Pecyn dogfennau cyhoeddus

Y Pwyllgor Cyfrifon Cyhoeddus

Lleoliad:
Ystafell Bwyllgora 3 - y Senedd

Dyddiad:
Dydd Mawrth, 17 Gorffennaf 2012

Amser:
09:00

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales

I gael rhagor o wybodaeth, cysylltwch â:

Policy: Tom Jackson
Clerc y Pwyllgor
029 2089 8597
Publicaccounts.comm@Wales.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon (9:00 - 9:05)

2. Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol:
Eitemau 3, 4, 5 a 7.

3. Ystyried Bil Archwilio Cyhoeddus (Cymru) (9:05 - 9:30) (Tudalennau 1 - 11)

4. Ystyried yr adroddiad drafft 'Rheoli Grantiau yng Nghymru' (9:30 - 9:35) (Tudalennau 12 - 60)

4. Trafod yr adroddiad drafft 'Cynnydd o ran cyrraedd Safon Ansawdd Tai Cymru'
5. (9:35 - 10:00) (Tudalennau 61 - 120)

5. Sesiwn Friffio gan Archwilydd Cyffredinol Cymru ar adroddiad Swyddfa Archwilio Cymru 'Cyllid Iechyd'
6. (10:00 - 10:30) (Tudalennau 121 - 165)
PAC(4) 16-12 - Papur 1 - Adroddiad Swyddfa Archwilio Cymru 'Cyllid Iechyd'

7. Opsiynau ar gyfer ymdrin ag adroddiad Swyddfa Archwilio Cymru 'Cyllid Iechyd' (10:30 - 10:45)

8. Papurau i'w nodi (Tudalennau 166 - 229)

PAC(4) 16-12 – Papur 2 – Gohebiaeth gan Drysorlys EM ynghylch Cynnydd ar gyflawni Safon Ansawdd Tai Cymru

PAC(4) 16-12 – Papur 3 – Gohebiaeth gan Lywodraeth Cymru ynghylch Cynnydd ar gyflawni Safon Ansawdd Tai Cymru

PAC(4) 16-12 – Papur 4 – National Audit Office report

Cofnodion y cyfarfod blaenorol

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

PAC(4)-16-12 Papur 1

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Eitem 6
12 Gorffennaf 2012
www.wao.gov.uk

Cyllid Iechyd

Cyllid Iechyd

Rwyf wedi llunio'r adroddiad hwn i'w gyflwyno i'r Cynulliad Cenedlaethol o dan adran 145A Deddf Llywodraeth Cymru 1998.

Roedd tîm astudiaeth Swyddfa Archwilio Cymru yn cynnwys Clare Stevens, Mark Jeffs a Matthew Coe dan gyfarwyddyd Gillian Body.

Huw Vaughan Thomas
Archwilydd Cyffredinol Cymru
Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd
CF11 9LJ

Mae'r Archwilydd Cyffredinol yn gwbl annibynnol ar y Cynulliad Cenedlaethol a'r Llywodraeth. Mae yntau'n archwilio ac yn ardystio cyfrifon Llywodraeth Cymru a'r cyrff cyhoeddus a noddir ganddi ac sy'n gysylltiedig â hithau gan gynnwys cyrff y GIG yng Nghymru. Mae ganddo hefyd y pŵer statudol i gyflwyno adroddiadau i'r Cynulliad Cenedlaethol ar economi, effeithlonrwydd ac effeithiolrwydd y defnydd a wna'r sefydliadau hynny o'u hadnoddau wrth gyflawni eu swyddogaethau, a sut y gallent wella'r defnydd hwnnw.

Mae'r Archwilydd Cyffredinol hefyd yn penodi archwilwyr i gyrff llywodraeth leol yng Nghymru, yn cynnal ac yn hyrwyddo astudiaethau gwerth am arian yn y sector llywodraeth leol ac yn asesu cydymffurfiaeth â gofynion gwerth gorau o dan Raglen Gwella Cymru. Fodd bynnag, er mwyn amddiffyn sefyllfa gyfansoddiadol llywodraeth leol, nid yw'n cyflwyno adroddiadau i'r Cynulliad Cenedlaethol sy'n ymwneud yn benodol â gwaith llywodraeth leol ei hun heblaw am pan fo angen gwneud yn ôl statud.

Yr Archwilydd Cyffredinol Cymru a'i staff gyda'i gilydd yw Swyddfa Archwilio Cymru. Am ragor o wybodaeth am Swyddfa Archwilio Cymru, ysgrifennwch at yr Archwilydd Cyffredinol yn y cyfeiriad uchod, ffôn 02920 320500, e-bost: info@wao.gov.uk, neu gweler y wefan www.wao.gov.uk

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Adroddiad a gyflwynwyd gan Archwilydd Cyffredinol Cymru i Gynulliad Cenedlaethol Cymru ar 12ain Gorffennaf 2012

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Cynnws

Crynodeb 6

Yn y gorffennol, er gwaethaf cyllidebau uwch, gwell system monitro ariannol a mwy o ffocws ar arbed arian, mae cyrff y GIG wedi gorfod cael arian ychwanegol ar ddiwedd y flwyddyn i fantoli'r gyllideb 7

Yn 2011-12, nododd cyrff y GIG arbedion sylweddol unwaith eto, ac mae Llywodraeth Cymru wedi ceisio sicrhau bod cyllid iechyd yn fwy cynaliadwy gan helpu i ddileu'r arfer o roi arian ychwanegol ar ddiwedd y flwyddyn 8

Mae arwyddion calonogol o ddiwygiadau hirdymor i fynd i'r afael â heriau ariannol yn y dyfodol nas gwelwyd erioed o'r blaen ond mae bylchau ariannu byrdymor yn achos pryder o hyd 9

Argymhellion 11

1 Yn y gorffennol, er gwaethaf cyllidebau uwch, gwell system monitro ariannol a mwy o ffocws ar arbed arian, mae cyrff y GIG wedi gorfod cael arian ychwanegol ar ddiwedd y flwyddyn i fantoli'r gyllideb 12

Mae cyllidebau iechyd wedi cynyddu bob blwyddyn rhwng 2006-07 a 2010-11 12

Dros y blynyddoedd diwethaf, mae Llywodraeth Cymru wedi gorfod defnyddio cronfeydd canolog wrth gefn Llywodraeth Cymru i alluogi cyrff y GIG i fantoli'r gyllideb 16

Yn dilyn yr ad-drefnu, atgyfnerthodd Llywodraeth Cymru y broses o fonitro cyrff y GIG a chanolbwyntiodd yn fwy ar reoli cost ond cyfleodd arwyddion cymysg o ran argaeledd arian ychwanegol 19

2 Yn 2011-12, nododd cyrff y GIG arbedion sylweddol unwaith eto, ac mae Llywodraeth Cymru wedi ceisio sicrhau bod cyllid iechyd yn fwy cynaliadwy gan helpu i ddileu'r arfer o roi arian ychwanegol ar ddiwedd y flwyddyn 22

Yn 2011-12, cafwyd bwlch ariannu yn ystod y flwyddyn oedd rhwng £280 miliwn a £380 miliwn ar ddechrau'r flwyddyn ariannol 22

Nododd cyrff y GIG arbedion o £285 miliwn yn 2011-12 ond cafwyd £157.4 miliwn ychwanegol oddi wrth Lywodraeth Cymru er mwyn ymdrin â phwysau cost a mantoli'r gyllideb 23

Mae Llywodraeth Cymru wedi newid ei dull gweithredu i ddarparu £63 miliwn o'r arian ychwanegol hwn ar sail reolaidd a defnyddio arian gwrthbwyso i atgyfnerthu neges fwy llym i gyrff y GIG 30

3 Mae arwyddion calonogol o ddiwygiadau hirdymor i fynd i'r afael â heriau ariannol yn y dyfodol nas gwelwyd erioed o'r blaen ond mae bylchau ariannu byrdymor yn achos pryder o hyd 32

Mae'r GIG yn wynebu toriadau termau real tan 2014-15 gyda bwlch ariannu sylweddol sy'n tyfu 32

Mae'r GIG yn wynebu her fawr i ymdopi o fewn y gyllideb yn y byrdymor 36

Ceir arwyddion cadarnhaol bod y GIG yn barod i wneud y dewisiadau anodd sydd eu hangen er mwyn cyflawni newid yn yr hirdymor ond ymddengys fod y nod i wella ansawdd a chynnal lefelau gwasanaethau a swyddi yn heriol 36

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Crynodeb

1 Yn ein hadroddiad, *Darlun o Wasanaethau Cyhoeddus 2011*, nodwyd yr heriau ariannol a gweithredol sylweddol sy'n wynebu'r GIG yng Nghymru. Dangosodd yr adroddiad hwnnw fod y GIG yng Nghymru yn wynebu setliad ariannol anos na'r tair gwlad arall yn y DU (rhoddir manylion pellach am y gymhariaeth â gweddill y DU yn *Darlun o Wasanaethau Cyhoeddus 2011*). Ac mae'n wynebu bwlch sylweddol a chynyddol rhwng yr arian sydd ei angen arno i leddfu pwysau cost hysbys, a'r arian gwirioneddol y mae'n ei gael.

2 Rhydd yr adroddiad hwn asesiad manylach o'r sefyllfa ariannol o fewn holl gyrff y GIG, a'r heriau ariannol a wynebir gan y GIG. Mae'n dadansoddi:

- data ariannol hanesyddol sy'n dangos sut mae'r GIG wedi ymdopi o fewn ei gyllideb yn ddiweddar;
- data ariannol a data arall sy'n dangos sut y gwnaeth Llywodraeth Cymru a chyrff y GIG reoli'r pwysau ariannol ar y GIG yn 2011-12;
- maint y bwlch ariannu y mae'r GIG yn ei wynebu yn y cyfnod i ddod, a'r heriau byrdymor a hirdymor yn sgil y cynnydd y mae'r GIG wedi'i wneud hyd yn hyn.

3 Yn ystod y cyfnod a drafodir yn yr adroddiad hwn mae'r GIG yng Nghymru wedi gweld newid strwythurol sylweddol. Ar 1 Hydref 2009, daeth y system lle'r oedd byrddau iechyd lleol yn comisiynu gwasanaethau oddi wrth naw o ymddiriedolaethau'r GIG i ben. Yn ei lle, mae saith bwrdd iechyd bellach yn gyfrifol am gynllunio a darparu gwasanaethau gofal iechyd mewn saith rhanbarth. Mae dwy o ymddiriedolaethau'r GIG yn parhau ac maent yn gyfrifol am ddarparu gwasanaethau arbenigol: Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru ac Ymddiriedolaeth GIG Felindre sy'n darparu gwasanaethau canser arbenigol. Mae Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru newydd ar gael hefyd. Mae'r newidiadau a wnaed yn 2009 wedi esgor ar system sy'n seiliedig ar waith cynllunio a chyflenwi integredig yn lle system darparu/ comisiynu. Bwriad Llywodraeth Cymru, drwy wneud hynny, oedd sicrhau mai un o fuddiannau'r newid hwn fyddai helpu i ddatrys rhai o'r problemau hanesyddol oedd yn gysylltiedig â gwaith cynllunio a rheoli ariannol yn y GIG a amlygir yn yr adroddiad hwn.

4 Mae'r adroddiad hwn yn trafod y cyfnod ers 2006-07. Yn ystod y cyfnod hwnnw, mae cyrff y GIG wedi gweithio o fewn dwy set o reolau cyfrifyddu, yn dibynnu ar b'un a ydynt yn ymddiriedolaeth neu'n fwrdd iechyd. Un o'r gofynion ariannol allweddol ar gyfer byrddau iechyd yw'r gofyniad ariannol statudol iddynt fantoli'r gyllideb bob blwyddyn. Lle na wneir hynny, ystyrir bod eu gwariant dros ben yn 'afreolaidd' a byddai'r dystysgrif archwilio ar eu datganiadau ariannol yn adlewyrchu hyn drwy gael barn archwilio 'amodol' ar reoleidd-dra. Yn ei thro, gallai barn amodol effeithio ar y farn archwilio ar ddatganiadau ariannol Llywodraeth Cymru. Yn achos ymddiriedolaethau'r GIG, y gofyniad statudol yw iddynt fantoli'r gyllideb, gan gymryd un flwyddyn gydag un arall. Fodd bynnag, mae Llywodraeth Cymru hefyd yn ei gwneud yn ofynnol iddynt fantoli'r gyllideb bob blwyddyn

o fewn trothwy hyblygrwydd penodol ac, yn wahanol i fyrddau iechyd, nid ystyrir bod unrhyw orwario o fewn y trothwyon hyn yn 'afreolaidd'.

5 Mae'n bwysig nodi bod yr adroddiad hwn yn bennaf seiliedig ar ddadansoddiad o sefyllfa ariannol y GIG. Ni fwriedir i'r adroddiad fod yn adolygiad manwl o systemau rheoli ariannol ym mhob rhan o'r GIG, nac ychwaith yn werthusiad o effaith y newidiadau strwythurol yn y GIG mewn blynyddoedd diweddar.

