Date: 17 May 2000
Venue: Committee Room 2, National Assembly for Wales
Title: Health Budget for 2000-01

Purpose

1. To report on the issue of health authority allocations for 2000-01 and consult the Committee on the proposed use of the uncommitted £86.1 million (some £51 million after allocation of emergency pressures and waiting time/lists funding) of additional resources made available for health purposes in 2000-01.

Summary/Recommendations

2. The Committee is invited to:

- note the issue of health authority allocations for 2000-01 incorporating £53.8 million of increases to the proposed level of allocations assumed in the preliminary consultation on the 2000-01 draft budget (HSS-112-99(p.2) of which some £28 million is non-recurrent funding in 2000-01;
- consider the broad spending options as set out at Annex C for spending the remaining £86.1 million available in 2000-01 to address key health priorities, noting the potential future year implications where indicated and that following consultation with party health spokespersons, the Assembly Secretary for Health and Social Services has decided that, in the first instance, £35 million of this should be made available to health authorities, as soon as individual agreements are reached on the deliverables to be achieved with the additional resources, in order to enable them to proceed with a range of initiatives, including joint working with social services and others, to cope with emergency pressures and reduce waiting times and lists;
- offer any written comments to the Assembly Secretary, noting that compensating savings will need to be identified for any proposals to increase expenditure above the lower end of the range indicated for main priority areas and that even the lower end of the spending range involves 17 per cent over-programming in 2000-01, with substantial excesses over the maximum levels of resources likely to be available in 2001-02 onwards following the Budget Planning Round. All expenditure figures are subject to further validation.

Timing

3. Immediate. Early decisions on the use of the additional resources available in 2000-01 are required in order to enable the National Health Service and its partners to make optimum use of available resources in the current year.

Background

4. Following consultation with the Committee on proposed health and social services expenditure plans for 2000-01, the Assembly approved the Budget following its plenary debate in February. A number of changes to health spending plans have since been made. These are summarised at Annex A.

5. The Committee subsequently discussed and agreed in March a package of measures costing some £1.8 million to extend entitlement to free eye examinations and increase cataract operations in 2000-01, leaving some £6.1 million of non-recurrent funding available for use on other health purposes. Meanwhile health authorities had been notified of their provisional allocations for 2000-01 in a technical consultation draft issued in December 1999. It was clear from responses to this that the proposed increases in funding consistent with the expenditure plans considered by the Committee in November would leave most health authorities and trusts facing serious financial problems this year. They advised that there would need to be significant curtailment of activity and services this financial year and, even then, the requirement for top up loans and brokerage would significantly exceed the £13.6 million of funding assumed for this purpose in the budget proposals.

6. Against this background, the Health and Social Services Secretary agreed a number of adjustments to the draft allocations in order to increase the levels of NHS income and reduce the forecast borrowing requirements. She and the Finance Secretary also decided that the balance of the £7.9 million non-recurrent funding not required for extending entitlement to eye examinations and other improvements in ophthalmic services (i.e. £6.1 million – see paragraph 5) should, as originally indicated, be used to fund improvements in mental health services and other health services, including capital projects. The Finance Secretary also agreed that some £10.5 million of uncommitted underspend on the health budget in 1999-2000 should be re-provided for health in 2000-01. In addition, she proposed that the £10.8 million **net** costs (after offsetting debt repayment and reduction in forecast borrowing requirements) of a non-recurrent £24. 2 million increase in health authority allocations to be distributed on a capitation shares basis should be funded from underspends elsewhere in the Assembly budget. This money is to be used to reduce the burden of debt repayment and borrowing requirements for those areas which would otherwise have needed them and also to fund capital projects or improve patient services in those health authority areas where there is no outstanding debt or forecast borrowing requirement.

7. These decisions, together with the Cabinet's decision that the full £99.2 million of Wales' Barnett (population) share of the additional resources for health which the Chancellor of the Exchequer announced in his Budget Statement on 21 March should be used for health purposes in Wales in 2000-

01, were reflected in the Finance Secretary's Budget statement to the Assembly on 28 March. She announced that the current year health authority allocations would be increased by some £54 million this year over previously planned levels. This includes a 1% increase (£15.7 million) in health authority discretionary revenue allocations for Hospital, Community, and Family Health Services which it is intended should be made available on a recurrent basis.

