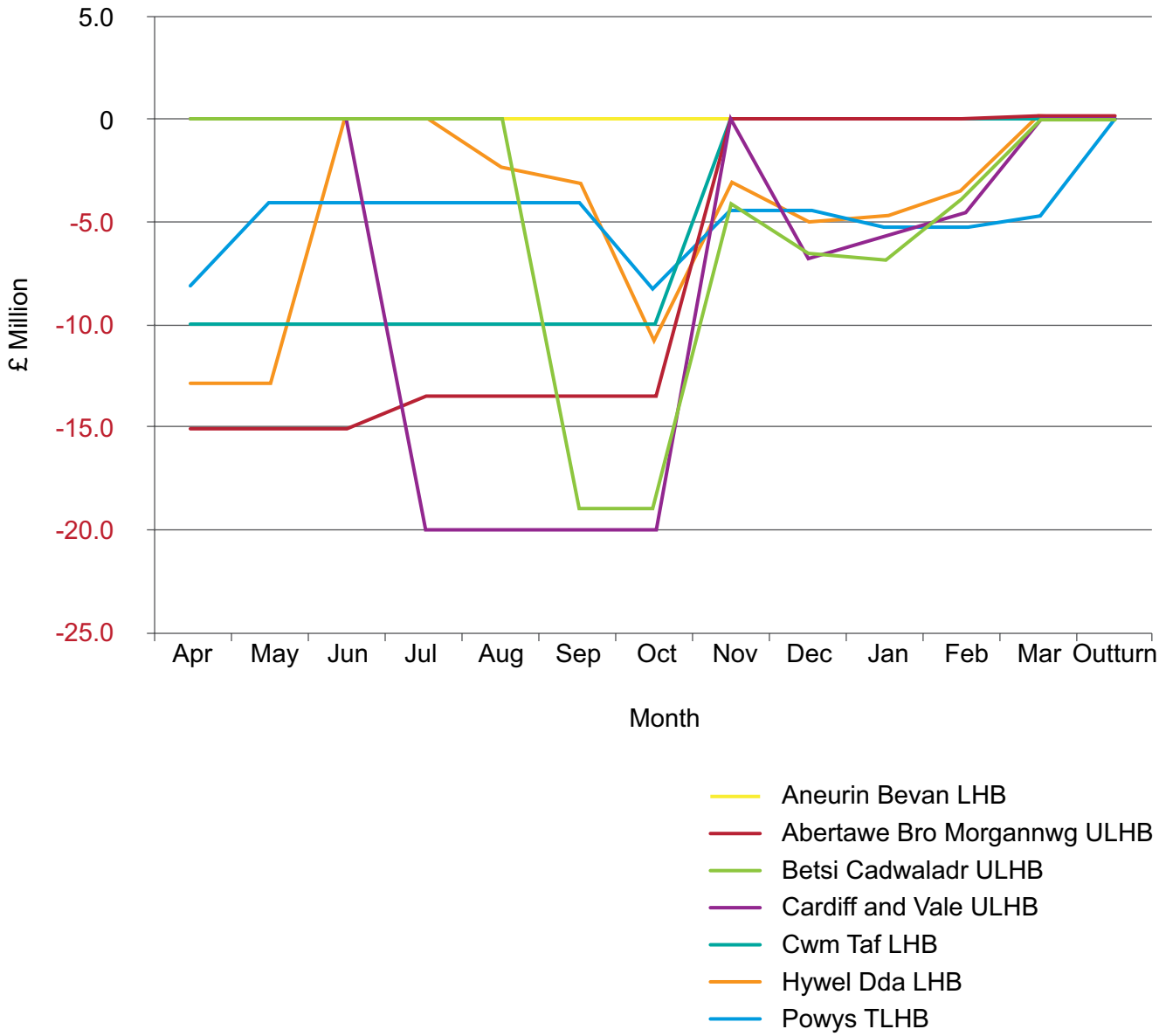
a Profiling of budgets and savings plans in many NHS bodies is based on the total budget and dividing this by 12 months which does not always capture the true profile of income and expenditure (we reported on this last year).

b Some NHS bodies are still making significant accounting adjustments at the year end despite the Department issuing guidance reflecting our recommendation to update accounting adjustments across the year. In particular, undertaking proper quarterly balance sheet reporting as a minimum (as one local health board has done) will enable bodies to improve control of their asset base and improve forecasting during the year.

c The reporting of savings in the monthly monitoring returns is inconsistent across NHS Wales. It is difficult to identify the make-up of savings and relate them back to the estimated financial gap and actual out-turn in the year. A large element of these savings appears to be cost containment/avoidance at some NHS bodies. One NHS body reported additional Departmental funding of £10 million as a cost saving and another reported £10.7 million of cost pressures that did not materialise, as savings. Both the funding gap and delivered savings are therefore likely to be overstated.

1.37 Our previous *Health Finances* report recommended the Department and NHS bodies needed to better balance optimism and realism in forecasting the end of year position. We still have some concerns about variability during the year and over-optimism. Figure 12, shows the variability of local health boards' forecasts across the financial year. In particular, in the final quarter, the forecasts predicting an end of year deficit appear to have been more pessimistic than was the case.

Figure 12 - Forecast out-turn through the year



Source: Wales Audit Office analysis of Welsh Government data

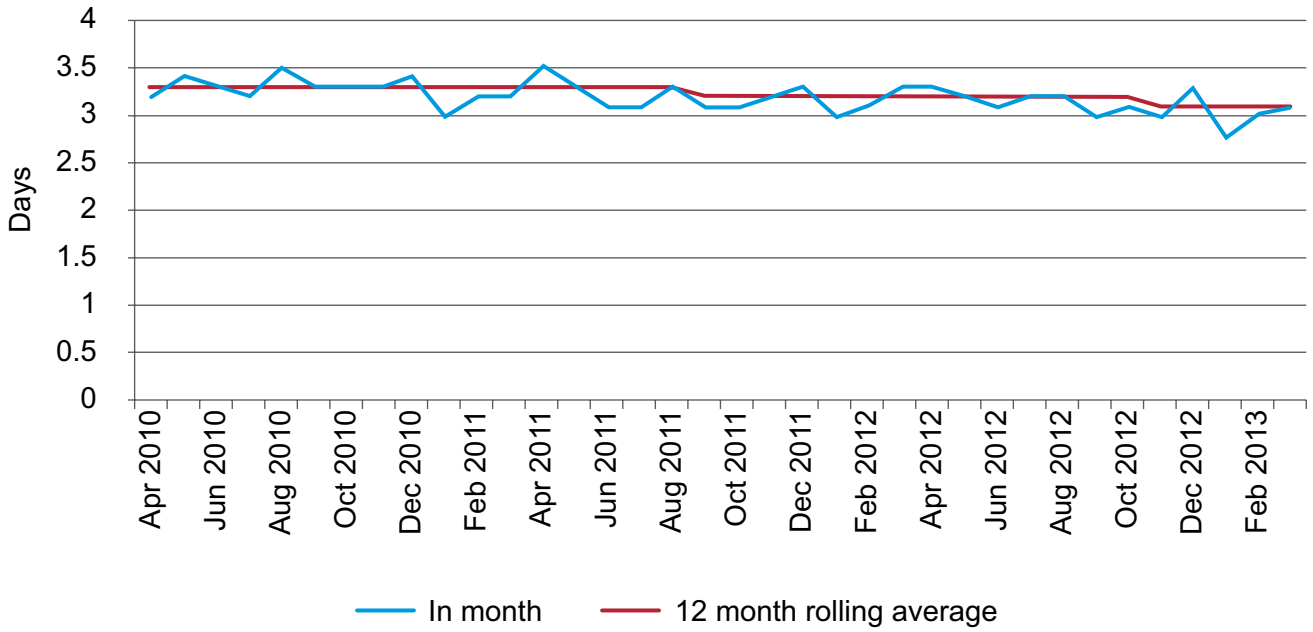
Part 2 - In the face of financial and service pressures in 2012-13, there have been some improvements in efficiency and quality but there has been a downturn in performance in some key areas

2.1 This part of the report considers whether NHS performance in 2012-13 has deteriorated during a period of financial and service pressures. We have focused on performance in relation to the top priorities within NHS Wales (Tier 1 priorities) where the Department has detailed quantitative data. Where possible we draw on data going back to 2010-11 to cover the full period of financial constraint in the NHS. The link between finance and performance is generally complex and we have not sought to definitively establish whether any changes in levels of performance are attributable to finance or other factors.

Efficiency indicators show patients are spending less time in hospital, thanks in part to rising rates of day surgery

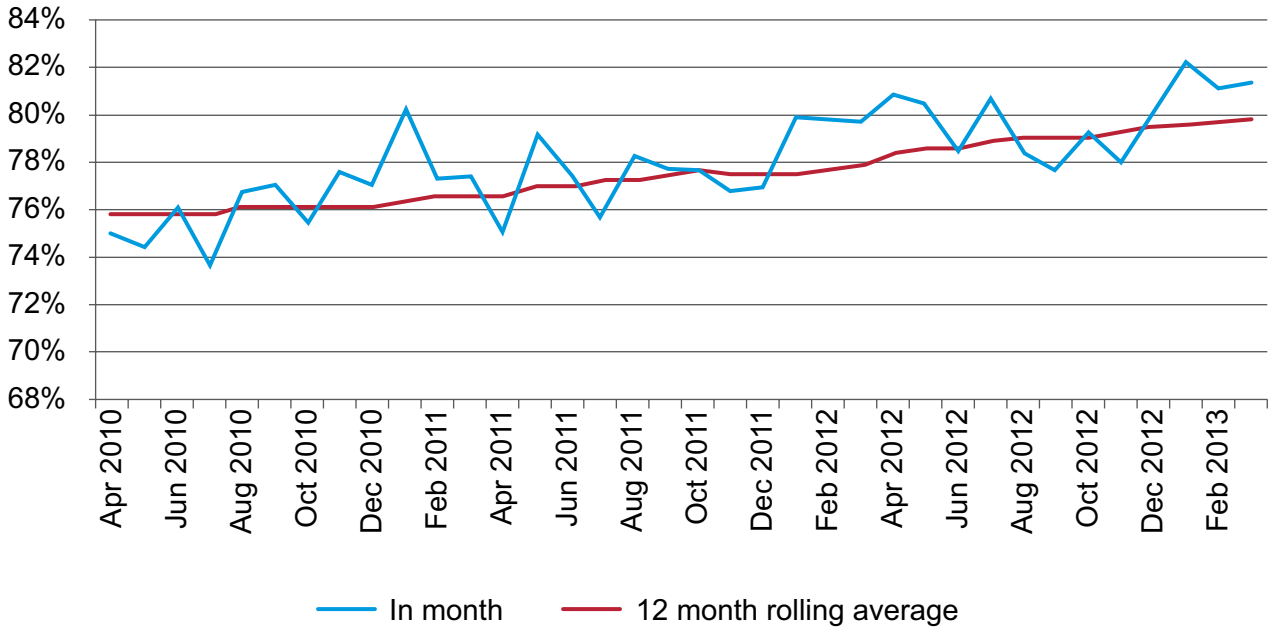
2.2 One of the key indicators of the efficiency of NHS services is how long people spend in hospital. The system is at its most efficient when patients are admitted shortly before treatment and discharged as soon as they are clinically fit to leave. The length of time elective patients spend in hospital has reduced since April 2010 (Figure 13). There has been an increase in the use of day surgery (Figure 14) and also an increase in the percentage of patients who are admitted on the day that they are treated (Figure 15). There has been a slight increase in the average length of stay for emergency patients which is likely to reflect the increase in older patients often with complex needs attending hospital as an emergency (Figure 16).