6 Y neges allweddol sy'n deillio o'r dadansoddiad hwn yw, gyda'r GIG a gwasanaethau cyhoeddus eraill yn wynebu heriau ariannol nas gwelwyd erioed o'r blaen, nid yw'r patrymau hanesyddol lle mae Llywodraeth Cymru wedi rhoi arian ychwanegol i gyrff y GIG yn ystod y flwyddyn i reoli diffygion yn gynaliadwy. Dros y blynyddoedd diwethaf, mae Llywodraeth Cymru wedi gweithio gyda chyrff y GIG i wella'r broses o reoli costau a gwneud arbedion ond mae angen gwneud newidiadau mwy radical i wasanaethau iechyd er mwyn sicrhau bod y GIG yng Nghymru yn gynaliadwy mewn termau ariannol.

Yn y gorffennol, er gwaethaf cyllidebau uwch, gwell system monitro ariannol a mwy o ffocws ar arbed arian, mae cyrff y GIG wedi gorfod cael arian ychwanegol ar ddiwedd y flwyddyn i fantoli'r gyllideb

7 Mae llif manwl cyllid drwy'r GIG yng Nghymru yn gymhleth, ond ceir fframwaith cyffredinol syml. I ddechrau, mae Llywodraeth Cymru yn penderfynu faint o arian y bydd yn ei wario ar iechyd. Ar hyn o bryd, caiff y gyllideb iechyd ei rheoli gan Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant Llywodraeth Cymru (yr Adran). Mae'r Adran yn dyrannu'r rhan fwyaf o'r gyllideb iechyd i gyrff unigol y GIG (y byrddau iechyd a'r ymddiriedolaethau) i ddarparu gwasanaethau iechyd i bobl Cymru. Cyrff y GIG eu hunain sy'n gyfrifol am reoli'r arian a gânt a sicrhau ei fod yn cael ei ddyrannu'n briodol er mwyn darparu gwasanaethau iechyd.

8 Rhwng 2006-07 a 2010-11, cynyddodd cyllideb Llywodraeth Cymru ar gyfer gwasanaethau iechyd yng Nghymru bob blwyddyn fel y gwnaeth yr arian a roddwyd i gyrff y GIG. Er i'r cyllidebau gynyddu bob blwyddyn, mae cyrff y GIG wedi gorfod cael arian ychwanegol i fantoli'r gyllideb. Rhwng 2006-07 a 2008-09, darparodd Llywodraeth Cymru arian ychwanegol i gefnogi gwelliannau gwasanaeth o fewn cyrff lleol y GIG drwy ddefnyddio tanwariant ac arian wrth gefn o fewn ei chyllideb rhaglen ganolog ei hun. Fodd bynnag, yn 2009-10 a 2010-11 bu'n rhaid i'r Adran ddefnyddio arian ychwanegol o gronfeydd canolog wrth gefn (arian a gedwir yng nghronfa gyffredinol wrth gefn Llywodraeth Cymru nas dyrannwyd eto i unrhyw adran benodol) er mwyn mantoli'r gyllideb iechyd gyffredinol a chyllidebau cyrff lleol y GIG.

9 Un o'r heriau mawr sy'n wynebu gwasanaeth a arweinir gan alw ac sydd o dan bwysau cynyddol yw sefydlu diwylliant lle cedwir costau dan reolaeth. Ar ddechrau pob blwyddyn, mae'r Adran yn nodi gofyniad clir i gyrff y GIG gynllunio a rheoli o fewn yr adnoddau sydd ar gael tra'n cyflawni targedau cytûn. Eto i gyd, erbyn diwedd pob blwyddyn, mae Llywodraeth Cymru wedi darparu arian ychwanegol i gefnogi gwelliannau gwasanaeth a chwmpasu diffygion lleol. Mae Llywodraeth Cymru dan bwysau i wneud iawn am y diffygion hynny yn rhannol oherwydd bod rheolau cyfrifyddu yn golygu y gallai ei chyfrifon ei hun gael eu gwneud yn amodol yn sgil gorwario gan un neu fwy o gyrff y GIG (gweler Paragraff 4).

10 Mae rhoi arian ychwanegol yn ei gwneud hi'n anos i reolwyr cyllid lleol bwysleisio'r angen i gadw costau dan reolaeth ymhlith clinigwyr a staff gweithredol, a all dybio y daw arian o rywle i ariannu unrhyw orwario yn y gyllideb. Roedd yn fwriad gan Lywodraeth Cymru i'r ad-drefnu yn 2009-10 helpu i fynd i'r afael â rhai o broblemau sylfaenol gwaith rheoli ariannol. Drwy ddileu'r rhaniad rhwng comisiynwyr a darparwyr, roedd Llywodraeth Cymru yn rhagweld y byddai gwell atebolrwydd o ran rheoli cyllid. Mae Llywodraeth Cymru wedi gwella'r broses o fonitro cyllid cyrff unigol y GIG yn ystod y flwyddyn, drwy gyflwyno ffurflenni monitro ariannol manylach a roddodd wybodaeth gyson ac amserol am y rhagolygon a'r sefyllfa gyfredol bob mis.

11 Mae Llywodraeth Cymru a chyrff y GIG hefyd wedi hoelio sylw ar reoli costau. Yn 2010-11, gosododd Llywodraeth Cymru dargedau ariannol llym iawn ar gyfer cyrff lleol, tra'n sicrhau bod rhywfaint o arian wrth gefn yn ei chyllidebau canolog. O ganlyniad i hyn, llwyddwyd i ganolbwyntio ar leihau costau, gyda chyrff y GIG yn datgan arbedion o £310 miliwn y flwyddyn honno. Fodd bynnag, tanseiliwyd y neges lem na fyddai mwy o arian ar gael pan roddodd Llywodraeth Cymru arian ychwanegol o'i chronfa wrth gefn ei hun a chronfeydd wrth gefn Llywodraeth Cymru. Mae risg bod yr hyn a wnaed yn 2010-11 wedi gwaethygu canfyddiadau rheolwyr a chlinigwyr y GIG bod gan Lywodraeth Cymru gronfa wrth gefn gudd y bydd yn ei defnyddio i ymdrin ag unrhyw ddiffygion.

Yn 2011-12, nododd cyrff y GIG arbedion sylweddol unwaith eto, ac mae Llywodraeth Cymru wedi ceisio sicrhau bod cyllid iechyd yn fwy cynaliadwy gan helpu i ddileu'r arfer o roi arian ychwanegol ar ddiwedd y flwyddyn

12 Yn 2011-12, wynebodd y GIG yng Nghymru ei flwyddyn anoddaf ers datganoli. Mae'n anodd rhagweld union raddau'r bwlch ariannu oedd yn wynebu'r GIG gan fod y broses o bennu union lefel y pwysau cost ar y GIG yn gymhleth ac mae sawl asesiad swyddogol gwahanol. Gan ddefnyddio'r rheini, a 2010-11 fel llinell sylfaen, gwnaethom amcangyfrif bod bwlch ariannu rhwng tua £280 miliwn a £380 miliwn ar ddechrau'r flwyddyn ariannol.

13 Erbyn diwedd y flwyddyn ariannol, llwyddwyd i fantoli'r gyllideb iechyd gyffredinol a chyllidebau holl gyrff unigol y GIG. Y prif reswm dros hyn oedd yr arbedion sylweddol a wnaed gan gyrff y GIG. Fodd bynnag, bu'n rhaid i'r Adran hefyd gael arian ychwanegol gan Lywodraeth Cymru er mwyn mantoli'r gyllideb.

14 Nododd cyrff y GIG eu bod wedi arbed £285 miliwn yn 2011-12. Ym maes staffio y gwnaed yr arbedion mwyaf, gan gynnwys costau rheoli, caffael a gofal iechyd parhaus. Nododd cyrff y GIG fod tua 87 y cant o'r arbedion yn rheolaidd, sy'n golygu y cânt eu cynnal yn y blynyddoedd i ddod. Er ei bod yn gadarnhaol bod y rhan helaeth o arbedion yn rheolaidd, cynyddodd y lefel o arbedion untro nad ydynt yn rheolaidd tuag at ddiwedd y flwyddyn wrth i rai o gyrff y GIG ei chael hi'n anodd cyflawni

arbedion digonol. Yn arbennig, bu cynnydd mewn arbedion caffael a staff untro, sy'n awgrymu bod rhai o gyrff y GIG wedi oedi cyn prynu pethau angenrheidiol a recriwtio staff tan y flwyddyn ariannol newydd. Hefyd, mae'n debygol bod rhai o'r arbedion wedi cael eu hailfuddsoddi, felly efallai y'u defnyddiwyd i wella ansawdd yn hytrach nag arbed arian.

15 Nid oedd yr arbedion a gofnodwyd gan y GIG yn ddigon i bontio'r bylchau ariannu. Ym mis Gorffennaf 2011, cytunodd Llywodraeth Cymru i roi £93 miliwn o arian ychwanegol o gronfeydd canolog wrth gefn y byddai £63 miliwn ohono’n rheolaidd (h.y.,fe'i hychwanegir at gyllidebau mewn blynyddoedd i ddod) i gyrff y GIG. Ychwanegwyd £40 miliwn arall o gyllideb yr Adran ei hun, gan greu cyfanswm o £133 miliwn. Darparwyd £12 miliwn ychwanegol hefyd gan Lywodraeth Cymru ar gyfer un bwrdd iechyd fel arian 'gwrthbwyso' – h.y., blaenswm ar gyllid y dyfodol, a fyddai'n cael ei ostwng yn briodol. Wrth gytuno ar gyllid, pwysleisiodd Llywodraeth Cymru ei bod yn bwriadu sicrhau bod cyllid y GIG yn dod yn fwy cynaliadwy gan ddileu’r arfer o roi arian ychwanegol ar ddiwedd y flwyddyn. Nododd Llywodraeth Cymru yn glir ei bod yn disgwyl i gyrff y GIG gyflawni o fewn y cyllidebau diwygiedig. Fodd bynnag, erbyn diwedd y flwyddyn ariannol, roedd angen i dri bwrdd iechyd gael £12.4 miliwn pellach. Cytunodd Llywodraeth Cymru i gwmpasu'r diffygion drwy arian 'gwrthbwyso', yn hytrach na darparu adnoddau ychwanegol, felly (fel y nodir uchod) byddai arian y dyfodol yn cael ei leihau'n briodol.

16 Yn 2011-12, parhaodd Llywodraeth Cymru i ddefnyddio ei system fonitro gryfach i gymryd camau mwy amserol er mwyn mynd i'r afael â materion oedd yn dod i'r amlwg. Ymyrrodd yn gynharach yn y flwyddyn i ddarparu'r arian ychwanegol a thrwy hynny roi mwy o sicrwydd i gyrff y GIG ynghylch faint o arian a fyddai ar gael yn gyfan gwbl. Drwy ddarparu arian gwrthbwyso ar ddiwedd y flwyddyn, yn hytrach na rhoi mwy o arian, mae Llywodraeth Cymru wedi dod yn nes nag o'r blaen at ategu ei neges na fydd rhagor o arian ar gael. Hefyd, mae'r defnydd synhwyrol o arian gwrthbwyso o bosibl yn helpu i fynd i'r afael â'r ffocws byrdymor sy'n deillio o'r gofyniad i fantoli'r gyllideb bob blwyddyn drwy ganiatáu i gyrff y GIG fantoli'r gyllideb dros gyfnod hwy, ac o bosibl gymryd camau i fuddsoddi i arbed.

Mae arwyddion calonogol o ddiwygiadau hirdymor i fynd i'r afael â heriau ariannol yn y dyfodol nas gwelwyd erioed o'r blaen ond mae bylchau ariannu byrdymor yn achos pryder o hyd

17 Mae'r GIG yn wynebu heriau ariannol nas gwelwyd erioed o'r blaen rhwng nawr a 2014-15. Yn dibynnu ar ba ragolygon a ddefnyddir, mae angen i gyrff y GIG reoli pwysau cost a galw o £870 miliwn i £1 biliwn rhwng 2010-11 a 2014-15.

18 Mae'r GIG yn wynebu her benodol yn 2012-13 ac mae cyrff y GIG wrthi'n llunio cynlluniau gwasanaeth a chyllid tair blynedd i sicrhau y gellir ateb yr her ariannol a nodwyd. Bydd yn bwysig sicrhau bod y cynlluniau hyn yn gadarn ac y gellir eu cyflawni. Wrth symud ymlaen, mae angen i'r GIG gynnal yr arbedion a wnaed ganddo eisoes, a chynyddu lefel yr arbedion sy’n rhyddhau arian parod tua £250 miliwn yn fwy bob blwyddyn. Mae'n debygol bod llawer o'r cyfleoedd i wneud 'enillion cyflym' o ran arbedion effeithlonrwydd wedi'u cymryd yn barod. O ganlyniad, bydd angen i gynlluniau ar gyfer y dyfodol ganolbwyntio'n fwyfwy ar y meysydd anos ar gyfer arbedion parhaus: lleihau costau drwy ad-drefnu gwasanaethau.