8. These proposed adjustments to the Assembly Budget were endorsed following plenary debate on 12 April. In the meantime, a meeting of the Health party spokespersons on 28 March endorsed the proposed increases in health authority allocations which were subsequently issued on 6 April, leaving some £86.1 million of uncommitted money available for allocation following wider consultation with the NHS, its partners, and the Health and Social Services Committee.

9. Since then, there has been extensive discussion within the Assembly, with NHS Chief Executives, and also with representatives of a wide range of other interests at a stakeholder prioritisation workshop meeting held at Hensol on 4 May. This and its results are described in further detail at Annex B but, apart from highlighting the need to consider re-designing and re-aligning existing services and make appropriate investment in strategic change, there was strong consensus on the need to tackle coronary heart disease effectively. At the meeting of the NHS/ Partnership Forum on 8 May the collective thoughts of Trade Union representatives across Wales were also sought and discussed. These discussions have also been informed by consideration of:

- the Committee's agreed priorities as summarised at Annex C of HSS-06-99 and records of its subsequent discussions of health funding priorities;
- Assembly plenary debates on health issues such as cardiac services;
- the Assembly's strategic plan, *Better Wales*;
- planning and priorities guidance;
- the Specialist Health Services Commission for Wales' reports on cardiac services;
- health authorities' Health Improvement Programmes;
- the emerging findings of the Corporate Strategy project and the Acute Services Review;
- discussion in the Joint Ministerial Committee meeting on health which took place in Cardiff on 6 April;
- liaison with counterparts in other administrations and colleagues on emerging pressures and other developments likely to have financial implications in Wales.

10. Although for future years, the Barnett consequential share of the additional resources is £154 million in 2001-2, £394 million in 2002-3, and £654 million in 2003-4, the Finance Secretary has made it clear that decisions on levels of health funding in future years will be made in this year's Budget Planning Round once the outcome of the rest of the Government's Spending Review, including any increases in funding for social services provision, is

known. The Committee will be given an opportunity to discuss its priorities for future years' spending plans in July.

Consideration

11. The NHS Stock-take report highlighted the importance of providing realistic funding for the NHS and, as set out in *Better Wales,* ensuring the financial sustainability of the NHS is a key Assembly priority. When considering how the additional resources now made available for health are to be used, it is therefore essential to ensure that health authority core allocations and other unavoidable commitments on centrally funded budgets are properly resourced in the first place.

12. Much of the increase in this year's health authority allocations is on a non-recurrent basis intended to provide short term assistance while those NHS bodies currently in deficit or forecasting deficits in future years develop and implement recovery plans. However, some of the additional funding already made available this year will need to be re-provided on a recurrent basis in future years in order to ensure financial sustainability.

13. The costs of this and funding other unavoidable commitments on central budgets will need to be reviewed in the context of the next Budget Planning Round (BPR) but, on the basis of rolling forward the estimates underpinning this year's allocations, are likely to amount to some £73 million over baseline provision in 2001-2, £262 million in 2002-3, and £481 million in 2003-4. If, for illustrative purposes, it is assumed that the health budget to emerge from the next Budget Planning Round was to be increased by the full levels assumed in the Chancellor's Budget Statement in March, this would leave up to £81 million of currently uncommitted resource available in 2001-2, £131 million in 2003-4, and £173 million in 2003-4.

14. Decisions on the most appropriate use of available uncommitted financial resources in the current year need to take into account:

- assessments of what is feasible in terms of available physical and workforce resources within the NHS and its partners as well as in the independent sector;
- value for money and key deliverables;
- the need to ensure that any spending commitments with recurrent effects in future years will be affordable within likely levels of 'available' resource once health authorities have been given their weighted capitation share of the overall level of increase necessary to ensure financial sustainability;
- the financial implications of implementing National Service Frameworks intended to ensure appropriate adoption of best practice in both the primary and secondary sectors and the recommendations of the National Institute for Clinical Effectiveness (NICE);
- commitments already given or unavoidable but not yet funded; the need for investment in capital, information management and technology, and workforce development to ensure that NHS Wales is able to optimise its use of available resources in future years and in order to support the

implementation of the corporate strategy for the medium and long term development of the NHS in Wales.