Figure 13 - Average length of stay for elective patients



Source: Wales Audit Office analysis of Welsh Government data

Figure 14 - Percentage of 'BADS 50' procedures carried out as day surgery

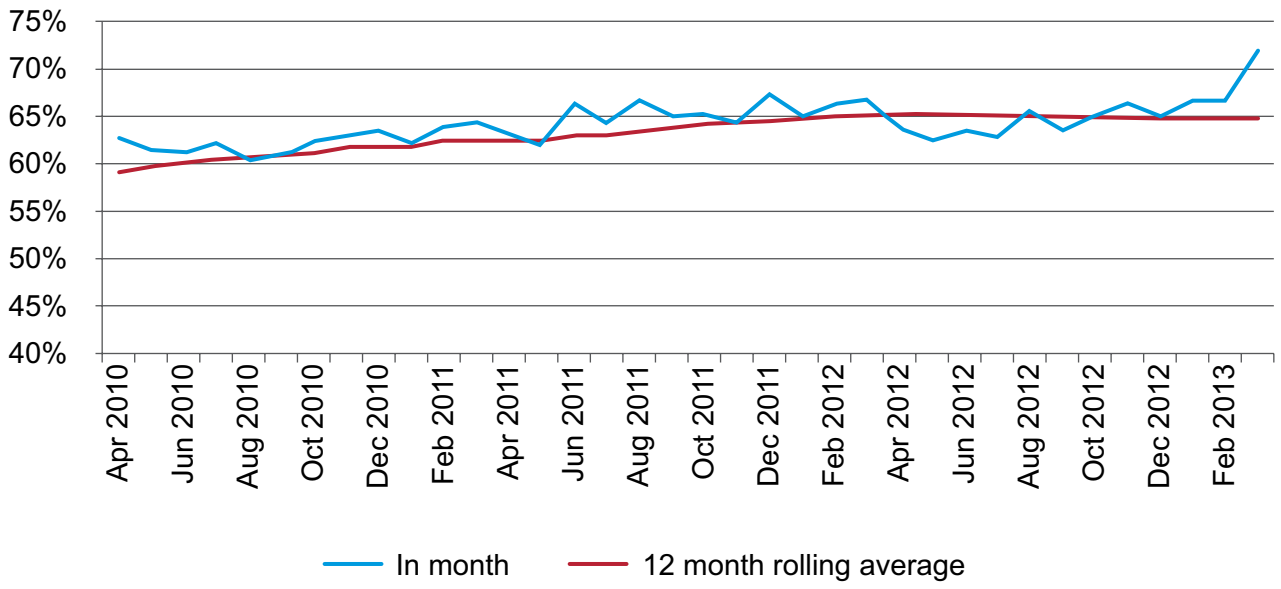


Note

The 'BADS 50' are 50 procedures that the British Association of Day Surgery has identified as appropriate to be carried out as day surgery.

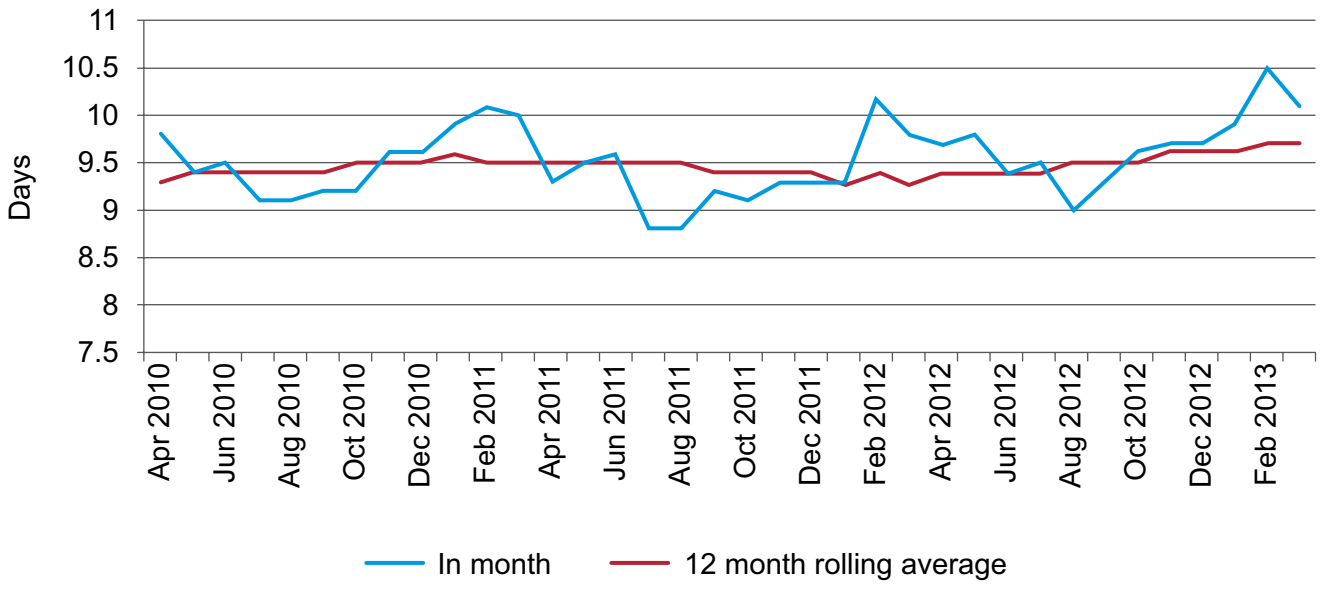
Source: Wales Audit Office analysis of Welsh Government data

Figure 15 - Elective treatments carried out on the day of admission



Source: Wales Audit Office analysis of Welsh Government data

Figure 16 - Average length of stay for emergency patients



Source: Wales Audit Office analysis of Welsh Government data

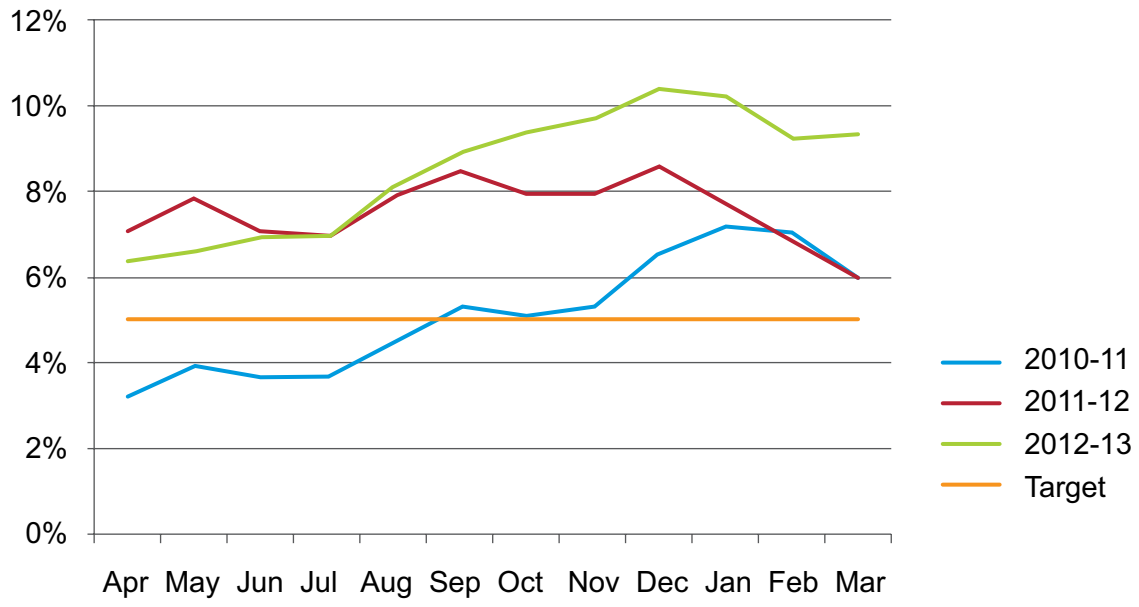
There has been a decline in waiting times performance for elective and unscheduled care and further work is required to understand the reasons and learn the lessons

Waiting times for planned treatments have generally increased and key targets including those for urgent cancer patients are not being met

2.3 The Welsh Government publishes two measures of waiting time for planned treatment. The first covers the length of time of those waiting for treatment. The second covers the length of time that patients actually waited by the time they were treated. Both measures, as shown in Figures 17 and 18, show significant increases in the proportion of patients waiting for more than 26 weeks. Since November 2010, the NHS in Wales has not met the target that less than five per cent of those on the waiting list should have waited more than 26 weeks. Figure 18 shows that almost one in five patients now wait more than 26 weeks before receiving their treatment compared with just 1 in 20 at the start of 2010-11.