19 Mae'r GIG yn llwyr ymwybodol o'r heriau mae'n eu hwynebu. Er bod arwyddion calonogol o ran diwygiadau hirdymor, bydd yr uchelgeisiau a nodwyd yn Fframwaith Pum Mlynedd y GIG yn ymddangos yn fwyfwy heriol yn y byrdymor. Mae Fframwaith Pum Mlynedd y GIG (sy'n cwmpasu 2010-11 i 2014-15) yn nodi'r uchelgais i gau'r bwlch ariannu tra'n gwella ansawdd a chynnal lefelau gwasanaeth a swyddi ar yr un pryd. Mae'r uchelgais o ran cynnal lefelau swyddi yn heriol iawn o ystyried bod cryn dipyn o wariant y GIG yn mynd ar gyflogau. Yn ei chynllun pum mlynedd diweddar ar gyfer gweithlu'r GIG, nid yw Llywodraeth Cymru yn ailadrodd yr uchelgais i gynnal lefelau swyddi. Gosoda nod penodol i leihau costau rheoli a sicrhau bod costau'r gweithlu yn gyffredinol yn fforddiadwy. Daw prosesau cynllunio'r gweithlu effeithiol, sy'n gysylltiedig â newidiadau yn y ffordd y darperir gwasanaethau, yn fwyfwy pwysig, i reoli effaith bosibl newidiadau mewn lefelau staffio ar lefelau a darpariaeth gwasanaethau. Yr her i'r GIG yw bod y gwaith o ad-drefnu gwasanaethau yn debygol o gymryd amser, ac mae'r gofyniad i wneud arbedion yn fwyfwy dybryd, a lywir yn rhannol gan dargedau ariannol blynyddol.

20 Gallai'r ffocws ar gyflawni targedau ariannol blynyddol annog meddylfryd a chamau gweithredu byrdymor, megis cwtogi neu ohirio gwariant ar ddiwedd y flwyddyn er mwyn mantoli'r gyllideb. Yn 2011-12, roedd angen i gyrff y GIG gyflawni tua 40 y cant o'u harbedion arfaethedig mewn tri mis yn unig. Byddai'n werth ystyried opsiynau, o fewn rheolau cyfrifyddu presennol, i ddatblygu dull mwy hyblyg o annog ffocws ar arbedion, diwygiadau a mantoli'r gyllideb dros gyfnod hwy na blwyddyn. Mae Llywodraeth Cymru wedi cydnabod yr angen i gefnogi newid mewn gwasanaethau a mesur gwelliant dros gyfnod hwy na blwyddyn. Mae wedi ymrwymo i adolygu'r gyfundrefn ariannol, a fydd, yn ôl ei bwriad, yn eang ac yn arwain at wella system ariannol gyfan y GIG.

21 Mae arwyddion clir o gynnydd o ran diwygio gwasanaethau'r GIG yn y tymor hwy, fel y gallant ddarparu gwasanaethau o ansawdd uchel o fewn yr adnoddau sydd ar gael. Mae Llywodraeth Cymru wedi pennu disgwyliad clir bod angen gwneud diwygiadau radical. *Mae Law yn Llaw at Iechyd: Gweledigaeth 5 mlynedd ar gyfer y Gwasanaeth Iechyd Gwladol yng Nghymru* yn ailategu rhai o brif elfennau diwygiadau a nodwyd yn flaenorol yng ngweledigaethau Llywodraeth Cymru ar gyfer y GIG. Y gwahaniaeth allweddol rhwng yr ymgyrch ddiwygio bresennol ac ymdrechion blaenorol yw'r gydnabyddiaeth gynyddol nad yw'r sefyllfa sydd ohoni yn fforddiadwy.

22 Yr her yw bod caethgyfle: nid yw'r sefyllfa sydd ohoni'n fforddiadwy ond mae'r broses o gyflawni'r diwygiadau ynddi'i hun yn cynnwys cost y gall fod yn anodd ei hariannu. Mae gostyngiad o 36 y cant mewn termau real yn yr arian cyfalaf sydd ar gael i'r GIG yn y cyfnod gwario cyfredol. Mae'n debyg y bydd angen cyfalaf i ariannu unrhyw seilwaith sy'n ofynnol i gyflawni'r ffyrdd newydd, diwygiedig o weithio. Gall rhannau eraill o'r gwasanaeth cyhoeddus, fel llywodraeth leol, gael benthyg arian i wneud iawn am y toriadau cyfalaf yn rhannol, ond nid yw hyn yn opsiwn i gyrff y GIG. Yn ddiweddar, bu moratoriwm ar Fentrau Cyllid Preifat yn y GIG yng Nghymru. Felly, mae her fawr yn wynebu'r GIG a Llywodraeth Cymru i nodi costau diwygio a'r opsiynau i'w ariannu.

Argymhellion

A1	Er iddynt nodi arbedion sylweddol, bu'n rhaid i gyrff y GIG gael arian ychwanegol dros y blynyddoedd diwethaf. Yn arbennig, mae heriau o ran cyflawni arbedion rhyddhau arian parod o gynllunio'r gweithlu. Er mwyn helpu i fynd i'r afael â'r bylchau ariannu byrdymor, **dylai Llywodraeth Cymru wneud y canlynol**: • **cynorthwyo cyrff y GIG ymhellach o ran rhannu arfer da ar leihau costau, yn enwedig arbedion effeithlonrwydd nad ydynt yn effeithio ar ansawdd na lefelau gwasanaethau; a** • **herio cyrff y GIG wrth iddynt lunio eu cynlluniau tair blynedd i sicrhau eu bod yn cyflymu'r arbedion rhyddhau arian parod o gynllunio'r gweithlu tra'n rheoli'r risgiau i lefelau gwasanaethau ac ansawdd.**
A2	Mae cynaliadwyedd tymor hwy gwasanaethau iechyd yn dibynnu ar ddiwygiadau radical i'r ffordd y caiff gwasanaethau eu darparu a'u trefnu. Mae'r GIG yn wynebu her fawr o ran ariannu'r diwygiadau hynny'n arbennig gan fod toriadau mawr i arian cyfalaf. **Dylai Llywodraeth Cymru weithio gyda chyrff y GIG i nodi costau cyfalaf diwygio gwasanaethau, sicrhau eu bod yn cael eu blaenoriaethu'n gywir o fewn yr adnoddau sydd ar gael ac ystyried opsiynau ariannu amgen neu ddarparu'r seilwaith angenrheidiol sy'n cefnogi'r gwaith o ddiwygio gwasanaethau'r GIG**.
A3	Yn y blynyddoedd diwethaf, mae faint o arian cyrff y GIG a ddyrannwyd yn ystod y flwyddyn ariannol, yn hytrach nag ar y dechrau, wedi cynyddu'n sylweddol. Er bod rhesymau dilys dros hyn, **dylai Llywodraeth Cymru sicrhau bod cyrff y GIG yn cael cymaint o wybodaeth â phosibl am yr arian sydd ar gael cyn dechrau blwyddyn ariannol er mwyn hwyluso gwaith cynllunio ariannol effeithiol**.
A4	Mae Llywodraeth Cymru wedi gwella'r wybodaeth fonitro y mae'n ei chasglu am sefyllfaoedd ariannol cyrff y GIG drwy gydol y flwyddyn. Mae'r wybodaeth well hon wedi helpu Llywodraeth Cymru i wneud penderfyniadau mwy amserol ynghylch pwysau ariannu yn ystod y flwyddyn. Fodd bynnag, ceir rhai meysydd lle y gellid atgyfnerthu'r system fonitro ymhellach er mwyn rhoi darlun mwy cywir o'r sefyllfa debygol ar ddiwedd y flwyddyn. **Dylai Llywodraeth Cymru weithio gyda chyrff y GIG i wneud y canlynol**: • **sicrhau bod y wybodaeth am alldro disgwyliedig ar ddiwedd y flwyddyn yn gyson ar gyfer holl gyrff y GIG, yn arbennig eu bod yn taro cydbwysedd tebyg rhwng bod yn optimistaidd ynghylch mantoli'r gyllideb a chynnal asesiad realistig o'r her; a** • **sicrhau, lle y bo modd, fod cyrff y GIG yn llunio proffil o'r arbedion disgwyliedig o gyllidebau canolog ac enillion cyfrifyddu drwy gydol y flwyddyn yn eu ffurflenni monitro er mwyn rhoi darlun mwy realistig yn ystod y flwyddyn.**
A5	Mae sawl asesiad swyddogol gwahanol o'r pwysau cost a wynebir gan y GIG rhwng nawr a 2014-15, gyda gwahaniaethau rhyngddynt. **Er mwyn cefnogi gwaith cynllunio ariannol gwell, ac egluro graddau'r her sy'n wynebu'r GIG a'r arbedion sy'n ofynnol, dylai Llywodraeth Cymru wneud y canlynol**: • **diweddaru'r asesiad o'r pwysau cost ar y GIG, a nodir yn y Fframwaith Pum Mlynedd ar hyn o bryd; ac** • **ystyried yr asesiad cyfredol hwn yn erbyn mesurau eraill o bwysau cost o rannau eraill o'r sector cyhoeddus yn y DU.**
A6	Mae cyfundrefn cyfrifyddu adnoddau'r GIG yn canolbwyntio yn y byrdymor ar fantoli'r gyllideb ym mhob blwyddyn ariannol. Mae hyn o bosibl yn ei gwneud hi'n anodd i gyrff y GIG greu cronfeydd i fuddsoddi mewn gwaith trawsnewid a newid er mwyn cyflawni arbedion mewn blynyddoedd i ddod. **O fewn y fframwaith cyfrifyddu adnoddau presennol, dylai Llywodraeth Cymru asesu'r gofyniad presennol i fyrddau iechyd fantoli'r gyllideb bob blwyddyn, a datblygu opsiynau a fyddai'n galluogi cyrff y GIG i fuddsoddi mewn ffyrdd newydd o weithio lle mae'r rhain yn debygol o gyflawni arbedion yn y dyfodol a'u galluogi i fantoli'r gyllideb dros gyfnod hwy**.

Rhan 1 – Yn y gorffennol, er gwaethaf cyllidebau uwch, gwell system monitro ariannol a mwy o ffocws ar arbed arian, mae cyrff y GIG wedi gorfod cael arian ychwanegol ar ddiwedd y flwyddyn i fantoli'r gyllideb

1.1 Mae'r rhan hon o'r adroddiad yn edrych yn fanwl ar yr arian a roddwyd ar gyfer iechyd yn y blynyddoedd diwethaf, hyd at 2010-11. Noda batrymau ariannu a gwario cyrff iechyd. Mae'n asesu'r ffactorau sy'n cyfrannu at y pwysau cost a galw a wynebir gan y GIG. Mae hefyd yn nodi datblygiadau ym mhrosesau goruchwylio a monitro Llywodraeth Cymru o ran perfformiad ariannol cyrff y GIG.

1.2 Yn ystod y cyfnod a drafodir yn y rhan hon o'r adroddiad, mae'r GIG yng Nghymru wedi gweld newid strwythurol sylweddol. Ar 1 Hydref 2009, daeth y system lle'r oedd byrddau iechyd lleol yn comisiynu gwasanaethau oddi wrth naw o ymddiriedolaethau'r GIG i ben. Yn ei lle, mae saith bwrdd iechyd bellach yn gyfrifol am gynllunio a darparu gwasanaethau gofal iechyd mewn saith rhanbarth. Mae dwy o ymddiriedolaethau'r GIG yn parhau ac maent yn gyfrifol am ddarparu gwasanaethau arbenigol: Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru ac Ymddiriedolaeth GIG Felindre sy'n darparu gwasanaethau canser arbenigol. Mae Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru newydd ar gael hefyd. Roedd yn fwriad gan Lywodraeth Cymru sicrhau mai un o fuddiannau'r newidiadau hyn fyddai helpu i ddatrys rhai o'r problemau hanesyddol oedd yn gysylltiedig â gwaith cynllunio a rheoli ariannol yn y GIG.

1.3 Mae'r adroddiad hwn yn trafod y cyfnod ers 2006-07. Yn ystod y cyfnod hwnnw, mae cyrff y GIG wedi gweithio o fewn dwy set o reolau cyfrifyddu, yn dibynnu ar b'un a ydynt yn ymddiriedolaeth neu'n fwrdd iechyd. Un o'r gofynion ariannol allweddol ar gyfer byrddau iechyd yw'r gofyniad statudol iddynt fantoli'r gyllideb bob blwyddyn. Yn achos ymddiriedolaethau'r GIG, mae'n ofynnol iddynt fantoli'r gyllideb, gan gymryd un flwyddyn gydag un arall (gweler Paragraff 4).