15. Even with the additional resources now made available for health, it will not be possible to fund fully all identified priorities while also making the most appropriate and necessary investments for the future development of the NHS in Wales. Altogether the costed investment proposals put forward from within the Assembly and the NHS amount to nearly three times the amount of available resource. Although some of these are only broad order costings it is clear difficult investment choices will need to be made. There are also real practical constraints on how far it is cost-effective or feasible suddenly to expand activity within the NHS.

16. There needs, therefore, to be an appropriate balance between addressing immediate and urgent priorities and investment to ensure medium and longer term benefits are realised. It is also important to ensure that where decisions on in-year expenditure commitments have spending implications in future years, they are likely to be affordable within the levels of available resources. As this will only be established during the coming Budget Planning Round and most of the proposed expenditure commitments will entail higher spending in future years, it is important that a significant proportion of the expenditure commitments made this year is on a non-recurrent basis.

17. Annex C therefore indicates a range of levels of expenditure in the current year against each of the priority areas while also indicating, on a very provisional and illustrative basis, the range of required levels of expenditure necessary to sustain them in future years. Even the lower of the proposed levels of expenditure amount to some £15 million or so more than the level of available resource in the current financial year. There would be substantial excesses in 2001-02 even if it were to be decided in the Assembly's forthcoming Budget Planning Round that overall resources for health should increase in line with the Barnett population shares indicated in paragraph 11 above. Further work is therefore required over coming weeks in order to validate and test the feasibility and sustainability of individual spending proposals for this year. This will be undertaken in the context of preparation for the Budget Planning Round but, subject to any comments from the Committee and further validation work, the Health and Social Services Secretary's in-year spending decisions and commitments are likely to be broadly in line with the lower estimates on the indicative spending range.

18. She has already decided, following consultation with party health spokespersons, to allocate £35 million, in the first instance, of the remaining money on a capitation share basis specifically to enable health authorities to address emergency pressures and waiting lists/times once individual agreements have been reached on the associated deliverables. Other figures are broad indicators only of how resources will be used to address agreed health priorities. There will necessarily need to be some flexibility between them as the feasibility of implementing individual expenditure proposals within the current year and affordability of any future years' expenditure

consequences is further assessed. Performance will need to be monitored closely and, to enable the Assembly to track expenditure and its impact more readily, we will be establishing separate Budget Expenditure Lines for this purpose.

Compliance

19. The Health Authorities Act 1995 (Section 47, Paragraph 5) covers powers to make allotments to health authorities. The National Health Service Act 1977 (Section 97, Paragraph 5) covers powers to make, increase or reduce an allotment to health authorities. The National Health Service Act 1977 (Section 1) covers the duty to promote a comprehensive health service and provide or secure provision of services. These powers were transferred to the Assembly under the Transfer of Functions Order 1999 and are delegated to the Assembly Secretary for Health and Social Services. The Government of Wales Act 1998 provides the Assembly with the power to do anything to facilitate, or conducive or incidental to, the exercise of any of its functions (Section 40) and to incur expenditure (Section 85, Paragraph 2) and to attach conditions to the giving of financial assistance by the Assembly (Section 85, Paragraph 3). There are no issues of regularity or propriety. The Assembly Compliance Office has seen and is content.

Action for subject committee

20. The Committee is invited to consider the recommendations at paragraph 2 and particularly to offer comment on the proposed use of the £51 million balance of the uncommitted additional resources available for use in the current year, noting the future years' implications.

Contact Point

Sarah Beaver
Head of NHS Finance Division

Annex A

Sources and application of funds made available since draft budget proposals HSS-12-99(p2) were submitted to the Committee in November:

£ million	
Source of funds	
16.4	Earmarked brokerage/uncommitted funds
7.9	"eye tests" funding
10.5	Uncommitted 1999-00 health underspend to be carried forward
99.2	Additional money arising from Chancellor's Budget
10.8	Carry-forward from other NAW budgets
144.8	**Total funding**
Application of funds	
1.8	Eye care initiative
1.0	Morriston A&E scheme/PFI support Porth-Madog
6.2	Residual brokerage requirement (further reduced since April)
53.8	Increases in health authority allocations (overall increases £196 million, average increase 9.4% of which some £28 million is non-recurrent)
0	Unavoidable additional costs to be funded from central Assembly budgets (e.g. mandatory dental training, increased contributions to Commission for Health Improvement) offset by savings elsewhere.
62.8	**Total agreed package**
82.0	**Balance of available funding after 6 April allocations**
4.1	Add Swansea debt repayment
86.1	**Total money remaining for distribution**
35.0	Joined up (emergency pressures) working and waiting times/lists capitation-based NHS allocation.
51.1	**Remaining sum available for distribution**