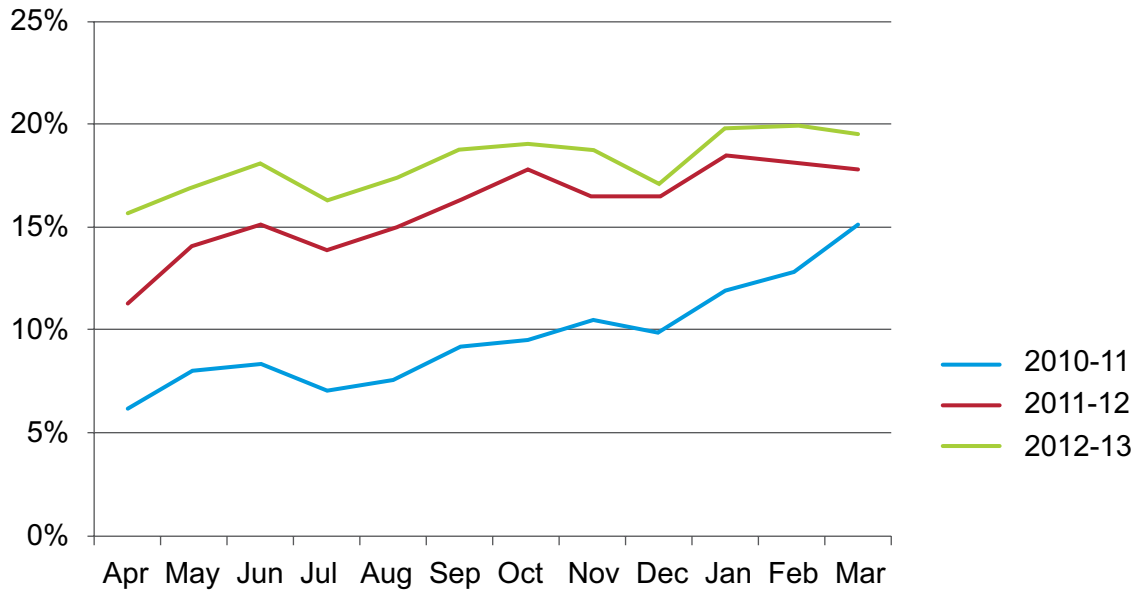
2.4 The Department has set a 'backstop' target that all patients must be treated within 36 weeks. Figure 19 shows that around five per cent of patients now wait more than 36 weeks. Overall, performance against the 36-week target was similar in 2012-13 and 2011-12 but represents a significant deterioration since 2010-11.

Figure 17 - Patients on waiting list waiting more than 26 weeks



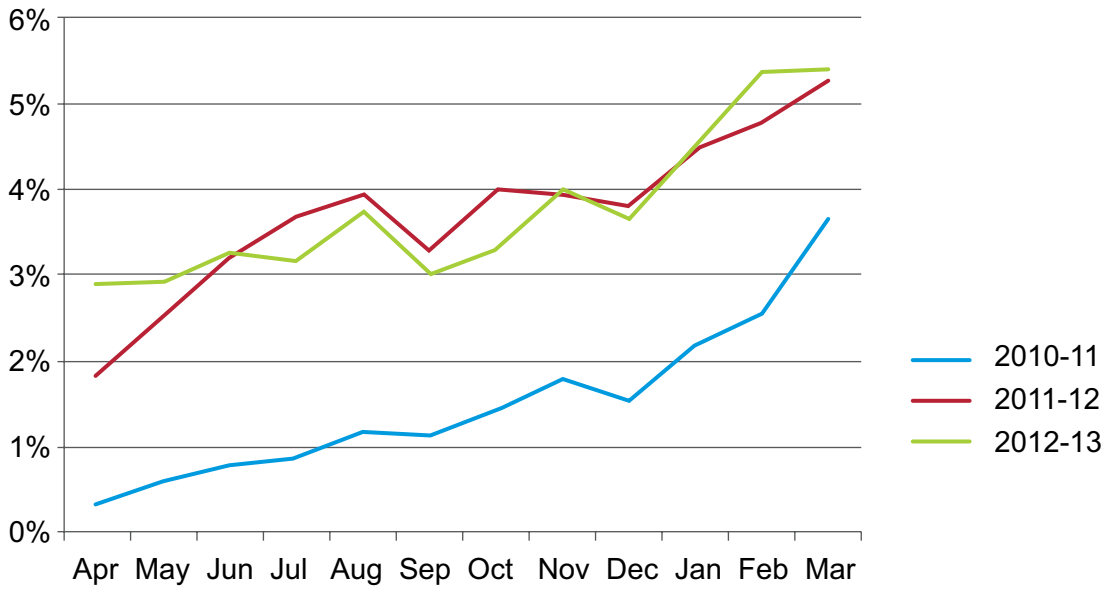
Source: Wales Audit Office analysis of data from StatsWales

Figure 18 - Treated patients that had waited more than 26 weeks



Source: Wales Audit Office analysis of data from StatsWales

Figure 19 - Patients treated who waited more than 36 weeks



Source: Wales Audit Office analysis of data from StatsWales

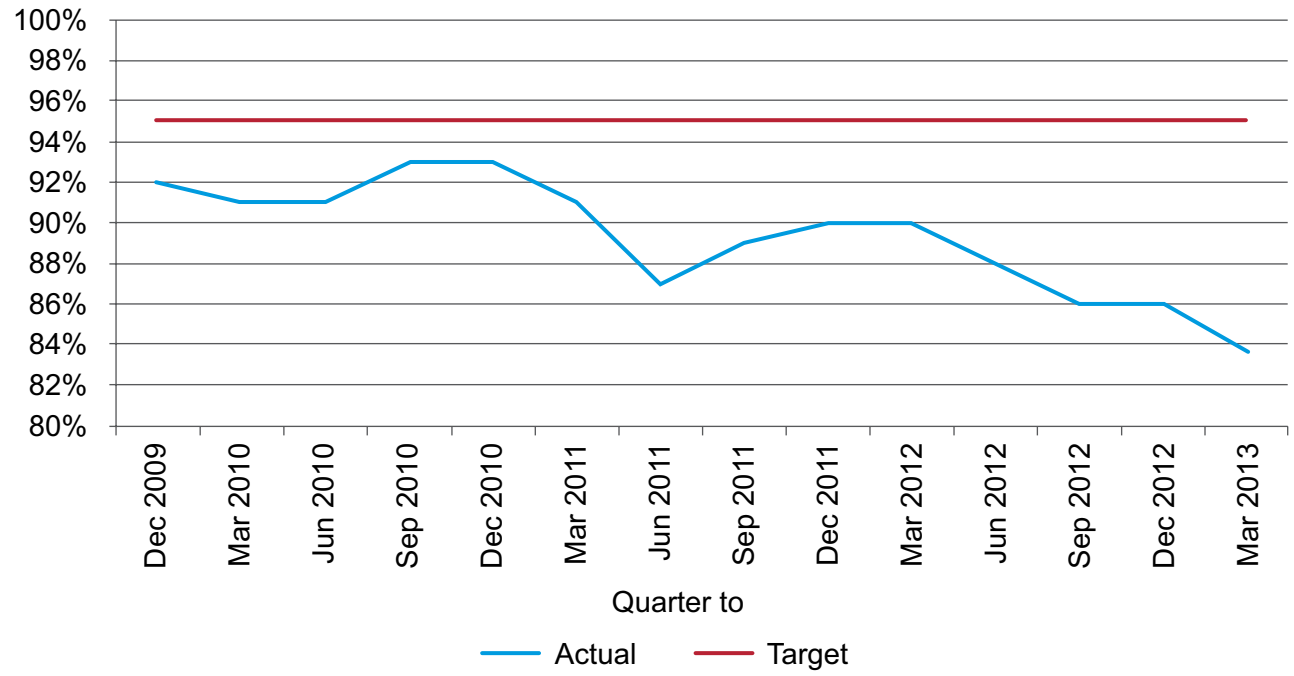
2.5 The Welsh Government has two key targets for the treatment of patients with cancer:

- **a** at least 95 per cent of patients referred by their GP with urgent suspected cancer and subsequently diagnosed as such by a cancer specialist will start definitive treatment within 62 days of receipt of referral; and
- **b** at least 98 per cent of patients not referred as urgent suspected cancer but subsequently diagnosed with cancer will start definitive treatment within 31 days of diagnosis, regardless of the referral route.

2.6 Figure 20 shows a decline in performance regarding the first cancer target. The target has not been achieved at any time during the past three years. The position had improved during 2011-12 but this has been reversed during 2012-13.

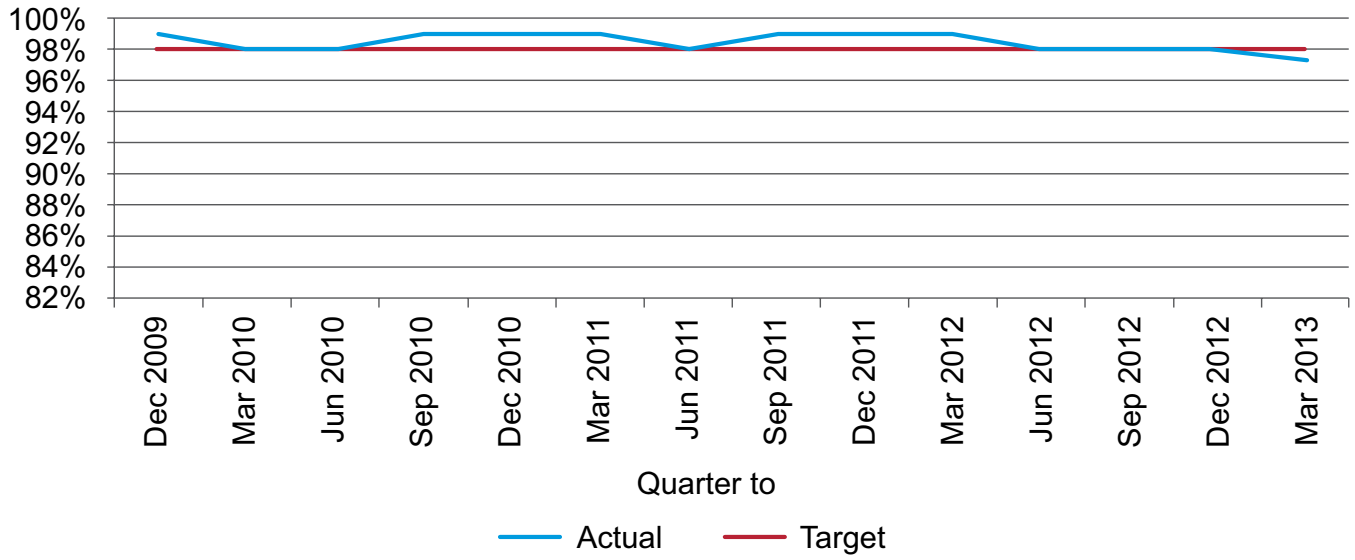
2.7 The second cancer target has been met during much of the past three years. However, as shown in Figure 21, in the final quarter of 2012-13 performance fell below the 98 per cent target for the first time.