Mae cyllidebau iechyd wedi cynyddu bob blwyddyn rhwng 2006-07 a 2010-11

Dros y pum mlynedd diwethaf, mae'r gyllideb iechyd wedi cynyddu uwchlaw chwyddiant bob blwyddyn er i'r cynnydd a welwyd yn ddiweddar fod yn fwy mewn rhai rhannau eraill o'r DU

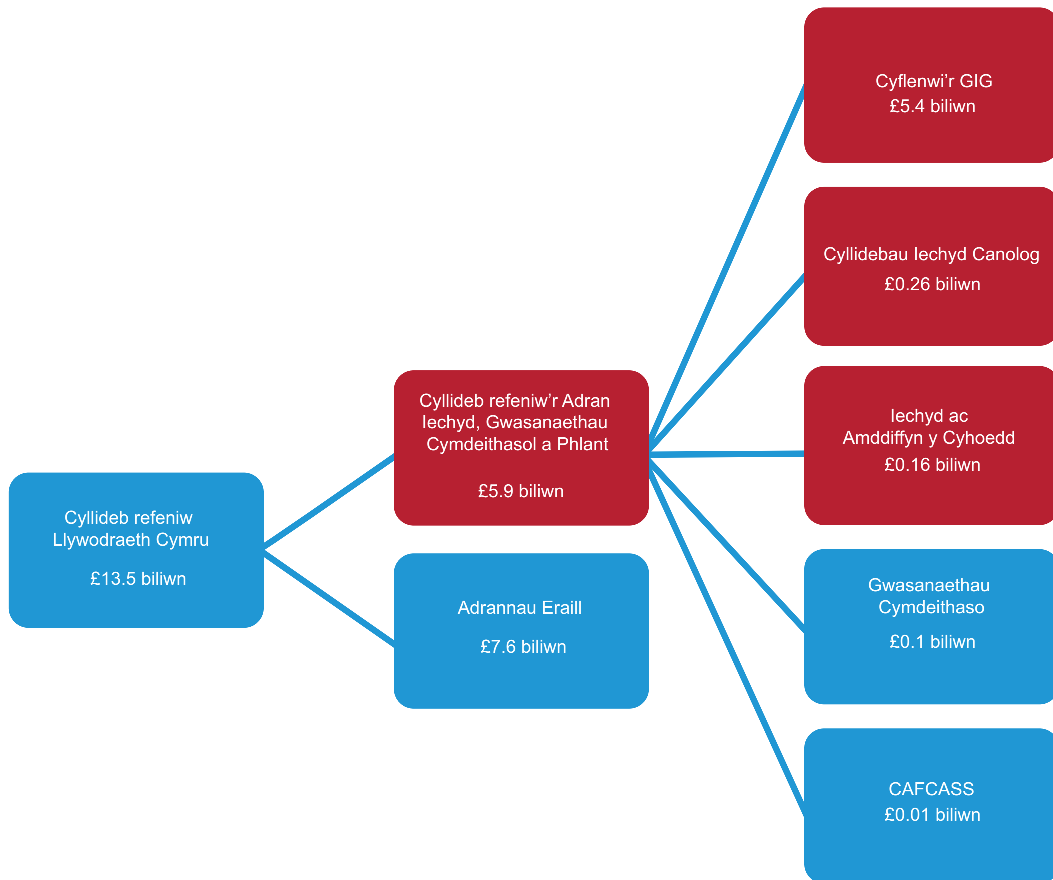
1.4 Mae'n bwysig nodi'n glir pa set o ffigurau rydym yn ei defnyddio at ddibenion dadansoddi yn yr adroddiad hwn. Bob blwyddyn, mae Llywodraeth Cymru yn pennu cyllideb. Rhennir y gyllideb yn 'Brif Grwpiau o Wariant'. Mae'r grwpiau hyn yn adlewyrchu strwythur Llywodraeth Cymru, gyda phob grŵp yn cynrychioli adran. Mae iechyd yn rhan o Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant ehangach (yr Adran). Felly, wrth ganolbwyntio ar gyllid iechyd, nid ydym wedi cynnwys yr elfennau hynny o'r gyllideb nad ydynt yn ymwneud ag iechyd. Mae Ffigur 1 yn nodi strwythur cyllideb iechyd Llywodraeth Cymru yng Nghyllideb Derfynol 2011-12[1]. Mae'r holl elfennau sydd wedi'u lliwio'n goch yn Ffigur 1 yn cwmpasu'r 'gyllideb refeniw iechyd'. Cyfeiria'r term hwn at yr holl refeniw a gyllidebwyd a ddyrannwyd i wariant iechyd. Fodd bynnag, dylid nodi, er bod y rhan fwyaf o'r gyllideb hon yn cael ei rhoi i gyrff y GIG, mae elfen yn cael ei rhoi i gyrff nad ydynt yn

1 Er y'i gelwir yn 'Gyllideb Derfynol' nid y fersiwn terfynol o'r gyllideb ydyw fel arfer. Y 'Gyllideb Derfynol' yw'r gyllideb y cytunir arni gan y Cynulliad Cenedlaethol cyn i'r flwyddyn ariannol ddechrau. Yn ystod y flwyddyn, caiff y gyllideb ei diweddaru drwy 'gyllidebau atodol'.

perthyn i'r GIG, megis yr Asiantaeth Safonau Bwyd, ac at ddibenion ymchwil a datblygu academaidd. Yn Rhan 1 o'r adroddiad hwn, sy'n trafod lefelau ariannu hanesyddol, canolbwyntiwn ar y gyllideb refeniw iechyd gyffredinol. Cyflwynwyd tri is-gategori sef Cyflenwi'r GIG; Iechyd y Cyhoedd ac atal; a Chyllidebau Iechyd Canolog ym mis Mehefin 2010, sy'n golygu na allwn gymharu'r categorïau lefel is dros amser. Yn Rhannau 2 a 3, defnyddiwn linell Cyflenwi'r GIG i ystyried y pwysau cost sy'n wynebu gwasanaethau iechyd rheng flaen.

1.5 Dengys Ffigur 1 sut mae Llywodraeth Cymru yn dosbarthu'r gyllideb refeniw iechyd rhwng y categorïau gwahanol. Fodd bynnag, nid yw cyllideb Llywodraeth Cymru yn nodi faint yn union o arian y mae'n bwriadu ei drosglwyddo i wahanol gyrff y GIG sy'n darparu gwasanaethau iechyd. Bob blwyddyn, mae Llywodraeth Cymru yn ysgrifennu at gyrff y GIG, gan nodi eu 'dyraniadau' ar gyfer y flwyddyn. Dengys Ffigur 2 y gyllideb refeniw iechyd rhwng 2006-07 a 2010-11. Gwelir bod y rhan fwyaf o'r arian a ddyrennir ar gyfer y gyllideb iechyd yn cael ei ddyrannu i wahanol

Ffigur 1 - Dadansoddiad o Gyllideb Refeniw Terfynol 2011-12 Llywodraeth Cymru, yn canolbwyntio ar iechyd

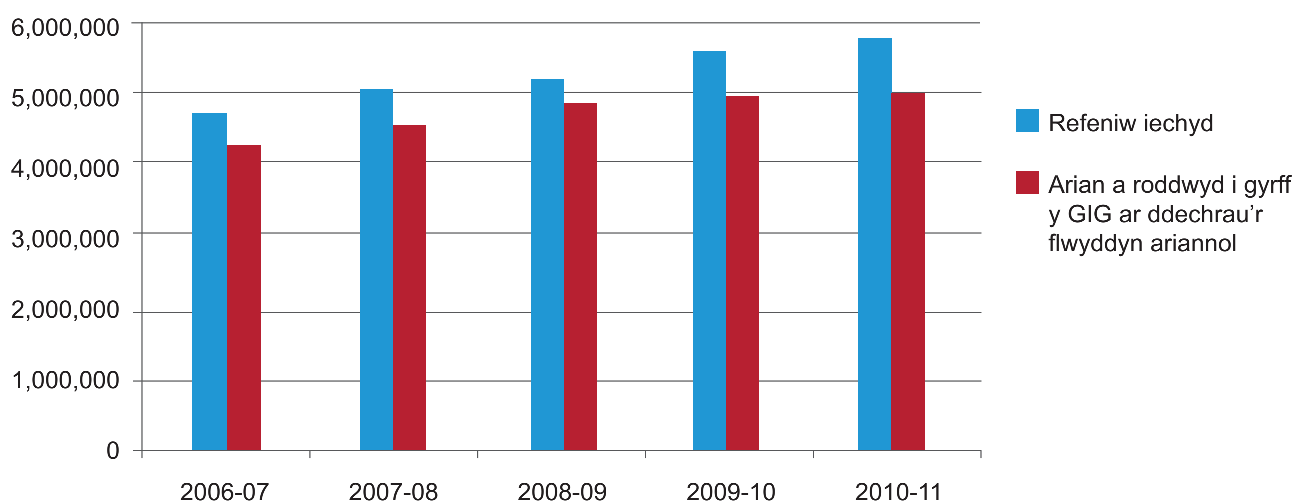


Ffynhonnell: Cyllideb Derfynol Llywodraeth Cymru 2011-12

gyrff y GIG. Mae'r swm a roddir i bob un o gyrff y GIG yn unigol yn bennaf seiliedig ar batrymau ariannu hanesyddol. Dyrennir y gyllideb sy'n weddill ar gyfer amrywiaeth o raglenni, gan gynnwys rhaglenni iechyd y cyhoedd a reolir gan Lywodraeth Cymru, a chyrff nad ydynt yn perthyn i'r GIG y cyfeiriwyd atynt ym Mharagraff 1.4.

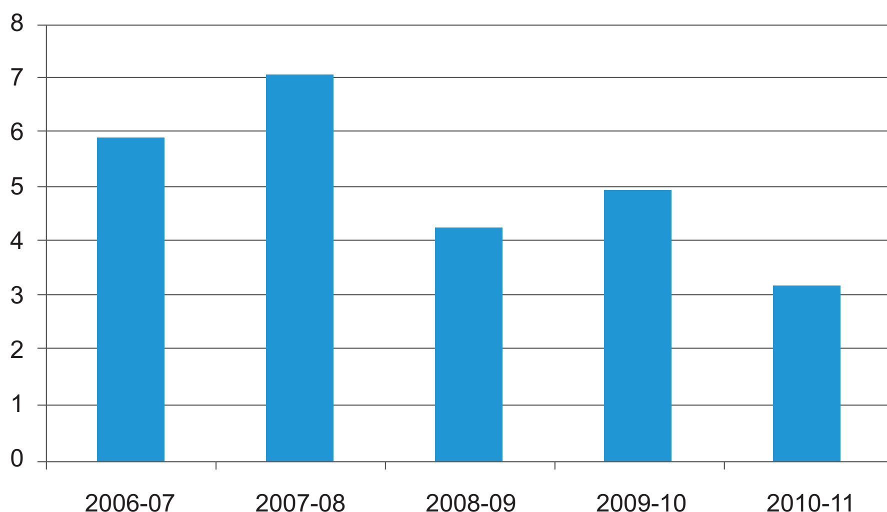
1.6 Mae'r gyllideb refeniw iechyd wedi cynyddu bob blwyddyn ers datganoli. Dengys Ffigur 3, dros y pum mlynedd diwethaf, fod y cynnydd wedi amrywio o tua 3 y cant i gymaint â 7 y cant, mewn termau arian parod. Roedd y cynnydd yn uwch yn 2006-07 a 2007-08 nag mewn blynyddoedd diweddarach. Mae'r gyllideb iechyd wedi cynyddu'n sylweddol, hyd yn oed ar ôl ystyried chwyddiant yn yr economi gyfan[2]. Mae'n gyffredin defnyddio'r

Ffigur 2 - Cyllideb Refeniw Iechyd 2006-07 i 2010-11 a'r arian a roddwyd i gyrff y GIG ar ddechrau'r flwyddyn ariannol



Ffynhonnell: Cyllidebau terfynol Llywodraeth Cymru a llythyrau dyrannu cyrff y GIG

Ffigur 3 - Cynnydd mewn termau arian parod yn y gyllideb refeniw iechyd (%)



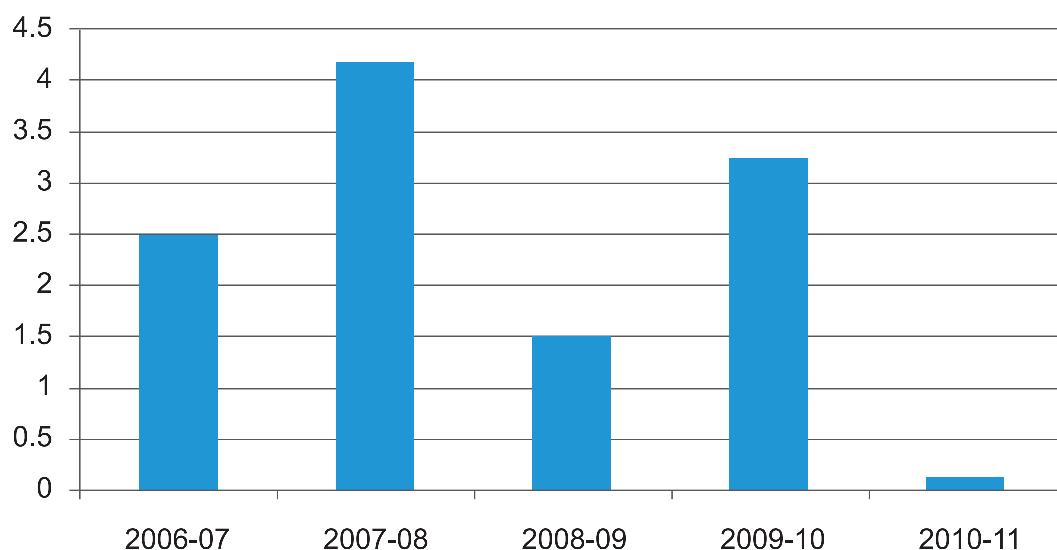
Ffynhonnell: Cyllidebau terfynol Llywodraeth Cymru

2 Ar gyfer yr adroddiad hwn, rydym wedi defnyddio cyfres datchwyddo CMC y Trysorlys a gyhoeddwyd ym mis Rhagfyr 2011.

datchwyddwyr CMC i gyfrifo a chofnodi newidiadau termau real yn y gyllideb, sef y rheswm dros ddefnyddio'r datchwyddwyr yn sail i Ffigur 4. Fodd bynnag, derbynnir yn eang bod pwysau cost a galw mewn gofal iechyd yn uwch na chwyddiant yn yr economi ehangach. Dengys Ffigur 4 i'r gyllideb refeniw iechyd gynyddu uwchlaw chwyddiant yn yr economi ehangach bob blwyddyn dros y pum mlynedd diwethaf.