'Eye tests' money
In the December Budget debate, the Finance Secretary announced additional funding would, subject to further consideration by the Health and Social Services Committee, be made available for an extension of entitlement to free eye tests, and that, in any event, £7.9 million (of non-recurrent money) would be available for health improvements including capital and/or Mental Health projects. It has now been allocated as follows:

Allocation of 'eye tests' money

	£m
Sight examinations/cataracts package	1.8
Morriston A&E scheme/PFI support Porth Madog	1.0
Mental health projects in Dyfed Powys/Bro Taf * (non-recurrent)	2.1
Tapering funding for Cardiac Services, South Wales *	1.5
(Part) transitional funding for Royal Glamorgan capital charges *	1.5
TOTAL	**7.9**

*Included in health authority allocation increases for 2000-01.

Annex B

OUTCOME OF STAKEHOLDER WORKSHOP ON PRIORITIES FOR HEALTH AND HEALTH SERVICES - 4 MAY

Introduction

1. This paper presents the outcome of a stakeholder workshop which was held on 4 May to help inform discussions regarding priorities for investment in health and health services. The aim of the exercise was to demonstrate the level of consensus regarding priorities. It was made clear that the workshop was not of itself a decision making forum, but offered a range of stakeholders the opportunity to influence the decision making process at national level.

2. This was the first time such an exercise had been undertaken and reflects the Assembly's commitment to more open government and inclusive decision making processes.

Participants

3. Participants were invited from a wide range of stakeholder organisations including professional organisations, the voluntary sector, local government, NHS Trusts, Health Authorities, Local Health Groups, advisory groups, and the Assembly.

4. Attendance was good in the context of the short notice provided although it should be noted that NHS Trusts were not fully represented at the workshop.

Process

5. The exercise was set in the context of the planning mechanisms through which the Assembly's priorities are identified and translated into local action. These priorities - over forty in total - were presented on a matrix (see Enc A) which was issued to participants in advance.

6. The process took the form of an interactive priority setting exercise which aimed to identify whether there were overriding priorities for investment or whether the relative importance of priorities was considered to be more evenly distributed.

7. This "long list" was supported by definitions of each of the broad priority areas, including headline information about the key service proposals and issues for each.

8. The process involved the following broad stages:

Stage 1

Participants discussed the long list of priorities to ensure that it was comprehensive and reflected established priorities. They then confirmed the broad definitions that were used to outline the service issues and proposals relating to each broad heading. Participants were then asked:

- to identify priority areas that should be removed from the list and presented as "givens" due to their critical importance, and,

- to agree a short list of priorities that reflected the importance attached to particular priorities by the Assembly and other stakeholders

The outcome of this is shown on the following table:

"Givens"	**Short listed priorities (not in priority order)**
• Waiting times • Emergency pressures • Workforce issues • Capital for strategic service change • Information and communication technology	• Mental health • Substance misuse • Coronary heart disease • Cancers • Primary care • Community health development • Children • Supporting people at home • Learning disabilities • Service realignment • Stakeholder engagement

NB This does not imply that the other priorities on the long list are not important. They are still priorities that need to be addressed.

Stage 2

Participants were then asked to discuss and agree the criteria that should be used to evaluate these priorities and to weight these to indicate their relative importance. It should be noted that these were non financial criteria to ensure that there was a focus on identifying what was important in absolute terms, rather than being influenced by what was believed to be affordable at this stage. The results of this are shown on the following table:

Rank	Criteria	Definition
1	Quality of life	having a positive impact on quality of life, benefiting people with long term / permanent health problems that impact fundamentally on the way they live their lives.
2	Equity of access	offering opportunities for reducing inequalities in access according to geography, social class, gender, ethnic group and age, and in relation to need
3	Health benefit / equality of health status	offering opportunities to target inequalities in the wider determinants of health status and to result in overall improvements in health status
4	Scope for prevention	shifting the emphasis from illness to health including prophylactic treatment, after care, health promotion
5	Efficiency	encouraging better use of resources, offering opportunities to get added valued from existing services
6	Promotion of integration	reflecting role of NHS in broader agenda, opportunities to promote independence, developing more effective relationships between agencies

Stage 3

With an agreed short list of priorities and an agreed set of criteria participants were asked to score each of the priority areas out of 100 according to each of the criteria. The result of this is shown on the following table and graphically at Enc B;

Position	Priority area	Score
1	Coronary heart disease	14,420
2	Children	8,392
3	Primary care	8,371
4	Community health development	8,069
5	Cancers	7,792
6	Service realignment	7,648
7	Supporting people at home	7,571
8	Mental health	7,460
9	Substance misuse	6,690
10	Stakeholder engagement	6,610
11	Learning disabilities	6,385

NB Participants decided to remove stakeholder engagement from the list as it was considered to be a process rather than an investment issue.

This table demonstrates that coronary heart disease was viewed by stakeholders as an overriding priority for investment. Differences between the other priorities were not significant.

Stage 4

The results of the scoring exercise were fed back to the participants for discussion and to ensure that they were content with the outcome of the process.

Issues

9. The following issues and comments arose during the course of the exercise:

- the need to consider redesigning existing services as well as looking at additional investment
- the need to consider proposals in the context of the NHS system as a whole
- the potential to link the results of the exercise with the survey currently being carried out in England of health care professionals in response to the Prime Ministers aspirations for the NHS in the UK.
- the importance of considering these proposals in the broader context of health improvement
- the need for new investment in primary care rather than relying upon a transfer of resources from secondary care
- the importance of addressing existing under funded areas in primary, community and acute services

Conclusions

10. The outcome of this exercise suggests that the first priority for investment should be given to

- improving waiting times
- addressing emergency pressures
- meeting the capital requirements needed to underpin strategic service change
- progressing the information and communications technology necessary to give all health professionals access to clinical information systems, and,
- addressing workforce issues.

11. Of the other areas for investment coronary heart disease is a key priority, reflecting the fact that it is a major cause of morbidity and mortality in Wales.

12. The remaining set of nine short listed priorities demand equal consideration against the balance of available investment. However, it should be noted that the infrastructure issues that have been identified as first order priorities in terms of workforce, capital and information and communication technology will benefit all of the short listed priorities.

Next Steps

13. The outcome of this workshop is useful in identifying broad areas for investment / redesign. It is important that these are seen in the context of the whole system and the totality of resources available.

14. As only non financial criteria were used to underpin this exercise the next step will be to undertake detailed work with the NHS and partner organisations to establish short and long term programmes for the priorities that have been identified supported by evidence of the greatest achievable health gain, value for money and appropriate performance targets.

Julie Gregory
Director
Health Service Strategy
5 May 2000

Annex C

Indicative Proposals for Use of Additional Health Resources in 2000-01 to Address Health Spending Priorities

Notes:

- 2000-01 figures are subject to further validation work and may be adjusted
- Future years' figures are illustrative only and will be subject to review in forthcoming Budget Planning Round
- Spending in support of individual priority areas has the potential to impact directly on others as shown in the chart at Appendix 1. In practice, the extent of linkage achieved will depend on final decisions on individual spending proposals, only a proportion of which will be funded.

1. Joined-up working: emergency Pressures	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	20	5	27	0	28	0	30	0
Total (range)	**15-25**		**20-27**		**20-28**		**20-30**	
This would enable the NHS, working in partnership with social services departments and others, to provide a range of additional services to cope with all year and winter pressures in 2000-01, with particular emphasis on minimising delayed discharges, and to put in place both investment and programmes to improve capability in the longer term. Action proposed includes increasing the number of critical care, high dependency and emergency medical beds and partnership schemes linking trusts, primary care and social services. **Note:** Excludes recommendations arising from the Emergency Pressures Task Force which call for further expenditure but has linkages to primary care and community health development measures (and includes some £5 million for primary care developments). There are also linkages to workforce measures and investment to tackle elective activity (waiting times/waiting lists).								
2. Waiting Times and Waiting Lists	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £ml	Capital £m
	21	5	26	2	29	0	30	0
Total (range)	**20-26**		**22-28**		**23-29**		**24-30**	
This level of funding would support programmes to tackle waiting times/lists in the short term and pump-prime investments to modernise the management of waiting times in most specialities. Depending on the size of the final allocation, programmes would be agreed with each local health community to reduce the in patient/day case waiting lists, tackle long waiters, reduce outpatient waits, significantly improve cataract services, and develop innovations in care. Action proposed in all parts of Wales includes expansion in theatre capacity, recruitment of additional clinical staff in key specialties, and agreed joint initiatives involving primary care, secondary care,								