Figure 20 - Patients on urgent cancer pathway starting treatment within 62 days



Source: Wales Audit Office analysis of data on StatsWales

Figure 21 - Patients on non-urgent route starting treatment within 31 days

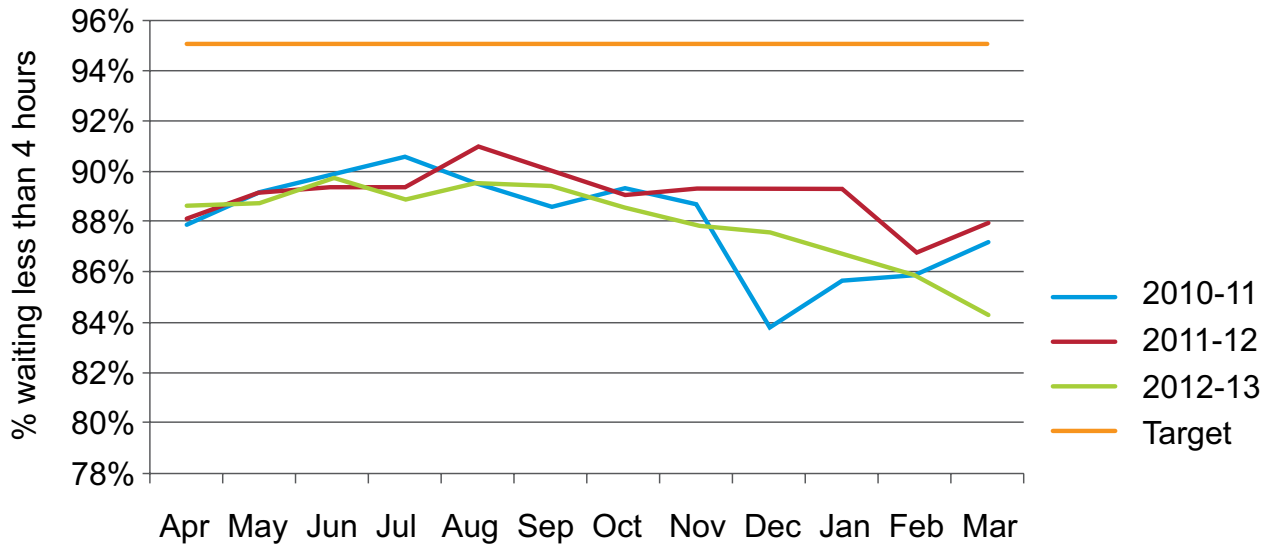


Source: Wales Audit Office analysis of data from StatsWales

Patients face longer waits in emergency departments than in previous years

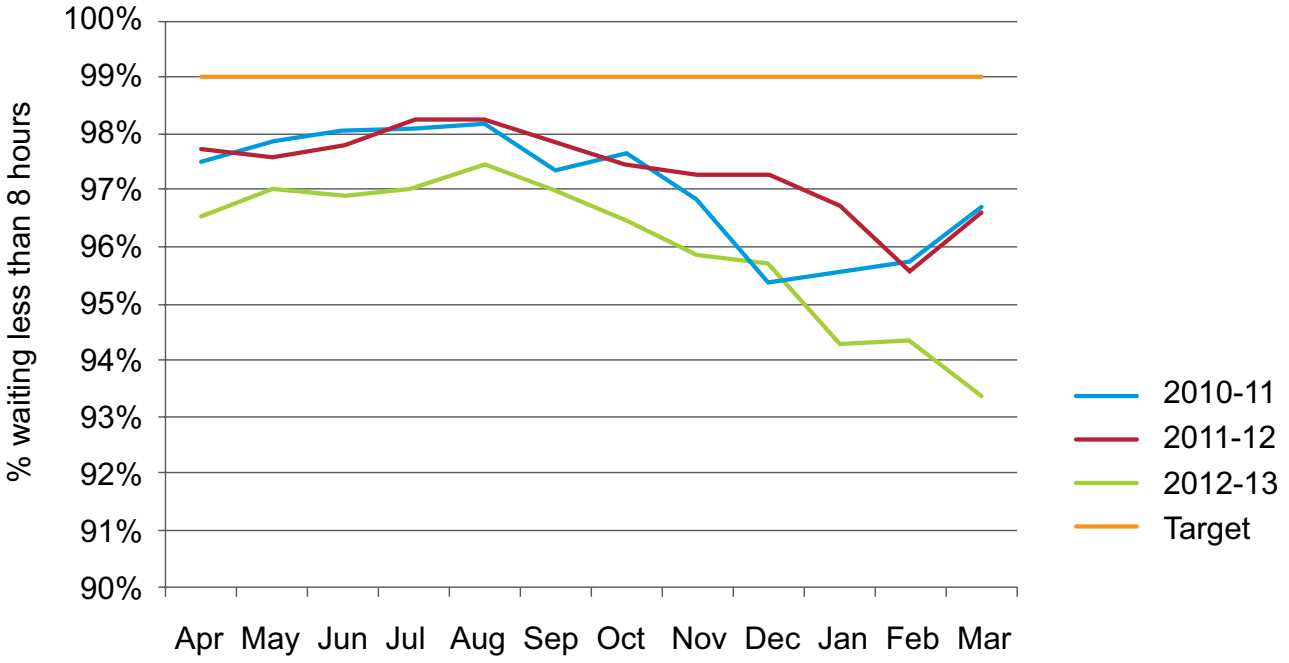
2.8 Our report on Unscheduled Care to be published Summer 2013 provides an in-depth analysis of the pressures facing emergency and out-of-hours care services. The Department has set two main targets for performance in emergency departments: 95 per cent of new patients should be treated, admitted or discharged within four hours and 99 per cent within eight hours. Figures 22 and 23 show that, following an improvement in 2011-12, performance against both measures has deteriorated significantly across 2012-13.

Figure 22 - Patients waiting less than four hours in emergency departments



Source: Wales Audit Office analysis of Emergency Department Data Set

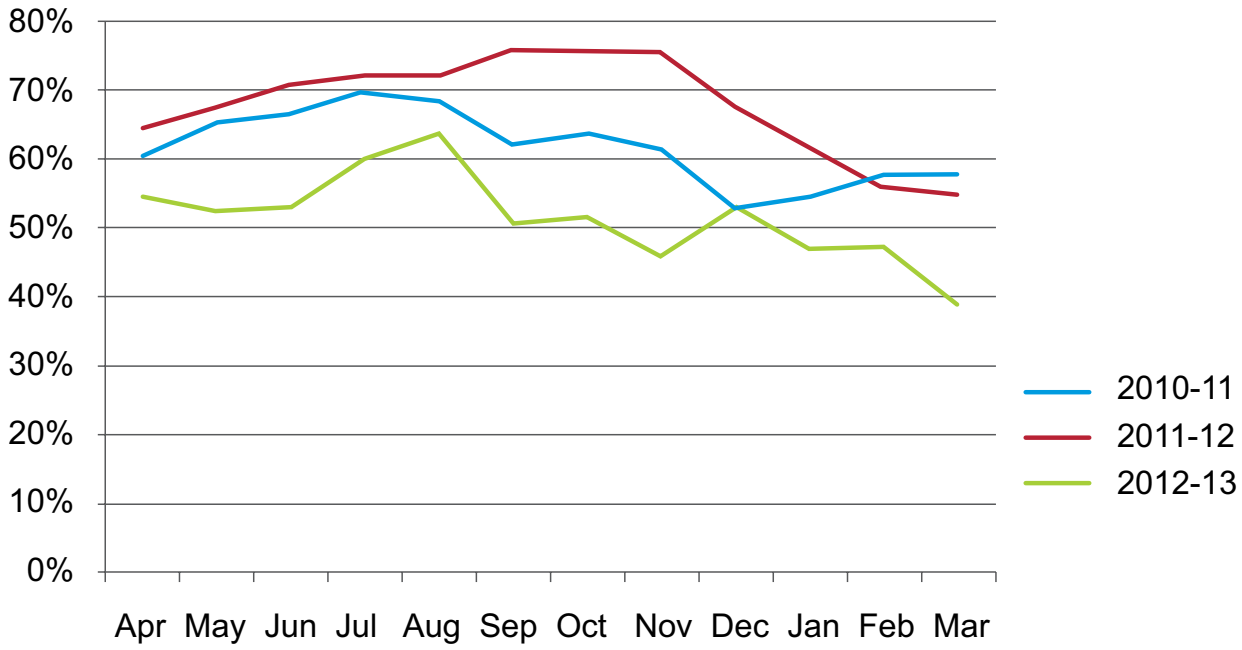
Figure 23 - Patients waiting less than eight hours in emergency departments



Source: Wales Audit Office analysis of Emergency Department Data Set

2.9 The Welsh Government also has a target for the time it takes to 'handover' emergency patients arriving at hospital by ambulance. This is an important indicator because delayed handovers mean that patients often wait for care in hospital corridors or in the back of ambulances. Also, ambulances waiting outside hospitals cannot be used to respond to emergencies, thereby impacting on the performance of the ambulance service. Figure 24 shows that after improving in 2011-12, hospital handover performance has deteriorated significantly across 2012-13.