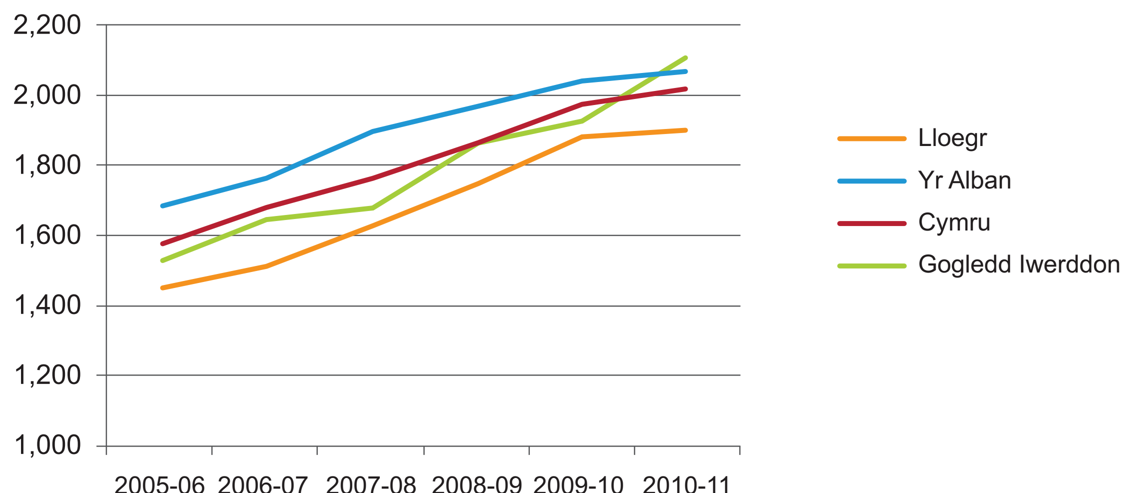
1.7 Adlewyrchir y patrwm lle mae gwariant yn cynyddu o flwyddyn i flwyddyn ledled y DU. Dengys Ffigur 5 wariant iechyd fesul pen o'r boblogaeth ym mhob cwr o'r DU. Dengys mai Cymru a wariodd y swm mwyaf ond un fesul pen o'r boblogaeth, yn ail i'r Alban tan 2008-09, pan gymerodd Gogledd Iwerddon ei lle. Roedd Cymru ar y blaen i Loegr yn 2010-11. Fodd bynnag, gwnaeth gwariant iechyd yn Lloegr gynyddu'n gyflymach nag yng Nghymru rhwng 2007-08 a 2009-10, er i wariant yng

Ffigur 4 - Cynnydd termau real yn y gyllideb refeniw iechyd (%)



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau Llywodraeth Cymru

Ffigur 5 - Gwariant ar iechyd fesul pen o'r boblogaeth



Ffynhonnell: Dadansoddiad Gryno Gwariant Cyhoeddus Trysorlys EM 2011

Nghymru gynyddu'n fwy na Lloegr yn 2010-11. Mae'n werth nodi bod gwariant fesul pen o'r boblogaeth yng Nghymru yn debycach i ranbarthau yn Lloegr â demograffeg debyg, megis Gogledd-ddwyrain Lloegr. Caiff y gwariant uwch ar iechyd fesul pen o'r boblogaeth yn y rhannau mwy difreintiedig hyn ei wrthbwyso gan wariant llawer is fesul pen o'r boblogaeth mewn ardaloedd fel De-ddwyrain Lloegr, gan olygu bod gwariant cyffredinol fesul pen o'r boblogaeth ar gyfer Lloegr yn is, a ddangosir yn Ffigur 5.

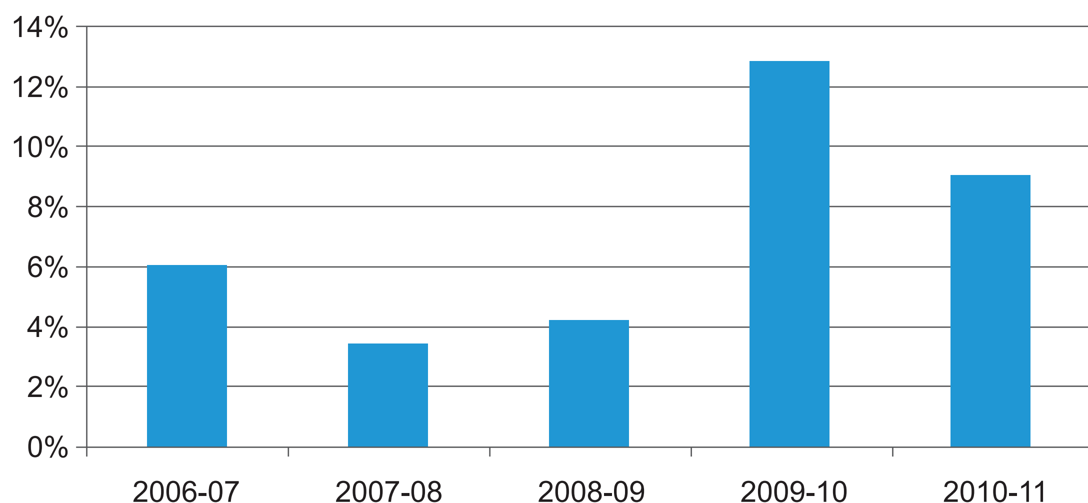
Dros y blynyddoedd diwethaf, mae Llywodraeth Cymru wedi gorfod defnyddio cronfeydd canolog wrth gefn Llywodraeth Cymru i alluogi cyrff y GIG i fantoli'r gyllideb

1.8 Fel y nodwyd uchod, mae'r gyllideb iechyd yn cynnwys dwy brif elfen. Ceir y gyllideb refeniw iechyd gyffredinol, y mae'r Cynulliad Cenedlaethol yn penderfynu arni drwy fwrw pleidlais, ac o fewn hyn, ceir dyraniad y GIG: yr arian a roddir i gyrff unigol y GIG. Caiff cyrff y GIG ddyraniad ariannol cychwynnol rai misoedd cyn dechrau'r flwyddyn ariannol, ond yn ystod y flwyddyn ariannol efallai y rhoddir arian ychwanegol iddynt fel a ganlyn:

- dyraniad ychwanegol o arian a gynlluniwyd ac a dargedwyd yn ystod y flwyddyn o'r gyllideb refeniw iechyd gyffredinol, a symudir o raglenni canolog i gyrff y GIG pan fydd ar ei ffurf derfynol;
- arian o'r gyllideb refeniw iechyd nas cynlluniwyd yn wreiddiol i'w roi i gyrff y GIG, fel arfer i fodloni pwysau ychwanegol; ac
- arian o gronfeydd canolog wrth gefn Llywodraeth Cymru ar ben y gyllideb refeniw iechyd a bennwyd yn y gyllideb derfynol, unwaith eto fel arfer i fodloni pwysau ychwanegol.

1.9 Dengys Ffigur 6 y cynnydd o ddyraniad ariannol cychwynnol cyrff y GIG i'w dyraniad ariannol terfynol ar ddiwedd y flwyddyn.

Ffigur 6 - Cynnydd rhwng y dyraniad cychwynnol a'r dyraniad terfynol i gyrff y GIG (%)



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ddata dyrannu'r GIG

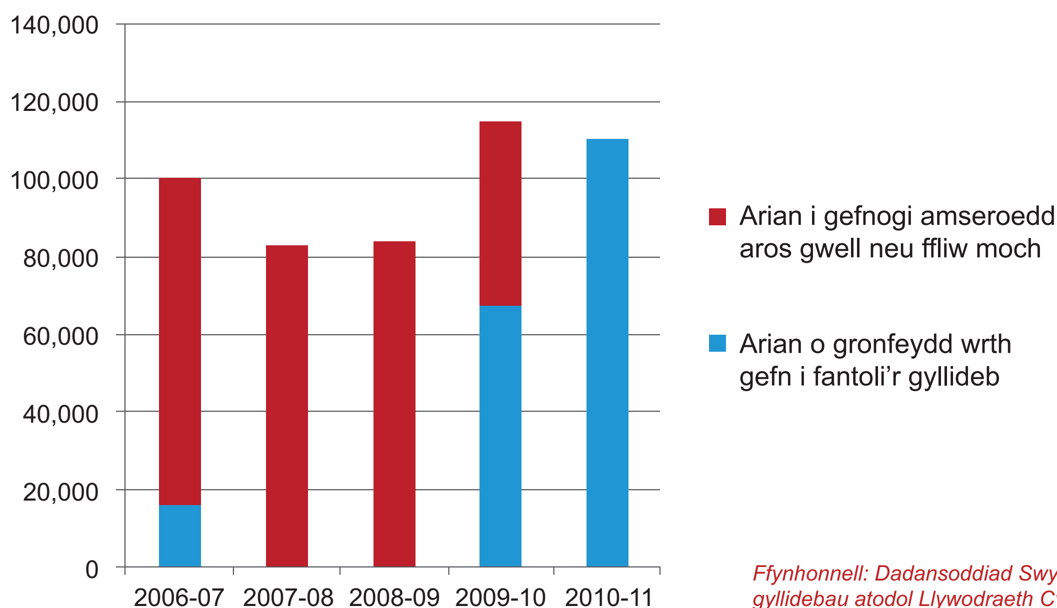
1.10 Mae nifer o resymau dilys dros roi peth o'r arian hwn i gyrff y GIG yn ystod y flwyddyn:

- caiff peth arian ei arwain gan alw, y mae Llywodraeth Cymru yn derbyn y risg ac yn cymryd cyfrifoldeb am dalu'r costau;
- mae peth arian yn dibynnu ar drafodaethau yn ystod y flwyddyn, megis arian gofal sylfaenol lle mae'r costau terfynol yn hysbys ar ddiwedd trafodaethau rhwng meddygon teulu a Llywodraeth y DU; a
- chaiff peth o'r arian ei ddyrannu i fodloni amcanion penodol Llywodraeth Cymru ar ôl i gyrff y GIG gyflwyno cynlluniau.

1.11 Dengys y siart gynnydd sylweddol yng nghyfran yr arian a roddwyd yn ystod y flwyddyn 2009-10 a 2010-11 o gymharu â blynyddoedd cynharach. Yn 2009-10, o ganlyniad i ad-drefnu'r GIG, dechreuwyd dyrannu arian sylweddol i ymddiriedolaethau'r GIG drwy'r byrddau iechyd yn hytrach nag yn uniongyrchol oddi wrth Lywodraeth Cymru. Er enghraifft, yn 2009-10, roedd a wnelo 4.6 y cant o'r cynnydd cyffredinol o 13 y cant â thaliadau dibrisio nad oeddent yn rheolaidd a thaliadau lleihad mewn gwerth a fyddai wedi'u hariannu'n uniongyrchol i ymddiriedolaethau'r GIG mewn blynyddoedd blaenorol. Er bod dyrannu arian i gyrff y GIG yn ystod y flwyddyn yn ymateb ymarferol i amgylchedd newidiol y GIG, erys yn hanfodol i gyrff y GIG gael cymaint o wybodaeth â phosibl cyn dechrau blwyddyn ariannol er mwyn eu galluogi i gynllunio'n effeithiol yn ariannol.

1.12 Elfen o'r cynnydd a ddangosir yn Ffigur 6, ac ar ben y cynnydd rheolaidd mewn arian y cyfeiriwyd ato uchod, yw'r arian ychwanegol a roddwyd gan yr Adran i gyrff y GIG o'i chyllideb refeniw iechyd ei hun i'w galluogi i fantoli'r gyllideb. Yr elfen derfynol o'r arian ychwanegol yn ystod y flwyddyn, a ddangosir yn Ffigur 6, yw'r arian a roddwyd gan Lywodraeth Cymru i gyrff y GIG o gronfeydd canolog wrth gefn. Dangosir y symiau hyn yn Ffigur 7 ac maent wedi newid o ran natur yn sylweddol dros y blynyddoedd. Roedd llawer o'r arian ychwanegol yn 2006-07, yr arian i gyd ar gyfer 2007-08 a 2008-09, a £21 miliwn

Ffigur 7 - Arian ychwanegol a roddwyd i gyrff y GIG o gronfeydd canolog wrth gefn



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau atodol Llywodraeth Cymru

yn 2009-10 yn arian i gefnogi gwelliannau mewn amseroedd aros. Hefyd, roedd £20 miliwn o'r arian ychwanegol o gronfeydd wrth gefn yn 2009-10 ar gyfer costau ffliw adar ac ad-drefnu'r GIG. Fodd bynnag, yn 2009-10 a 2010-11, bu'n rhaid i Lywodraeth Cymru roi arian ychwanegol o gronfeydd wrth gefn yn bennaf i alluogi cyrff y GIG i fantoli'r gyllideb. Yn 2010-11, roedd yr arian ychwanegol i'r GIG o gronfeydd wrth gefn yn cyfrif am 42 y cant o gronfeydd wrth gefn Llywodraeth Cymru.