and social services. In addition, innovative developments include protected elective surgical facilities, a primary care unit, booked admission and treatment prioritisation systems and enhanced GP services.
Note: This programme excludes cardiac services (which are separately covered) and orthopaedics (which needs a sizeable additional parallel programme to tackle signficant shortfalls in physical and workforce capacity). Most gain will accrue from recurrent allocations; non-recurrent funding would not support sustainable programmes, enable staff to be recruited of guarantee that short-term initiatives would succeed. Health authority bids totalled £25 million which was wanted recurrently.

3. Workforce Development	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	10	1	14	0	17	0	18	0
Total (range)	**8-11**		**10-14**		12-17		14-18	

Increased investment in the training and development of the current and future workforce is, as highlighted in the NHS Human Resource Strategy, essential to the realisation of other key priorities for the NHS in Wales. Key priorities, some of which are mandatory, which could be funded from within projected levels of expenditure at the higher range are:

- central funding of pilots of new ways of working to combat emergency pressures, e.g. use of GPs and physiotherapists in A&E, and 7 day working in some areas to enable quicker diagnosis, treatment, and discharge from hospital; a recruitment and retention campaign
- enhancement of medical and dental post-graduate training in line with the increases already in train for undergraduate medical education, including expanding and enhancing GP vocational training
- expansion of range of non-medical health professional training in Wales (by up to 265 places a year) and implementation of UKCC 'Fitness for Practice' Report; provision of training to address skills shortages in specialist nursing areas, e.g.ITU, theatre, and one year trial of nurse consultant posts
- additional funding for reduction in intensity of junior hospital doctors' working

Note: Does not include funding for extra 65 medical undergraduate students, which has been discussed but not yet agreed, as costs would not impact within this period.

4. ICT (Information and Communication Technology)	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	9	19	15	10	14	10	14	10
Total (range)	**18-28**		**12-25**		**15-24**		**15-24**	

Substantial investment in ICT (over and above that assumed in current NHS plans) is necessary to optimise the benefits of higher spending on direct clinical services, to improve clinical practice, support clinical governance developments, and ensure better quality information. The key priorities are:

- Information quality improvement programme by provision of tools and support (capital cost £2.6 million, full year revenue costs £9 million), including the funding of ward based clinical information support staff which would release up to 500 whole time nursing staff for other duties, support improved clinical governance, and meet Assembly requirements for more reliable data
- Telecommunications enhancements, including the upgrade and connection of GP systems to DAWN to support improved bed management and data/information flows to/from GPs (£13 million over 2 years with £3 million on-going costs); the upgrade of the Digital All-Wales Network (DAWN) to allow increased volume of information exchange (£3.5 million with on-going annual costs of £0.5 million); and the upgrade and extension of trust local networks (£7 million capital; on-going costs £1 million) to support and improve clinical practice and clinical governance; and
- Introduction of video-conferencing equipment to trusts, health authorities, and local health groups freeing up significant management, clinician, and patient time by reducing the need to travel (£1 million capital; £2 million revenue)

5. Capital for Strategic Service Change	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	0	10	0	30	0	40	0	50
Total (range)	**5-10**		**15-30**		**20-40**		**25-50**	

In addition to the schemes for which Capital Modernisation Fund resources will be made available, this would allow a publicly funded capital investment programme to support the implementation of the NHS Wales corporate strategy, including the recommendations of the Acute Services Development Group, where public and private partnership funding is inappropriate or not cost-effective or requires additional Assembly support.