Figure 24 - Ambulance handovers within 15 minutes



Source: Wales Audit Office analysis of Welsh Government data

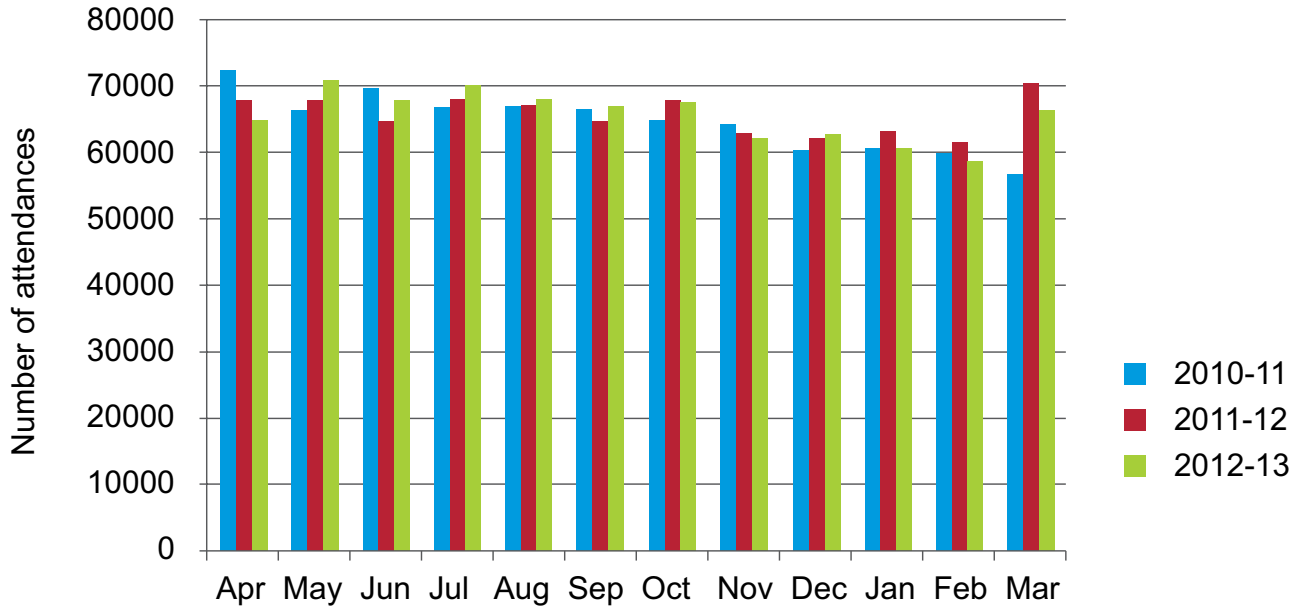
Further work is required to understand the reasons behind the decline in elective and emergency performance and learn the lessons

2.10 The NHS is a very complex system and identifying the reasons behind the deterioration in elective and emergency performance requires considerable analysis. The Department, alongside Public Health Wales, is currently carrying out a detailed review of the reasons behind the changes. In 2012-13 the Department attributes much of the decline in performance to issues in unscheduled care, which can have knock-on effects for performance in elective waiting times. Initial analysis by Public Health Wales has identified a range of demand and supply side factors impacting unscheduled care including:

- **a** socio-economic factors, including issues of poverty and deprivation, in particular the impacts of fuel poverty;
- **b** demographic factors, in particular an increase in demand from older people; and
- **c** environmental factors, in particular cold winters and prevalence of diseases such as influenza in the population.

2.11 The picture of demand for emergency care is complicated. In overall terms, as shown in Figure 25, the number of attendances at major emergency departments was generally higher in the first half of 2012-13 than 2011-12, but lower in the second half. However, as set out in Figure 26, while overall attendance is down year on year, there has been a significant increase in attendances from older people. As our Unscheduled Care report to be published Summer 2013 identifies, older people tend to be more likely to be admitted and tend to stay longer when they are admitted.

Figure 25 - Total attendances at major emergency departments



Source: Wales Audit Office analysis of Emergency Department Data Set

Figure 26 - Age profile of patients attending major emergency departments

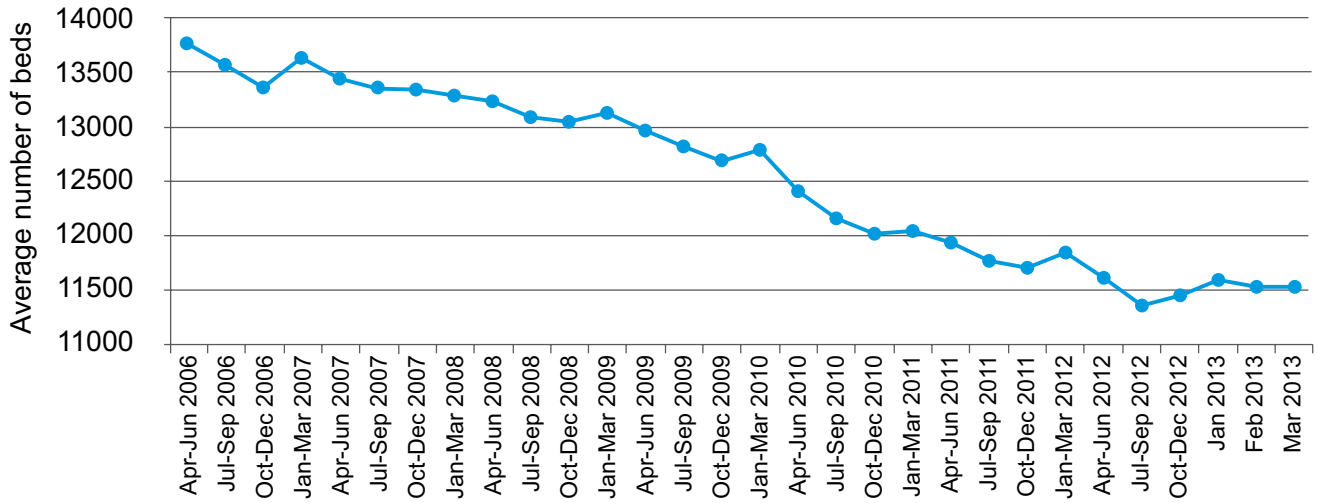
Age group	2010-11	2011-12	2012-13
0-15 years	166,304	169,459	160,335
16-64 years	477,107	487,647	479,812
65-74 years	59,505	63,873	68,049
75-84 years	58,215	61,875	65,186
85+ years	38,022	41,307	44,348
Total	**799,153**	**824,161**	**817,730**

Source: Wales Audit Office analysis of Welsh Government data

2.12 Increased demand is clearly a factor behind the declining performance, but it is unclear to what extent it explains all or indeed most of the problem. The Department's analysis of the problems in emergency care tends to focus on the 'demand side' issues. However, there are some critical 'supply side' issues that need to be explored further. In particular, our local work identified that the impact of financial pressures is a factor behind the decline in elective performance. Several local health boards have taken difficult decisions to allow performance against waiting times targets to slip in order to manage the financial pressures, although the extent to which such decisions are clearly expressed, documented and publicised varies.

2.13 Another potential explanatory factor is the availability of beds. There has been a long-term trend of a reduction in the number of beds available across the NHS (see Figure 27). This bed reduction has been partly offset by decreased length of stay, although bed occupancy rates have been increasing. However, there is a point at which rates of bed occupancy become unsustainable. Further work is required to test whether the NHS in Wales has reached that point.

Figure 27 - Average number of beds available for use across the NHS in Wales



Source: Wales Audit Office analysis of Welsh Government data

Data on other specific key areas of quality of care shows a mixed picture with some areas of improvement

Mortality data suggests a long-term improvement in quality of care but there has been some deterioration in the first half of 2012-13 and we have significant concerns about the reliability of the data

2.14 In March 2013, the Department announced the publication of Risk Adjusted Mortality Index (RAMI) for each local health board and district general hospital. Hospital mortality rates are adjusted for risk based on factors such as age, diagnosis and co-morbidity. The index identifies a UK national average score of 100. Scores above 100 indicate that there may be more deaths than expected. However, the scores should not be interpreted as indicating the level of 'avoidable deaths'. NHS Wales uses RAMI alongside a range of other measures as an indicator of patient safety. RAMI is an early warning that there may be a problem – a definitive conclusion on whether any specific deaths were avoidable is identified through a much more detailed review of individual case notes.

2.15 Overall, the RAMI scores which cover the period from October 2009 to September 2012 show an improvement over time. However, for four of the six local health boards with district general hospitals, the scores increased during the first half of 2012-13. While there is a general trend of improvement, the data also shows most are above the expected score of 100. The scores suggest that the number of deaths in Welsh hospitals are higher than expected.

2.16 We have concerns about the quality of the data underpinning the index. The index is reliant on accurate 'clinical coding' which records the conditions for which patients are admitted into hospital. When the data was produced, Cardiff and Vale University Local Health Board reported that it had a significant backlog in clinical coding entries which may have impacted on the scores. It reported that its own clinical assurance processes, including detailed case notes, did not corroborate the data suggesting a high number of unexpected deaths.[10] We have concerns that there may be other weaknesses in the quality of clinical coding data. We intend to carry out a study in the future looking at clinical coding across the NHS in Wales. In addition to coding issues, differences between Wales and other parts of the UK in methods of recording activity and delivering activity, could also impact on the reliability of the RAMI scores.

Performance against 'stroke bundles' shows a mixed picture with improvement against two out of the four bundles

2.17 Based on clinical research, the NHS in Wales has identified four bundles of care – a set of specific interventions at specific points in time – for patients who experience a stroke. The Department has identified that patients receiving these bundles are likely to experience better outcomes. The Department has set a target that 95 per cent of patients should receive each bundle at the correct time. Figure 28 shows the make-up of each stroke bundle. Figure 29 shows that performance has improved for the timely delivery of bundles 1 and 4 but deteriorated slightly for bundle 3 and more significantly for bundle 2 which is still some way from the target of 95 per cent.