Mae achosion o orwario yn debygol o gael eu hegluro'n rhannol gan weithgarwch i wella mynediad i wasanaethau iechyd a'u hansawdd yn ogystal â phwysau o ran galw a chwyddiant

1.13 Mae'r GIG yn wynebu amrywiaeth o bwysau cost sy'n golygu bod angen mwy o arian arno bob blwyddyn dim ond i aros yn yr unfan. Mae cyflogau yn brif ffactor o ran cost; mae'r bil cyflog cyffredinol yng nghyrff lleol y GIG wedi cynyddu 25 y cant neu £576 miliwn rhwng 2005-06 a 2010-11. Mae codiadau cyflog yn cyfrif am 17.5 o'r 25 o bwyntiau canran uwch, gyda chyflogau'n codi 3.5 y cant ar gyfartaledd bob blwyddyn yn ystod y cyfnod hwnnw. Mae'n bwysig nodi bod y codiad cyflog yn cynnwys y prif 'godiad cyflog' yn ogystal â'r hyn a elwir yn 'ddrifft cyflog'. Ymhlith yr enghreifftiau o ddrifft cyflog mae staff yn symud i fyny 'pwyntiau meingefn' o fewn eu graddfeydd, a chodiadau yswiriant gwladol, sy'n cynyddu'r bil cyflog cyffredinol. Mae gweddill y cynnydd o ran cyflogau o ganlyniad i'r ffaith bod nifer y gweithwyr Cyfwerth ag Amser Cyflawn (CACau) wedi cynyddu o 68,686 i 73,074 yn ystod y cyfnod, sef cynnydd o 6.5 y cant (4,388 o CACau).

1.14 Mae meddyginiaethau yn ffactor allweddol arall o ran cost. Yn 2005-06, gwariodd y GIG £855 miliwn ar gyffuriau, cyfarpar a chyflenwadau clinigol. Yn 2010-11, roedd y gost wedi cynyddu i dros £1 biliwn, sef cynnydd o 18 y cant, neu 3.5 y cant ar gyfartaledd bob blwyddyn.

1.15 Mae galw yn effeithio ar gostau yn yr hirdymor. Nododd ein hadroddiad, sef *Darlun o Wasanaethau Cyhoeddus*, y ffactorau demograffig, yn enwedig gwariant sy'n gysylltiedig ag oedran, sy'n cynyddu'r galw ar y GIG dros amser. Mae Cronfa'r Brenin a'r Sefydliad Astudiaethau Cyllid[3] wedi amcangyfrif bod galw cynyddol yn cyfrif am tua 1.1 y cant o'r cynnydd termau real mewn cost bob blwyddyn. Ceir hefyd ffactorau ffordd o fyw, megis alcohol a gordewdra, sy'n rhoi pwysau cynyddol ar wasanaethau iechyd.

1.16 Mae'r ymgyrch i wella mynediad at ofal ac ansawdd gofal hefyd yn cyfrannu at gostau uwch o fewn y GIG. Mae cynlluniau, gan gynnwys targedau, i ostwng amseroedd aros, lleihau nifer yr heintiau a ddelir wrth gael gofal iechyd a gwella ansawdd gofal weithiau'n gofyn am fwy o weithgarwch a chostau ychwanegol. Dros y degawd diwethaf, gwnaed ymrwymiadau hirsefydledig i gynyddu'r arian a gaiff y GIG er mwyn cefnogi'r gwelliannau hyn. Cynhaliodd Cronfa'r Brenin ddadansoddiad o'r hyn a alwyd yn 'fwlch cynhyrchiant' yn y GIG yn Lloegr . Daeth i'r casgliad bod mwy na hanner y 'bwlch cynhyrchiant' sy'n wynebu'r GIG yn Lloegr[4] oherwydd gwelliannau arfaethedig i fynediad ac ansawdd gwasanaethau. Er na chaiff y costau hyn eu nodi'n uniongyrchol mewn cyllidebau a chyfrifon, fe'u hadlewyrchir mewn lefelau cynyddol o staff - a chostau staff - i gyflawni'r gweithgarwch i sicrhau'r gwelliannau o ran mynediad ac ansawdd.

1.17 Mae rhai gwahaniaethau o ran yr union ffyrdd o fesur y pwysau cost a wynebir gan y GIG. Ddiwedd 2009, roedd y Cytundeb Cyllid Cenedlaethol, a ddefnyddiodd data a gwaith a roddwyd gan gyrff y GIG i Lywodraeth Cymru, yn darogan pwysau cost o tua 7.2 y cant yn 2010-11. Fodd bynnag, ym mis Mehefin 2010, cyhoeddodd Llywodraeth Cymru ei Fframwaith Pum Mlynedd, a nododd y pwysau o ran chwyddiant a'r tybiaethau

3 Cronfa'r Brenin a'r Sefydliad Astudiaethau Cyllid, *How cold will it be? Prospects for NHS funding 2011-17*, 2009

4 Cronfa'r Brenin, *Improving NHS productivity: More of the same not more with the same*, 2010

o ran twf demograffig a galw yr asesodd y byddai'r gwasanaeth iechyd yng Nghymru yn eu hwynebu rhwng 2010-11 a 2014-15. Yn ôl y Fframwaith Pum Mlynedd, byddai'r pwysau chwyddiant a gweithgarwch ar gyfer 2010-11 rhwng 3.7 y cant a 4.4 y cant. Er bod y ddau ddull hyn yn defnyddio systemau gwahanol at ddibenion cynllunio ariannol, byddai'n fuddiol datblygu a defnyddio dull a set o dybiaethau cyffredin.

Yn dilyn yr ad-drefnu, atgyfnerthodd Llywodraeth Cymru y broses o fonitro cyrff y GIG a chanolbwyntiodd yn fwy ar reoli cost ond cyfleodd arwyddion cymysg o ran argaeledd arian ychwanegol

Yn dilyn yr ad-drefnu yn 2009-10, atgyfnerthodd Llywodraeth Cymru'r broses o fonitro perfformiad ariannol cyrff y GIG a phennodd dargedau ariannol ar gyfer 2010-11 a oedd yn sicrhau bod mwy o ffocws ar reoli cost er bod angen arian ychwanegol o hyd

1.18 Yn dilyn yr ad-drefnu yn 2009-10, mae Llywodraeth Cymru wedi monitro perfformiad ariannol cyrff y GIG yn fwy gofalus. Un o nodau'r ad-drefnu, sydd wedi arwain at lai o gyrff a llai o le i ddrysu ynghylch pwy sy'n atebol am gyllid, oedd helpu i hwyluso proses rheoli ariannol well. Yn 2010, aeth Llywodraeth Cymru ati i fanylu ar y weithdrefn fonitro fisol, sy'n ei gwneud yn ofynnol i gyrff y GIG gyflwyno ffurflenni manwl i Lywodraeth Cymru o fewn pythefnos i ddiwedd pob mis. Mae'r ffurflenni monitro hyn yn gofyn i gyrff y GIG roi gwybodaeth amserol a chyson am eu sefyllfa ariannol. Maent hefyd yn ei gwneud yn ofynnol i gyrff y GIG adrodd ar achosion o orwario wrth iddynt godi a darogan y sefyllfa debygol ar ddiwedd y flwyddyn yn sgil y cynnydd hyd yn hyn. Hefyd, cyflwynodd Llywodraeth Cymru gyfarfodydd rheolaidd rhwng Cyfarwyddwr Cyllid yr Adran a chyfarwyddwyr cyllid cyrff y GIG i drafod cynnydd yn erbyn targedau ariannol.

1.19 Ochr yn ochr ag atgyfnerthu trefniadau monitro, gosododd Llywodraeth Cymru dargedau ariannol llym iawn ar gyfer cyrff y GIG ar ddechrau'r flwyddyn. Tra cynyddodd y gyllideb refeniw iechyd tua 3 y cant, dim ond cynnydd o 0.7 y cant a welwyd yn yr arian a roddwyd i gyrff y GIG. Nododd Llywodraeth Cymru yn glir ei bod yn disgwyl i gyrff y GIG ymdopi â'r cynnydd bach hwn oedd islaw chwyddiant. Dengys hyn fwriad Llywodraeth Cymru i bwyso ar gyrff y GIG i gyflawni arbedion cost sylweddol tra hefyd yn parhau i fod yn hyblyg o ran darparu arian ychwanegol o'r gyllideb refeniw iechyd fel y bo angen. O ystyried y cynnydd bach yn yr arian a roddwyd i gyrff y GIG, gyda'i gilydd pennwyd targed i arbed £413 miliwn, ac yn dilyn hynny nodwyd eu bod wedi arbed £314 miliwn. Mae'r arbedion hyn o bosibl yn gyflawniad mawr i'r GIG. Fodd bynnag, mae'n debygol nad oedd rhai o'r arbedion hyn yn rhyddhau arian parod ac felly ni wnaethant gyfrannu'n uniongyrchol at gau'r bwlch ariannu y flwyddyn honno (gweler Ffigur 8). Y canlyniad net oedd bod angen i gyrff y GIG gael cryn dipyn o arian ychwanegol yn 2010-11. Ni allai'r Adran ymateb i'r angen hwn o fewn y gyllideb refeniw iechyd a bu'n rhaid iddi ddarparu £110 miliwn arall o gronfeydd wrth gefn Llywodraeth Cymru.

Ffigur 8 - Cysoni arbedion a nodwyd yn 2010-11 â'r pwysau o ran y gyllideb a chost

Ym mharagraff 1.16 soniwyd am natur gymhleth asesu'n gywir y pwysau cost a wynebai gyllidebau iechyd yn 2010-11. Gan ystyried y dulliau gweithredu gwahanol hynny, a'r diffyg sylfaenol o 2009-10, cyfrifwn fod bwlch ariannu o rhwng £126 miliwn[5] a £281 miliwn[6] yn y gyllideb refeniw iechyd. Mae'r ffigurau hyn yn awgrymu y byddai gwarged wedi bod petai'r holl arbedion yn rhyddhau arian parod ac wedi'u defnyddio i gau'r bwlch ariannu. Fodd bynnag, fel y dengys Ffigur 7, bu'n rhaid i Lywodraeth Cymru roi £110 miliwn yn ychwanegol i'r GIG o'i chronfeydd wrth gefn.

Yn rhannol, gallai'r anhawster i gysoni'r arbedion a nodwyd yn y gyllideb â'r rhagolygon o ran pwysau cost gael ei egluro gan y gwahanol fathau o arbedion a wneir gan gyrff y GIG. Nid yw pob math o arbedion yn rhyddhau arian parod. Mae'n bosibl bod cyfran sylweddol o'r arbedion a nodwyd wedi'u hailfuddsoddi mewn gwelliannau ac felly na wnaethant gyfrannu'n uniongyrchol at gau'r bwlch ariannu. Mae hefyd yn debygol bod rhai o'r arbedion yn cynrychioli 'osgoi cost', er enghraifft rheoli costau uwch, yn arbennig nwyddau neu wasanaethau i lefel islaw pwysau cost chwyddiant a nodwyd yn y Fframwaith Pum Mlynedd a'r Cytundeb Cyllid Cenedlaethol. Mae'r GIG hefyd yn cefnogi newidiadau strategol i wasanaethau drwy ailfuddsoddi rhai arbedion sy'n rhyddhau arian parod mewn modelau newydd a lleoliadau gofal.

1.20 O ganlyniad i brosesau monitro ariannol gwell, roedd Llywodraeth Cymru yn ymwybodol o'r angen am arian ychwanegol yn gynharach nag mewn blynyddoedd blaenorol. Cydnabu y byddai angen mwy o arian a rhoddodd yr arian ychwanegol i gyrff y GIG ym mis Rhagfyr 2010, yn hytrach nag aros tan ddiwedd y flwyddyn ariannol.