6. Coronary Heart Disease	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	15	9	26	0	28	0	30	0
Total (range)	**10-24**		**15-26**		**16-28**		**17-30**	

This level of funding would allow an immediate increase in cardiac surgery at UHW and, in the short term, increased use of any available capacity with English service providers while also funding investment in the expansion of cardiac surgery facilities at Morriston, UHW, and for North Wales to enable the progressive implementation of the SHSCW recommendations and the National Service Framework. It also provides some additional funding towards the increased costs of meeting the NSF in a primary care setting.

7. Children	2000-01		2001-02		2002-03		2003-04	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	3	0	4	0.1	5	0.1	5	0.1
Total	**2-3**		**3-4.1**		**3-5.1**		**3-5.1**	

The additional expenditure is necessary to:

- improve health and protection for children in public care
- commence implementation of standards for the care of critically ill children

8. Primary and Community Care and Health Development* (including health promotion/disease prevention)	2000-01		2001-02		2002-03		2003-04	
	11	0	20	1	21	1	24	1
Total (range)	**8-11**		**12-21**		**13-22**		**15-25**	

The additional expenditure would allow implementation of a range of initiatives to promote better health, particularly in community settings, to support health protection measures, and support improved standards and local developments in primary care. These include funding to support:

- the development of Local Health Alliances
- the development of the Welsh Network of Healthy Schools
- development of national coronary heart disease prevention programme
- health authorities' implementation of the Sexual Health Strategy
- implementation of fluoridation of water (from 2001-2)
- continuation of the eye care initiative
- ante-natal screening for HIV
- increasing uptake levels for influenza and pneumococcal immunisation
- improvement of primary care premises
- expansion of nurse prescribing
- continuation of the Welsh dental initiative scheme to attract new NHS dentists to Wales
- increased funding for the Welsh Medicines Resource Centre
- support for local primary care development

Note: a number of other suggested funding priorities (joined-up working - emergency pressures (£5 m), workforce development (£1.5 m), and ICT (£10m) would result in significant additional investment in the development of primary care.

9. Cancer	2000-01		2001-02		2002-03		2003-04	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m

	17	18	18	0.3	18	0	18	0
Total (range)	**10-35**		**15-18.3**		**15-18**		**15-18**	

The additional expenditure would enable:

- improved speed and quality of access to services, in particular improving diagnostic capacity with the provision of additional medical staff and access to specialist services as outlined in the minimum cancer standards for Wales
- better access to effective treatments and therapies, including those endorsed by the National Institute of Clinical Excellence

10. Mental Health Services	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	6	0	22	0	22	0	22	0
Total (range)	**5-6**		**10-22**		**15-22**		**15-22**	

The additional expenditure would enable progressive implementation of the:

- Adult mental health strategy
- Children and Adolescent Mental Health Strategy

and compliance with the National Service Framework.

11. Learning Disability	**2000-01**		**2001-02**		**2002-03**		**2003-04**	
	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m	Revenue £m	Capital £m
	0	0	4	0	7	0	9	0
Total	**0**		**2-4**		**5-7**		**7-9**	

The additional funding would allow:

- Completion of the Hensol residents re-settlement programme
- Start on a comprehensive re-settlement programme for Bryn – y- Neuadd and Llanfechra Grange.
- Note: No additional expenditure is proposed this year as it is not considered practically possible to advance these timescales

Appendix 1/Annex C

ACTION PROPOSALS	PRIORITIES	Joined up (Emergency Pressures) working	Waiting Lists/Times	Workforce Development	ICT	Capital for Strategic Service Charge	CHD	Childrens Primary & Community Care/HD	Cancer	Mental Health	Learning Disabilities
Joined up (Emergency Pressures) working		✓	✓	✓		✓		✓			
Waiting Lists/Times		✓	✓	✓		✓	✓	✓	✓		
Workforce Development		✓	✓	✓		✓	✓	✓	✓		
ICT			✓		✓	✓		✓			
Capital for Strategic Service Charge		✓	✓	✓	✓	✓	✓	✓	✓		
Coronary Heart Disease		✓	✓	✓		✓	✓	✓			
Children Primary & Community Care & Health Development		✓	✓	✓		✓		✓			
Cancer			✓	✓		✓		✓	✓		
Mental Health Services		✓	✓	✓				✓		✓	
Learning Disabilities		✓						✓			✓