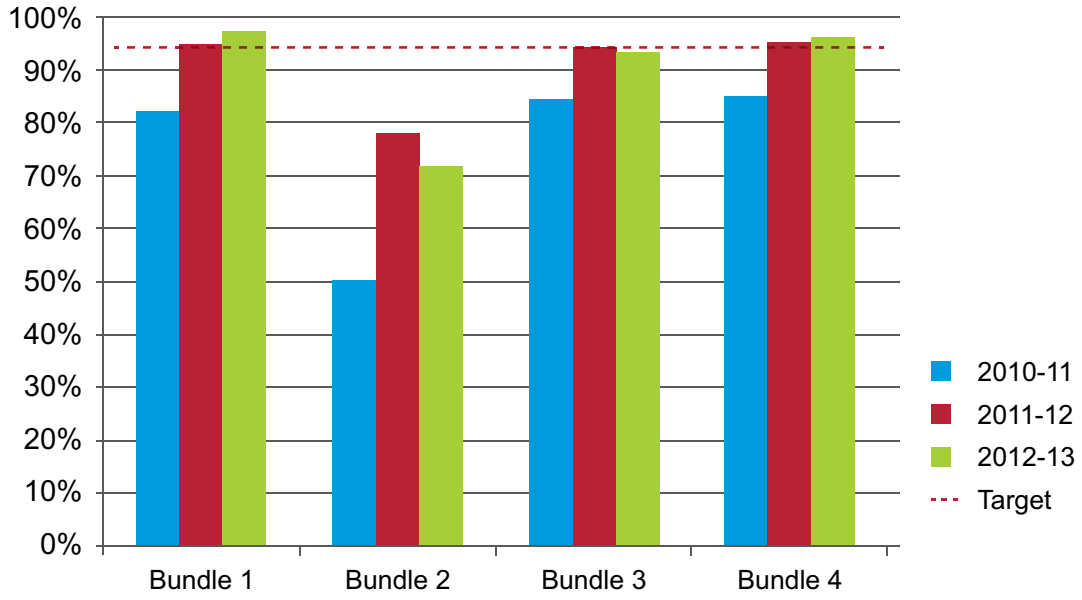
10 www.cardiffandvaleuhb.wales.nhs.uk/rami

Figure 28 - Stroke bundles

Content	Drivers	Interventions
	First Hours Bundle – Rapid recognition of symptoms and diagnosis within 3 hours	• Rapid diagnosis tool • Confirmation of diagnosis by experienced clinician • Start asprin
Improve the outcomes for people following a stroke	**First Day Bundle –** Emergancy treatment for people with stroke within 24 hours	• Computerised tomography scan • Admission to co-located beds • Swallow screen • Prescription of regular aspirin (if non-haemorrhagic stroke)
	First 3 Days bundle – Early mobilisation following stroke within 3 days	• 36 hours continuous physiological monitoring • Manual handling assessment • Nutritional screening • Physiotherapy assessment commenced • Getting patients out of bed
	First 7 Day Bundle – Patient centred and goal-orientated specialist care following stroke within 7 days	• Occupational therapy assessment commenced • Multi disciplinary team goal setting meetings • Information sharing with patients/carers • Estimating discharge dates

Source: NHS Health in Wales, www.wales.nhs.uk/strokecarebundles

Figure 29 - Stroke patients receiving relevant bundles of care



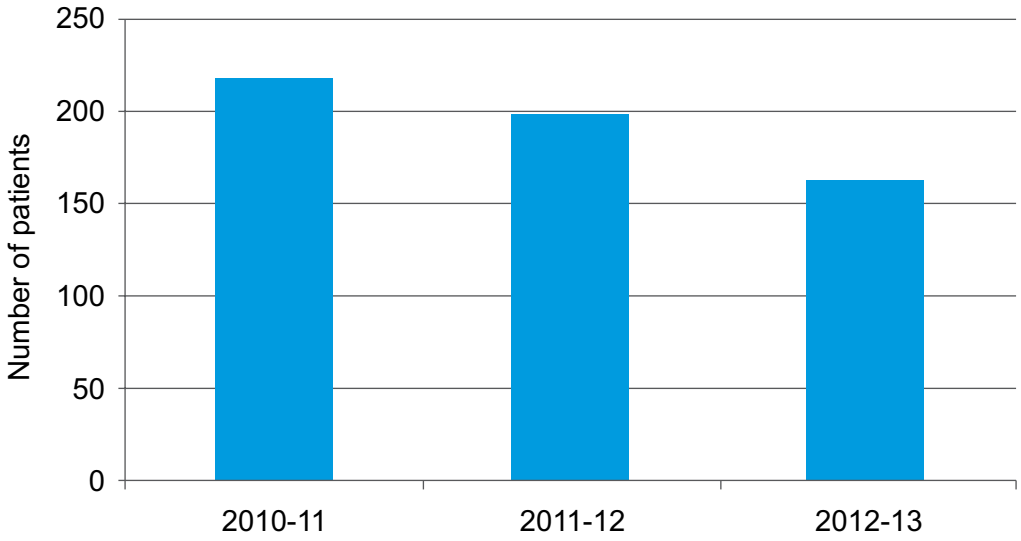
Source: Wales Audit Office analysis of Welsh Government data

Healthcare-associated infections are reducing although we have concerns that some incidents may not be reported

2.18 Rates of healthcare-associated infection are a good indicator of the quality of care, particularly the attention paid to issues around hospital cleanliness and hygiene control. The NHS has targets to reduce the occurrence of certain healthcare-associated infections such as those caused by Methicillin-Resistant Staphylococcus Aureus (MRSA) and *C. difficile*.

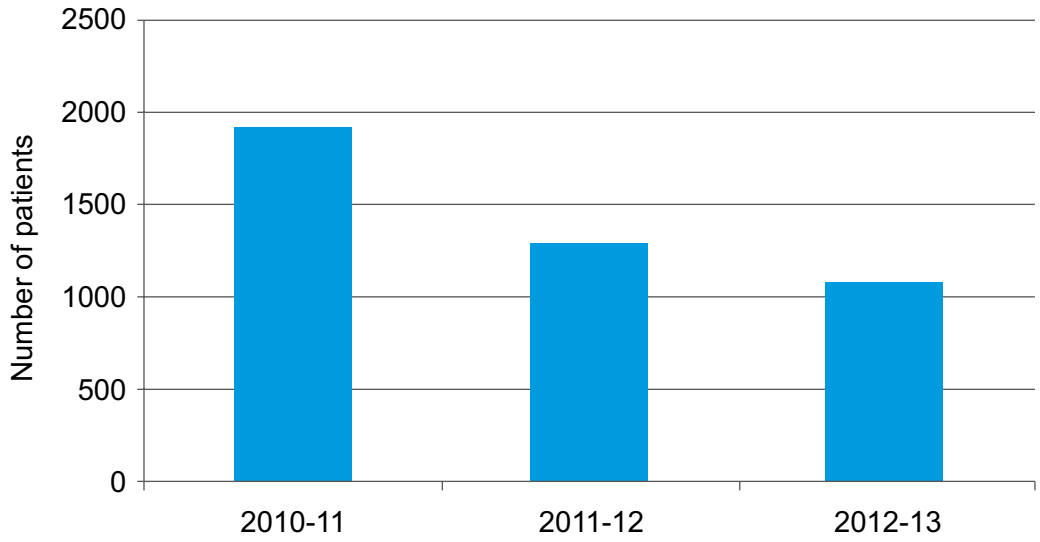
2.19 Figure 30 shows that levels of MRSA bloodstream infections have reduced across Wales in 2012-13. The Department's data, as shown in Figure 31, also shows that the number of *C. difficile* infections in over 65s has decreased. However, our recent review at Betsi Cadwaladr University Local Health Board showed that a significant number of *C. difficile* infections have not been recorded. Therefore, the national data will understate the true position.

Figure 30 - Number of patients reported with MRSA bloodstream infections



Source: Wales Audit Office analysis of Welsh Government data

Figure 31 - Number of patients over 65 reported with *C. difficile*



Source: Wales Audit Office analysis of Welsh Government data

Part 3 - The Department and NHS bodies continue to face major service and financial challenges and are likely to struggle to sustain current levels of service and performance

3.1 This part of the report considers the scale of the financial gap facing the Department and NHS bodies in 2013-14 and beyond. It considers the actions that the Department is taking in order to support NHS bodies in managing the financial and service pressures. It sets out the scale of the financial pressures NHS bodies face and considers their plans for addressing those pressures in 2013-14. It also sets out the medium and long-term challenges facing the Welsh NHS in light of sustained financial pressures across public services in the UK.

The Department is undertaking a range of actions to help NHS bodies manage the financial and delivery pressures

3.2 Our previous *Health Finances* report identified some of the perverse effects of the short-term annual focus of NHS bodies on breaking even. Over the last 12 months, the Department has made progress in developing a more flexible financial regime:

a in June 2013, the Minister for Health and Social Services announced that the Department intends to bring forward legislation for 2014-15 that will remove the statutory requirement for NHS bodies to break-even annually;

b for 2014-15, the Department is introducing a 'Financial Flexibility' scheme which it intends will enable NHS bodies to plan break-even over a three-year period, with the Department providing upfront 'pump-priming' funding to enable savings over the three-year period; and

c the Department intends to strengthen and formalise the system of brokerage to enable NHS bodies to manage short-term unexpected financial pressures.

3.3 The Department is continuing to develop the detail of each of these measures. It is currently working closely with NHS bodies as they develop their three-year plans covering the period 2014-15 to 2016-17. There remain some uncertainties, for example, as to the level of pump-priming required and where any additional funding to support three-year financial plans will come from. Nevertheless, we welcome these measures which, once implemented, will help NHS bodies to move away from the current short-term approach to planning and managing financial pressures. As they move to a three-year cycle, the Department and NHS bodies will still need to closely manage annual spending and planning to ensure that NHS bodies do not build up large deficits in years 1 and possibly 2 on the promise of achieving an unrealistic level of savings by year 3.

3.4 To support NHS bodies in meeting delivery pressures, the Department has introduced a new Delivery Framework (the Framework). The Framework involves an expanded focus on preventative services and service integration. As a result, the Department has considerably expanded the number of Tier 1 priorities that it expects NHS bodies to deliver. As part of the new Framework, the Department will hold monthly 'quality and delivery meetings' with each NHS body. While the broader focus of the Framework is to be welcomed, the NHS faces the high expectation of improving a wider range of services despite declining financial resources. This expectation seems highly optimistic in light of the variable performance against the Tier 1 priorities in the past two years.

The scale of ongoing financial challenges suggests that even with the planned actions NHS bodies are likely to struggle to sustain current levels of service and performance

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

3.5 The NHS in Wales estimates a gross financial challenge of nearly £404 million for 2013-14 compared to £330 million last year – ie, NHS bodies need to reduce costs, find savings or increase income by this amount to achieve financial balance. This funding gap is made up of a combination of in-year cost pressures and the underlying deficit from 2012-13. The detailed analysis is set out in Figure 32.