Mae Llywodraeth Cymru yn cydnabod bod rhoi arian ychwanegol yn peri rhai heriau o ran datblygu diwylliant lle cedwir costau dan reolaeth

1.21 Un o'r heriau mawr sy'n wynebu gwasanaeth a arweinir gan alw ac sydd o dan bwysau cynyddol yw sefydlu diwylliant lle cedwir costau dan reolaeth. Mae Llywodraeth Cymru wedi nodi gofyniad clir i gyrff y GIG gynllunio a rheoli o fewn yr adnoddau sydd ar gael tra'n cyflawni targedau cytûn. Fodd bynnag, mae Llywodraeth Cymru hefyd wedi rhoi arian ychwanegol yn ystod y flwyddyn ariannol sydd wedi helpu cyrff y GIG i gyflawni'r targedau hynny a mantoli'r gyllideb. Lle mae cyrff y GIG yn gorwario, mae Llywodraeth Cymru dan bwysau i wneud iawn am y diffygion hynny: yn rhannol oherwydd bod rheolau cyfrifyddu yn golygu y gallai ei chyfrifon ei hun gael eu gwneud yn amodol yn sgil gorwario gan un neu fwy o gyrff y GIG. Byddai'r angen i wneud cyfrifon Llywodraeth Cymru yn amodol yn beth cwbl newydd iddi ac er nad yw'r union ganlyniadau'n sicr byddai'n debygol o beri cryn niwed i enw da Llywodraeth Cymru.

1.22 Mae pryderon bod canolbwyntio ar fantoli'r gyllideb ar ddiwedd y flwyddyn ariannol yn annog gorbwyslais ar y tymor byr. Yn un o gyfarfodydd Pwyllgor Cyfrifon Cyhoeddus y Cynulliad Cenedlaethol, dywedodd Prif Weithredwr Bwrdd Iechyd Aneurin Bevan fod yr her o fantoli'r gyllideb iechyd gwerth £6 biliwn fel 'glanio awyren fawr ar stamp'.

5 Mae'r ffigur hwn yn seiliedig ar y bwlch rhwng y cynnydd gwirioneddol o 3.2 y cant yn y gyllideb refeniw iechyd a'r pwysau cost o 4.4 y cant a nodwyd yn y Fframwaith Pum Mlynedd, yn ogystal â diffyg sylfaenol o £60 miliwn o 2009-10.

6 Mae'r ffigur hwn yn seiliedig ar y bwlch rhwng y cynnydd gwirioneddol o 3.2 y cant yn y gyllideb refeniw iechyd a'r pwysau cost o 7.2 y cant a nodwyd yn y Cytundeb Cyllid Cenedlaethol, yn ogystal â diffyg sylfaenol o £60 miliwn o 2009-10.

1.23 Dros y blynyddoedd, ymddengys fod patrwm wedi dod i'r amlwg lle mae Llywodraeth Cymru yn dweud wrth gyrff y GIG na fydd rhagor o arian ar gael ond yna rydd gymorth sy'n gwneud iawn am y diffygion. Mae risg bod y fath batrwm yn ei gwneud hi'n anos i reolwyr cyllid bwysleisio'r angen i gadw costau dan reolaeth ymhlith clinigwyr a staff gweithredol, a all dybio y daw arian o rywle i ariannu unrhyw orwario yn y gyllideb.

1.24 Mae risg y gallai'r dull ariannu ar ddechrau 2010-11 fod wedi gwaethygu'r canfyddiadau o gronfa ariannol gudd ar gyfer gorwariant. Roedd cadw swm cymharol fawr o arian yn ôl, pennu targedau uchelgeisiol a chyfleu neges lem na fyddai rhagor o arian ar gael yn risg. Mae cael cronfa wrth gefn i ymateb i ddigwyddiadau annisgwyl yn synhwyrol, ond mae angen ei chyflwyno'n ofalus fel nad yw cyrff na staff y GIG yn camddeall maint y fath gronfa wrth gefn. Hefyd, mae risgiau'n gysylltiedig â chyfleu neges lem nad oes rhagor o arian ar gael pan ei bod yn amlwg i lawer o fewn y GIG bod rhywfaint o arian wrth gefn ar gael. Tanseiliwyd y neges lem pan ddarparwyd arian ychwanegol wedyn. Gallai'r cyfuniad o ffactorau fod wedi cyfrannu at ganfyddiadau bod cronfa gudd o arian ar gael i ariannu diffygion. Dengys Rhannau 2 a 3 fod Llywodraeth Cymru wedi dysgu gwersi a'i bod yn symud tuag at fwy o dryloywder o ran cyllid ac yn ategu ei negeseuon drwy beidio â darparu rhagor o arian ar ddiwedd y flwyddyn.

Rhan 2 – Yn 2011-12, nododd cyrff y GIG arbedion sylweddol unwaith eto, ac mae Llywodraeth Cymru wedi ceisio sicrhau bod cyllid iechyd yn fwy cynaliadwy gan helpu i ddileu'r arfer o roi arian ychwanegol ar ddiwedd y flwyddyn

2.1 Mae'r rhan hon o'r adroddiad yn ystyried maint bwlch ariannu y GIG yn 2011-12 a'r camau a gymerwyd gan Lywodraeth Cymru a chyrff y GIG i gau'r bwlch hwnnw erbyn diwedd y flwyddyn ariannol. Ystyrir:

- maint y bwlch ariannu ar ddechrau'r flwyddyn;
- yr arbedion y nodwyd bod cyrff y GIG wedi'u gwneud a'r cynnydd o ran aros o fewn y gyllideb drwy gydol y flwyddyn;
- yr arian ychwanegol sydd ei angen i fantoli'r gyllideb; a
- goruchwylio a monitro cynnydd gan Lywodraeth Cymru.

Yn 2011-12, cafwyd bwlch ariannu yn ystod y flwyddyn oedd rhwng £280 miliwn a £380 miliwn ar ddechrau'r flwyddyn ariannol

2.2 Fel y nodir yn Rhan 1, mae'r GIG yn wynebu amryw bwysau cost ac mae'n nodi yn union faint o 'fwlch ariannu' sydd - y gwahaniaeth rhwng yr arian a roddwyd i gyrff y GIG a'r pwysau cost a galw amcangyfrifedig - yn gymhleth. Ceir tri fersiwn gwahanol o'r bwlch ariannu, sy'n seiliedig ar y canlynol:

- rhagolygon cost a galw o Fframwaith Pum Mlynedd y GIG;
- rhagolygon o'r Cytundeb Cyllid Cenedlaethol, sy'n seiliedig ar asesiadau byrddau iechyd eu hunain; ac
- asesiad cyfunol cyrff y GIG eu hunain o'r bwlch ariannu.

2.3 Dengys Ffigur 9 y bwlch ariannu sy'n seiliedig ar Fframwaith Pum Mlynedd y GIG a'r Cytundeb Cyllid Cenedlaethol. Rydym wedi defnyddio llinell Cyflenwi'r GIG o'r gyllideb (gweler Atodiad 1 am esboniad). Mae Fframwaith Pum Mlynedd y GIG yn amcangyfrif pwysau cost a galw sydd tua 3.3 y cant yn y flwyddyn. Gan ddefnyddio'r amcangyfrifon hyn, gwelir bod bwlch ariannu o tua £280 miliwn. Er y gall hwn ymddangos yn isel, adlewyrcha'r ffaith bod cyflogau wedi cael eu rhewi ym mhob rhan o'r GIG. Mae'r Cytundeb Cyllid Cenedlaethol yn amcangyfrif pwysau cost o 5.2 y cant.

2.4 Ar ddechrau'r flwyddyn, nododd cyrff y GIG eu hunain fwlch o £279 miliwn yn ystod y flwyddyn. Roedd gan gyrff y GIG hefyd ddiffyg sylfaenol[7] o £187 miliwn o 2010-11. Er mwyn pontio'r bwlch yn ystod y flwyddyn a dileu'r diffyg sylfaenol, nododd cyrff y GIG gyfanswm bwlch ariannu o £466 miliwn. Gyda'i gilydd, roedd gan gyrff y GIG gynlluniau i arbed £267 miliwn er mwyn pontio'r bwlch ariannu yn rhannol.

7 Caiff y diffyg sylfaenol ei gyfrifo bob blwyddyn drwy ystyried incwm nad yw'n rheolaidd, gwariant ac arbedion nad ydynt yn rheolaidd.

Ffigur 9 - Bwlch ariannu yn 2011-12

Refeniw (miliynau)	2010-11	2011-12
Cyllideb Cyflenwi'r GIG	£5.47 biliwn	£5.37 biliwn
Pwysau cost yn Fframwaith Pum Mlynedd y GIG		3.3%
Pwysau cost yn y Cytundeb Cyllid Cenedlaethol		5.2%
Bwlch ariannu gan ddefnyddio'r Fframwaith Pum Mlynedd		£279 miliwn
Bwlch ariannu gan ddefnyddio'r Cytundeb Cyllid Cenedlaethol		£383 miliwn

Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau Llywodraeth Cymru ac amcangyfrifon o bwysau cost
Noder: I ddangos y bwlch ar ddechrau'r flwyddyn ariannol, mae'r ffigur ar gyfer 2010-11 yn cynnwys arian ychwanegol a ddyrannwyd mewn dwy gyllideb atodol (cyfanswm o £5.506 biliwn llai arian nad oedd yn arian parod). Mae'r ffigur ar gyfer 2011-12 yn adlewyrchu'r gyllideb ar ddechrau'r flwyddyn ariannol, fel y nodwyd yng Nghyllideb Derfynol 2011-12 a gymeradwywyd ym mis Rhagfyr 2011, ac nad yw'n cynnwys yr arian ychwanegol a ddyrannwyd yn ystod y flwyddyn.

Nododd cyrff y GIG arbedion o £285 miliwn yn 2011-12 ond cafwyd £157.4 miliwn ychwanegol oddi wrth Lywodraeth Cymru er mwyn ymdrin â phwysau cost a mantoli'r gyllideb

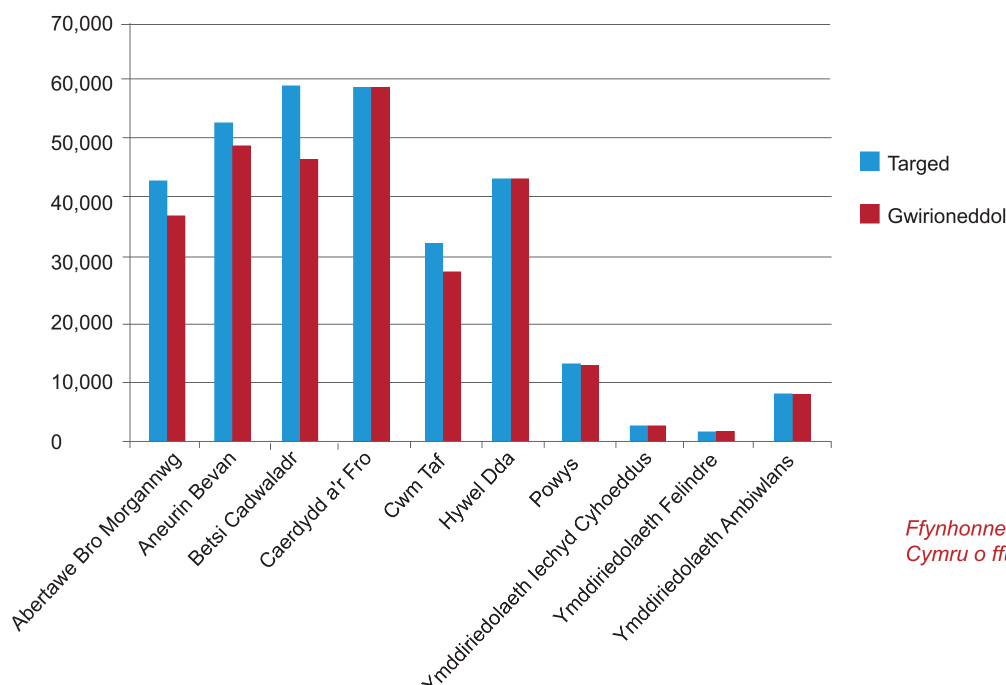
Nododd cyrff y GIG arbedion o £285 miliwn yn 2011-12 a oedd fymryn yn is na'r targed terfynol ac yn cynnwys cryn dipyn yn fwy o arbedion untro na'r bwriad gwreiddiol

2.5 Yn ystod y flwyddyn, cynyddodd cyrff y GIG lefel yr arbedion posibl o £267 miliwn (Paragraff 2.4) i £312 miliwn. Ar ddiwedd mis Mawrth 2012, nododd cyrff y GIG eu bod wedi arbed £285 miliwn. Mae'r ffigur hwn yn is na'r arbedion o £314 miliwn a nodwyd ar gyfer 2010-11, ond mae'n dal i fod yn gyflawniad sylweddol. Fodd bynnag, nid yw'n glir ai lleihad sylweddol mewn arbedion cost sy'n gyfrifol am hyn neu broses nodi a dosbarthu arbedion fwy trwyadl. Mae Ffigur 10 yn nodi lefel yr arbedion a gofnodwyd yn erbyn targedau.

2.6 Dengys Ffigur 11 y categorïau o arbedion a nodwyd. Ym maes y gweithlu y mae'r arbedion mwyaf o gryn dipyn, gydag £85 miliwn o arbedion a nodwyd yn cael eu gwneud drwy foderneiddio'r gweithlu a £7 miliwn arall drwy leihau costau rheoli. Fodd bynnag, yn y ddau gategori, ni chyflawnodd cyrff y GIG yr arbedion targed cyfunol. Ym maes caffael ac eitemau eraill nad ydynt yn ymwneud â chyflogau y mae'r arbedion mwyaf nesaf; gyda'r £66 miliwn o arbedion a nodwyd yn rhagori ar y targed o £57 miliwn. Y trydydd maes mwyaf o arbedion yw gofal iechyd parhaus lle, unwaith eto, roedd y £44 miliwn o arbedion a nodwyd uwchlaw'r cynllun ar gyfer y flwyddyn.