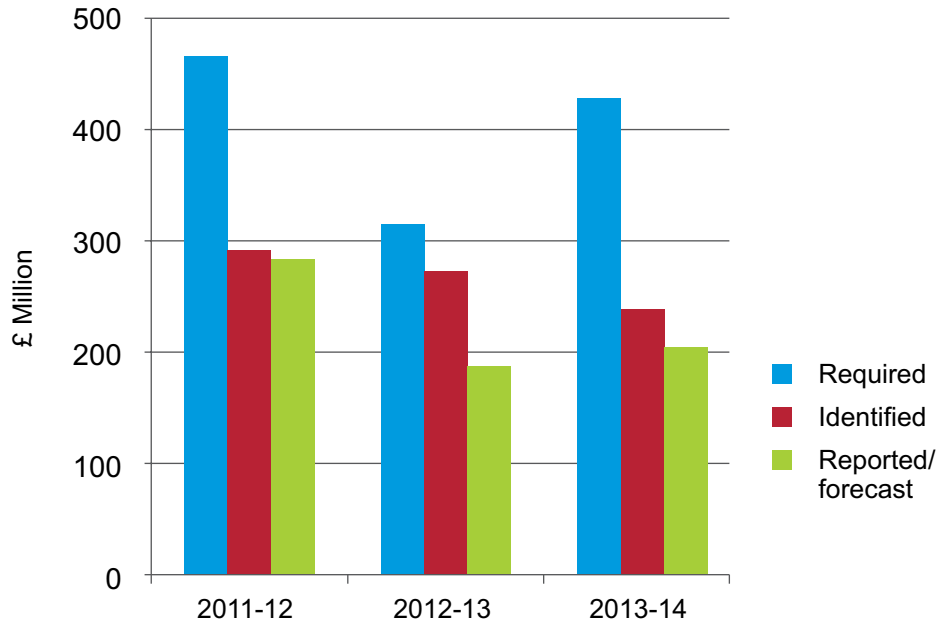
3.6 As at April 2013, NHS bodies have identified savings amounting to £192 million (48 per cent) of the total gap. The trend in savings required and what the NHS delivered or estimates that it can deliver can be seen in Figure 33. In 2011-12, NHS bodies reported achieving 61 per cent of savings required; in 2012-13 they only achieved 64 per cent but for 2013-14 they estimate only being able to deliver 48 per cent.

Figure 32 - Gross and net 2013-14 funding gaps by Welsh NHS body

NHS body	Gross 2013-14 funding gap (£'000)	Savings identified to date (£'000)	Net 2013-14 funding gap (£'000)
Aneurin Bevan LHB	44,840	25,819	19,021
Abertawe Bro Morgannwg ULHB	46,000	18,000	28,000
Betsi Cadwaladr ULHB	78,048	30,880	47,168
Cardiff and Vale ULHB	90,000	53,900	36,100
Cwm Taf LHB	40,624	19,800	20,824
Hywel Dda LHB	56,400	28,000	28,400
Powys TLHB	27,500	9,917	17,583
Public Health Wales NHS Trust	1,341	1,341	0
Velindre NHS Trust	4,393	4,393	0
Welsh Ambulance Services NHS Trust	14,700	0	14,700
Total	**403,846**	**192,050**	**211,796**

Source: Wales Audit Office analysis of Welsh Government data

Figure 33 - NHS savings 2011-12 to 2013-14



Source: Wales Audit Office analysis of Welsh Government data

Despite some improvements to forecasting of cost pressures there is still some inconsistency in the budget assumptions used by NHS bodies

3.7 Our previous report on Health Finances recommended that the Department should update its assessment of the cost pressures facing the NHS. The Department acted on this recommendation through the Financial Modelling Group, led by the NHS directors of finance. The Department asked the group to provide a three-year assessment of the cost pressures. As set out in Figure 34, the group produced very detailed assessments covering a wide range of cost pressures over three years. It is notable that external analysts, such as the Nuffield Trust[11], have assessed that the annual cost and demand pressures on NHS services are around four per cent in real terms (around 6 to 6.5 per cent once economy-wide inflation is taken into account).

11 *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22* (2012) Nuffield Trust, www.nuffieldtrust.org.uk/publications/decade-austerity-funding-pressures-facing-nhs

Figure 34 - Three-year cost pressure assessment

Pressures	2013-14 (%)	2014-15 (%)	2015-16 (%)
Cost pressures			
Pay inflation	1.25	1.19	1.13
Pensions costs	0.11	0.02	0.00
Non-pay inflation	0.47	0.54	0.54
Travel allowance changes	0.07	0.02	0.00
Statutory compliance and national policy	0.11	0.11	0.11
Continuing health care	0.36	0.26	0.31
Funded nursing care	0.15	0.02	0.02
Prescribing	0.45	0.00	0.00
Total cost pressures	**2.97**	**2.16**	**2.11**
Demand/service growth pressures			
NICE and new high-cost drugs	0.40	0.31	0.31
Continuing health care	0.07	0.23	0.27
Funded nursing care	0.00	0.02	0.03
Prescribing	0.27	0.48	0.38
Specialist services	0.33	0.33	0.30
Demographic/demand on acute services	0.64	0.64	0.64
Total demand/service growth pressures	**1.71**	**2.01**	**1.93**
Grand total	**4.68**	**4.17**	**4.04**

Note

This information shows the cost pressure as a proportion of total revenue spending. For example, the group has assessed that a one per cent pay rise in addition to annual increments represents a total pressure equivalent to 1.25 per cent of the total revenue budget.

Source: NHS Wales Financial Modelling Group

NHS bodies are struggling to maintain existing buildings and other assets thereby storing up problems for the future

3.8 Good-quality buildings and other assets such as equipment and Information Management and Technology are essential to support the delivery of high-quality and safe NHS services. For estates (buildings), the Shared Services Partnership reported in 2012 that based on 2011-12 data[12], over the last 11 years the age profile of the Welsh NHS estate is improving – the proportion of the estate built since 1995 has increased from eight per cent to 27 per cent while the proportion of the estate pre-dating 1948 has shrunk from 32 per cent to 19 per cent.

3.9 However, the Shared Services Partnership reported that the Welsh NHS needs to do more to improve the functional stability, space utilisation and energy efficiency of the estate. As set out in Figure 35, the report also identifies a 2011-12 gross 'backlog maintenance'[13] of £395 million across Wales which is 'risk adjusted' to £185 million.

Figure 35 - Actual and risk-adjusted estates maintenance backlog

NHS body	Actual backlog 2011-12 (£ million)	Risk-adjusted backlog 2011-12 (£ million)	Risk-adjusted backlog 2010-11 (£ million)
Aneurin Bevan LHB	38.1	12.6	16.0
Abertawe Bro Morgannwg ULHB	61.9	40.8	41.9
Betsi Cadwaladr ULHB	127.1	41.0	41.3
Cardiff and Vale ULHB	44.7	27.9	43.9
Cwm Taf LHB	40.0	20.8	28.6
Hywel Dda LHB	56.3	27.5	29.9
Powys TLHB	8.9	5.2	4.9
Public Health Wales NHS Trust	Unknown	Unknown	Unknown
Velindre NHS Trust	2.9	0.9	0.4
Welsh Ambulance Services NHS Trust	15.1	8.1	7.5
Total	**395.0**	**184.8**	**214.4**

Source: The NHS Estate in Wales – Estate Condition and Performance Report 2011/12, Shared Services Partnership, www.wales.nhs.uk/sites3/Documents/254/EstCondRep201112web.pdf

12 2011-12 is the latest period for which we could find data. The Shared Services Partnership intends to produce an update in late 2013.

13 Backlog maintenance is essential maintenance work that has not been undertaken and is deemed necessary to bring the condition of a maintainable asset up to a standard or acceptable level of risk that will enable the required service delivery functions of the asset to continue.

3.10 Of further concern are the findings of Internal Audit Services' 2012 report on the Management of the NHS Wales Capital Programme. The report provided 'limited assurance' and the significant recommendations included:

- **a** the capital programme needs to be reviewed and updated and a capital programme strategy developed;
- **b** a formal programme board should be considered to oversee the capital programme including smaller projects;
- **c** revised guidance for the management of the programme and projects should be completed; and
- **d** the Department should work more closely with NHS bodies to ensure compliance and monthly reporting.

3.11 Internal Audit undertook a follow-up review in 2013 and reported that the Department is making good progress in addressing the recommendations although further work is required.

3.12 From our audit work there is evidence that the condition of other assets such as medical equipment and IM&T across Wales is mixed. Figure 36 identifies that a significant number of assets are now beyond their useful economic life.

3.13 The condition of the estate and other assets is therefore a significant additional demand on the NHS's current and future revenue and capital expenditure budgets. The Welsh NHS will also need to consider the quality and safety of services being provided using these assets.

Figure 36 - Equipment and other assets which are classified as 'out of life'

Asset type	Actual March 2012 (£ million)	Estimate March 2013 (£ million)	Estimate March 2014 (£ million)	Estimate March 2015 (£ million)
Medical equipment	195	232	268	308
IM&T	45	56	68	83
Other equipment including vehicles	26	31	49	55
Intangible assets	14	17	23	27
Total	**280**	**336**	**408**	**473**

Source: Wales Audit Office analysis of Welsh Government data

Further real terms cuts to public spending over the medium and longer term seem likely to result in further deterioration without either radical transformation or the reshaping of priorities

3.14 The outlook for public spending in Wales remains bleak. UK Government spending plans show that there will be further cuts to public spending until at least 2016-17. The Institute for Fiscal Studies predicts that even with positive growth in the economy, public spending in Wales will not reach 2010-11 levels until the mid-2020s.[14] With estimated cost and demand pressures on the NHS running at between 4.5 and 6.5 per cent, the Welsh Government faces difficult medium to long-term spending choices. If it is to increase spending on the NHS to meet demand it will need to reprioritise and significantly cut spending on other services. There is the risk that cuts to other services, particularly social care, end up creating more demand for NHS services.

3.15 It is clear that the Welsh NHS has done much to operate services within the ongoing financial constraints. However, as set out in Part 2 of this report, the NHS has struggled to sustain levels of service, particularly waiting times. The financial analysis in Part 1 of this report suggests the financial position is getting more and more challenging. With the 'low-hanging fruit' already picked, savings are increasingly difficult to find with lower and lower levels of savings from traditional methods each year. The combination of a trend of declining service performance and delivery of savings suggests if nothing changes, there will be continued deterioration in services.

3.16 Staff costs remain the largest proportion of the NHS's expenditure. In the short and medium terms, staff costs are likely to come under significant pressure as NHS bodies look for further cost savings. A number of NHS bodies are predicting significant reductions in their staffing numbers in the current and future financial years which will be very challenging to deliver and will not be achievable from just natural wastage. In line with our previous recommendation, the Department is challenging NHS bodies to link their financial and service plans to their workforce plans. However, the financial pressure to reduce staff costs needs to be balanced against the pressures to sustain and improve quality and safety particularly in light of the recent Francis review.[15] The Department is also introducing new minimum staffing level standards and for some NHS bodies these changes may require an increase in certain types of staff which could not only be difficult to implement but also have financial implications.

3.17 Another key variable that will impact the financial sustainability of NHS services is the planned reconfiguration of services. In our previous Health Finances report, we noted the positive signs that NHS bodies were prepared to make the tough choices needed to reform services. Since then, NHS bodies have made some progress and the future configuration of NHS services in Wales is becoming clearer. Two local health boards have held public consultations on the first round of reforms and are in the process of developing more detailed plans following those consultations. Local health boards in South Wales have consulted on their plans for changes to some services across South Wales.

14 Institute for Fiscal Studies, *Local Government Expenditure in Wales*, October 2012

15 The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust January 2005 to March 2009, http://www.midstaffsinquiry.com/pressrelease.html

3.18 It is positive that progress is being made. However, the pace of progress remains relatively slow with considerable public and political opposition to some of the proposed changes. While the case for change is, as it should be, primarily based on the clinical benefits for patients, the detailed financial implications of the proposals are not yet in place and it is unclear whether a reconfigured NHS will be affordable and at a significantly lower cost than the existing provision. The scale of continued financial pressure across public services may mean that even more radical changes than have been proposed to date will ultimately be required. The level of change required, the time it will take to implement and the likelihood that there will be 'upfront' costs, makes it unlikely that the planned reconfiguration will provide the solution to the short and medium-term financial and service pressures facing the NHS in Wales. However, over the longer term, service transformation offers the opportunity to put the Welsh NHS on a more sustainable footing.

Appendix 1 - Audit methods

Data analysis

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

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

We have also used a range of service performance data, most of which was provided to us by the Department. The data sources include:

- The Patient Episode Database Wales (PEDW);
- Emergency Department Data Set (EDDS);
- StatsWales data on performance on elective waiting times; and
- the Department's performance data on other Tier 1 priorities.

Document review

In interpreting the financial data we have also drawn on published strategic documents specifically related to the NHS in Wales. These include *Together for Health: A Five Year Vision for the NHS in Wales* and the NHS Wales *Delivery Framework 2013-14 and Future Plans*.

Local fieldwork

Our assessment of the national picture draws on local audit work examining financial management at each NHS body as part of our 'Structured Assessment' work. The audit work on which we drew includes:

- audit of accounts;
- review of savings plans and delivery;
- interviews with senior NHS body officials and board members; and
- review of 2012-13 and 2013-14 financial and strategic planning documents.

Appendix 2 - Welsh Government response to Wales Audit Office recommendations 2012

Wales Audit Office recommendation	Welsh Government response
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.**	Through membership of the NHS Directors of Finance Sustainability Sub Group, Welsh Government officials support the sharing of analysis and good practice based on the consistent analysis of the Savings Schedule from the Financial Monitoring Returns. As part of the 2012-13 Financial Planning submissions Welsh Government officials have reviewed and challenged the original plans requiring NHS bodies to be more explicit in profiling their workforce wholetime savings.
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.**	As set out in the Wales Infrastructure Investment Plan, the Welsh Government view is that public infrastructure investment should be primarily funded through direct government capital expenditure. However there is clearly a strong case for change to increase the resources available for investment – the imperative to boost jobs and growth, the significant reduction in the Welsh Government capital budget, the relatively low cost of borrowing and the benefits of bringing forward investment. The Minister for Finance and Leader of the House's officials have been leading on this work and Health officials are already working closely together to explore a number of emerging opportunities which involve different funding partners and delivery mechanisms. In terms of the consideration of NHS service plans, Betsi Cadwaladr University Health Board and Hywel Dda Health Board recently consulted on their proposals for future services in North Wales and Mid and West Wales respectively. They are now considering responses to the consultations before presenting their final proposals. South Wales commenced its three month engagement programme on 26 September 2012 and this will be followed by a formal consultation process next year. There are therefore no firm or final capital proposals at this stage. There needs to be timely and regular evaluations of LHB capital requirements and officials are in regular dialogue with NHS organisations to identify and manage investment opportunities as they emerge to ensure that we continue to identify, fund and deliver the priority schemes.

Wales Audit Office recommendation		Welsh Government response
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.**	Health Boards receive their initial allocation notification in the December prior to the start of the financial year. Any funding allocated after this point, including funding notified before the start of the financial year, is considered as an in-year adjustment. In practice, most regular funding that is not included in the initial allocation will be issued early in the financial year, and health boards will have been notified of the intended levels of funding before the formal allocation is made. A significant proportion of the funding allocated to Health Boards during the financial year is also for non-recurrent and exceptional items of expenditure, for example to cover accounting costs for impairments and accelerated depreciation. The Welsh Government has reviewed the budgets it holds centrally and is planning to incorporate a number of these funding streams into Health Board's core revenue allocations in future years.
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.**	We have a systematic process of working with NHS organisations to ensure a consistent approach in the calculation of their out-turn position. This is done through a working group comprising Welsh Government officials and NHS finance staff. Currently organisations who report that accountancy gains have been identified are notified that these must be phased into the monthly profile. This is being actioned. Organisations who assess potential accountancy gains are unable to include these until later in the year when they are confident that they have materialised.

Wales Audit Office recommendation	Welsh Government response
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.**	As part of developing Integrated Medium Term Plans, the Welsh Government is supporting joint work with NHS professionals to develop clearer resource planning assumptions for inclusion in modelling individual plans. This will effectively update the challenge the NHS faces, based on assessment of future pressures as well as the underlying position moving from 2012-13 into 2013-14. This will include evidence and validation against other measures.
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.**	The current legislative regime within which NHS organisations currently operate imposes certain financial duties, which includes a requirement for health boards to break even each and every year. This constrains the ability of health boards to plan and manage their finances over the medium term. Therefore work has been instigated to explore opportunities that may be available by making changes to primary legislation that governs the financial operating environment within which health board's function. The options also take account of the annual budgetary constraints which apply to the Welsh Government's health budget. Changes to primary legislation are longer term solutions and consequently other options are being considered which will provide additional flexibility within the current legislative framework. These include arrangements to support; planned financial flexibility, to allow the management of resources across financial years over the medium term, by providing access to a dedicated fund, as part of a three year planning horizon and also shorter term flexibility arrangements, to address unforeseen circumstances and short term challenges that may occur during the year. Further information will be provided as part of the publication on the work of the 'new finance regime' as announced in the Departments NHS plan 'Together for Health' launched by the Minister in October 2011.

Appendix 3 - Overall financial summary by NHS body

NHS body	Estimated funding gap 2012-13 £'000	Reported savings £'000	Departmental additional funding £'000	Cost containment/ avoidance/ technical accounting gains £'000	Intra-NHS brokerage required/ (offered to others) £'000	Year end surplus limit £'000	Gross operating expenditure £'000	Estimated funding gap as % of gross operating expenditure
Aneurin Bevan LHB	(48,000)	33,058	11,694	5,557	(2,275)	34	1,071,838	4.5%
Abertawe Bro Morgannwg ULHB	(38,600)	21,431	11,522	8,270	(2,482)	141	1,296,186	3.0%
Betsi Cadwaladr ULHB	(74,473)	49,112	17,021	8,345	-	5	1,404,656	5.3%
Cardiff and Vale ULHB	(66,886)	35,651	26,388	4,913	-	66	1,178,996	5.7%
Cwm Taf LHB	(28,400)	7,671	10,861	10,240	(355)	17	672,284	4.2%
Hywel Dda LHB	(41,630)	19,807	9,123	10,456	2,300	56	757,150	5.5%
Powys TLHB	(19,122)	9,610	4,391	917	4,210	6	257,090	7.4%
Public Health Wales NHS Trust	(2,317)	2,317	0	10	-	10	98,314	2.4%
Velindre NHS Trust[16]	(3,112)	3,112	0	950	(900)	50	288,168	1.1%
Welsh Ambulance Services NHS Trust	(7,970)	5,850	1,000	1,294	(125)	49	156,101	5.1%
Total	**(330,510)**	**187,619**	**92,000**	**50,952**	**373**	**434**	**7,180,783**	**4.6%**
Percentage of estimated 2012-13 funding gap		**56.7%**	**27.8%**	**15.4%**	**0.1%**			

16 The figures for Velindre Trust shown above include income for both NWIS and NWSSP (two agencies hosted by Velindre NHS Trust) whilst excluding their £6.842m savings requirement. When the reported savings for the Trust are compared to the income which is directly managed by the Trust the funding gap increases to 4.3%.

Appendix 4 - Definition of Tier 1 priorities

Priority	Definition of target/measure
Quality in care	Further reduction in *C. difficile* and MRSA against agreed local targets.
Mortality rates	Demonstrable reduction in mortality rates for stroke, cardiac, major trauma and fractured neck of femur patients.
Access	95 per cent of patients will be waiting less than 26 weeks with a maximum wait of 36 weeks.
Unscheduled care	95 per cent of patients to be treated or discharged from emergency departments within four hours. Ambulance to arrive on the scene within eight minutes for 65 per cent of category A ambulance calls. Minimum expectation that 95 per cent of all cardiac, major trauma and stroke patients are handed over within 15 minutes.
Cancer	At least 95 per cent of patients referred by their GP with urgent suspected cancer and subsequently diagnosed as such by a cancer specialist will start definitive treatment within 62 days of receipt of referral. At least 98 per cent of patients not referred as urgent suspected cancer but subsequently diagnosed with cancer will start definitive treatment within 31 days of diagnosis, regardless of the referral route.
Stroke	Sustain 95 per cent compliance with each of the four acute stroke care bundles.
Efficiency and productivity	80 per cent of planned surgical interventions under the BADS 50 will be treated on a day case basis. The percentage for all surgical procedures undertaken by day case will improve. Admission on day of surgery to become the norm unless clinically determined supported by pre-operative assessment for all patients. Reduced bed days/improved length of stay.
BADS 50	The 'BADS 50' are 50 procedures that the British Association of Day Surgery has identified as appropriate to be carried out as day surgery.