2.7 Cafodd y byrddau iechyd anawsterau i gyflawni eu harbedion targed ym maes rheoli meddyginiaethau. Eu bwriad oedd i'r maes hwn gyflawni'r lefel uchaf o arbedion namyn un ond mewn gwirionedd dim ond y pedwaredd uchaf a gyflawnwyd. Yn ôl y ffurflenni monitro, gwnaeth pump allan o'r saith bwrdd iechyd orwario ar gyffuriau presgripsiwn gofal sylfaenol, gan wario cyfanswm o £20 miliwn gyda'i gilydd. Gorwariodd byrddau iechyd tua £36 miliwn ar 'gyflenwadau clinigol' ym maes gofal eilaidd, sy'n cynnwys meddyginiaethau a roddir mewn ysbytai.

Ffigur 10 - Arbedion a nodwyd gan gyrff y GIG o gymharu ag arbedion targed 2011-12



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ffurflenni monitro mis 12

2.8 Dengys Ffigur 11 y ddau fath o arbedion craidd: arbedion rheolaidd ac arbedion eraill. Mae arbedion rheolaidd yn arbedion cynaliadwy y dylid eu gwneud mewn blynyddoedd i ddod (felly maent yn cynrychioli lleihad parhaol mewn costau). Ymhlith yr enghreifftiau o'r fath arbedion mae lleihau cost uned prynu eitem mewn contract hirdymor, neu newid y ffordd y caiff gwasanaeth ei drefnu fel bod modd ei ddarparu'n barhaol gan lai o staff. Mae arbedion eraill yn lleihad untro mewn costau. Ymhlith yr enghreifftiau mae oedi cyn prynu eitem tan y flwyddyn ariannol newydd neu oedi cyn llenwi swydd wag y bydd angen ei llenwi yn y pen draw. Mae'n gadarnhaol bod 87 y cant o arbedion yn cael eu nodi'n rhai rheolaidd. Fodd bynnag, mae lefel yr arbedion eraill wedi cynyddu'n sylweddol tuag at ddiwedd y flwyddyn. Ym mis Rhagfyr 2011, roedd cyrff y GIG yn darogan mai dim ond £23 miliwn o'r arbedion na fyddent yn rheolaidd, o gymharu â'r sefyllfa derfynol lle cafwyd £38 miliwn o arbedion o'r fath. Ym meysydd y gweithlu a chaffael y gwelwyd y cynnydd mwyaf mewn arbedion nad oeddent yn rheolaidd yn yr ychydig fisoedd olaf.

2.9 Dengys Ffigurau 12 a 13 sut y gwnaed yr arbedion yn ystod y flwyddyn a'r rhaniad rhwng arbedion rheolaidd ac arbedion eraill. Ar y cyfan, llwyddodd y byrddau iechyd hynny a gyflawnodd arbedion yn fwy cyson drwy gydol y flwyddyn (a ddangosir gan linell fwy syth yn Ffigur 12) i sicrhau mwy o arbedion rheolaidd, tra dibynnodd y byrddau iechyd hynny a gyflawnodd arbedion yn agosach at ddiwedd y flwyddyn (a ddangosir gan linell grom) ar arbedion eraill i raddau mwy.

Roedd angen i'r Adran gael gafael ar £93 miliwn ychwanegol o gronfeydd canolog wrth gefn, gan gynnwys £63 miliwn a wnaed yn rheolaidd i fynd i'r afael â diffygion hanesyddol a £30 miliwn i gynorthwyo Hywel Dd

2.10 Cydnabu Llywodraeth Cymru yn gynharach yn y flwyddyn ariannol nad oedd cyrff y GIG yn debygol o gyflawni eu targedau ariannol na mantoli'r gyllideb. Roedd yr holl fyrddau iechyd, namyn un, yn darogan diffyg sylweddol ar ddiwedd y flwyddyn. Ystyriodd Cabinet Llywodraeth Cymru y sefyllfa ym mis Gorffennaf 2011, yn seiliedig ar gynlluniau ariannol 2011-12 ac adroddiadau monitro

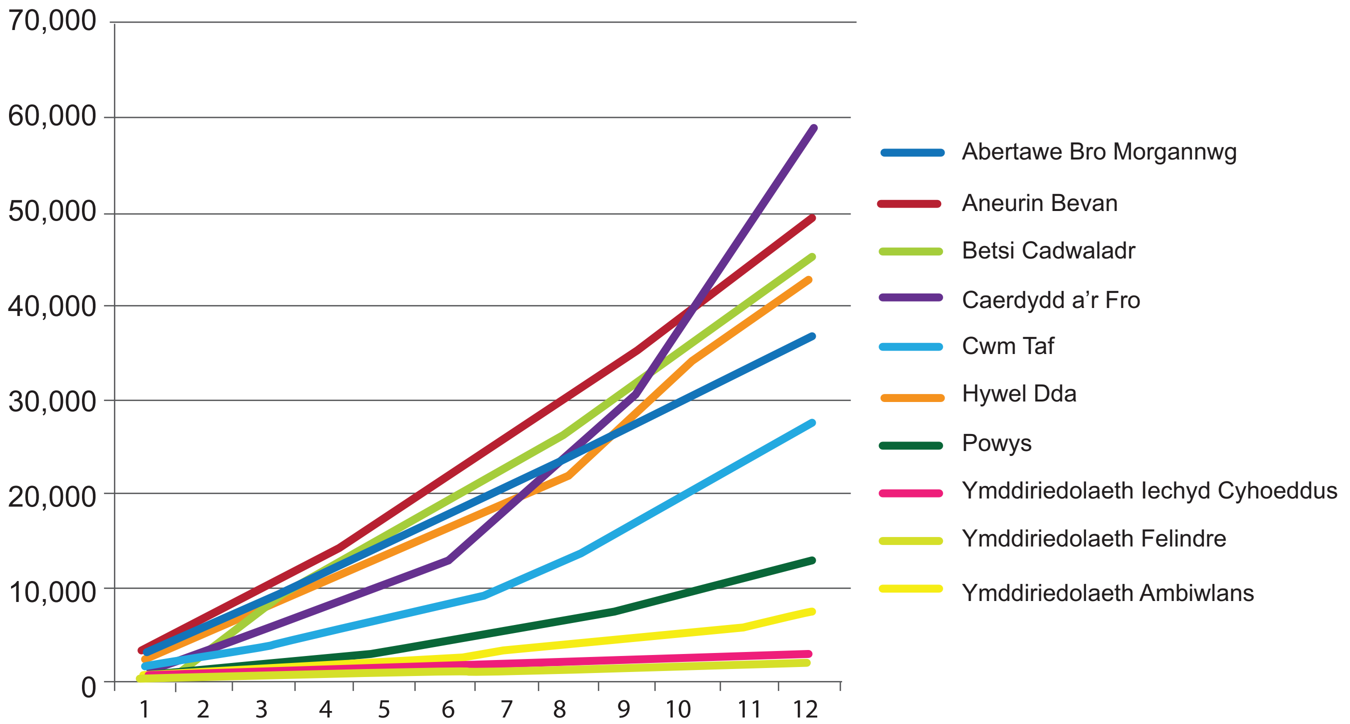
Ffigur 11 - Categorïau o arbedion a nodwyd yn 2011-12

Categorïau Arbedion	Cynllun blwyddyn gyfan £000's	Cynllun blwyddyn gyfan %oedran	Blwyddyn gyfan wirioneddol £000's	Blwyddyn gyfan wirioneddol %oedran	Yn cynnwys: Rheolaidd £000's	Yn cynnwys: Nad yw'n rheolaidd £000's
Moderneiddio'r Gweithlu	111,392	35.7%	84,551	29.7%	74,609	9,942
Rheoli Meddyginiaethau (Gofal Sylfaenol ac Eilaidd)	51,330	16.5%	42,710	15.0%	40,331	2,379
Caffael ac Eitemau Eraill nad ydynt yn Ymwneud â Chyflogau (heblaw am Ynni)	56,882	18.2%	65,991	23.1%	45,002	20,989
CIC (heblaw am oedi wrth drosglwyddo gofal)	36,094	11.6%	44,447	15.6%	43,600	847
Gwasanaethau a Gomisiynwyd yn Allanol	32,726	10.5%	28,548	10.0%	25,971	2,578
Lleihau Costau Rheoli	9,078	2.9%	7,844	2.8%	7,009	835
Ystadau / Ynni	5,899	1.9%	4,460	1.6%	4,433	27
Gwasanaethau Arbenigol	6,808	2.2%	4,946	1.7%	4,929	16
Gwasanaethau a Rennir	1,584	0.5%	1,620	0.6%	1,585	35
Cyfanswm	311,792	100%	285,117	100%	247,468	37,648
					86.8%	13.2%

Ffynhonnell: Ffurflenni monitro mis 12

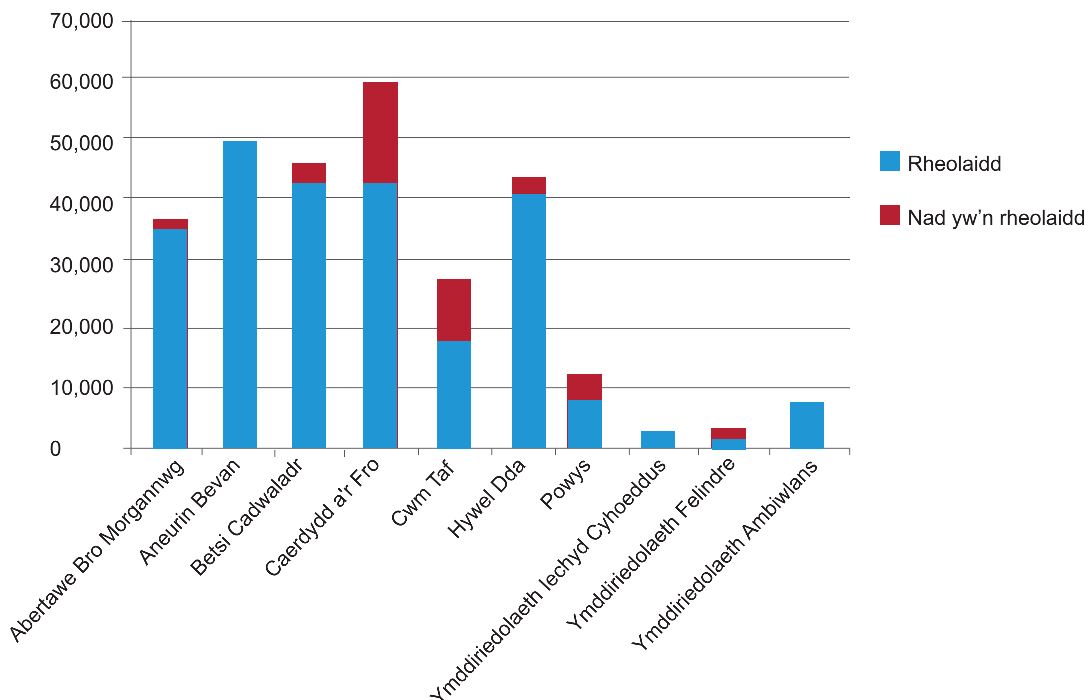
Mai 2011, a chytunodd i wneud y GIG yn fwy cynaliadwy; sefyllfa a gafodd ei datrys o'r blaen ar sail ad hoc bob blwyddyn gydag arian ychwanegol ar gael yn ddiweddarach yn y flwyddyn. Felly, cytunwyd i roi £133 miliwn ychwanegol (£93 miliwn o gronfeydd canolog wrth gefn, £40 miliwn o gyllideb yr Adran) i gyrff y GIG. Cytunodd y Cabinet y byddai £63 miliwn o'r arian ychwanegol yn rheolaidd ac yn cael ei gynnwys yng nghyllidebau'r Adran yn y blynyddoedd i ddod. Yn ogystal â'r arian hwn, cytunodd yr Adran i roi £12 miliwn o arian 'gwrthbwyso' i Fwrdd Iechyd Prifysgol Caerdydd a'r Fro. Cynrychiola hyn flaenswm o 2012-12 a 2013-14; dyrennir £6 miliwn yr un yn llai yn y blynyddoedd hynny. Darparwyd yr arian yn bennaf i sicrhau bod y Bwrdd Iechyd yn cyflawni ei dargedau ariannol ar gyfer 2011-12, ond hefyd i gefnogi Rhaglen Gwella Carlam (i ategu gwaith cyflawni llwyddiannus yn y tri phrif faes perfformiad: ansawdd, cyllid a mynediad).

Ffigur 12 - Gwneud arbedion drwy gydol y flwyddyn



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ffurflenni monitro mis 12

Ffigur 13 - Rhaniad rhwng arbedion rheolaidd ac arbedion eraill



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ffurflenni monitro mis 12

2.11 Mae darparu arian ychwanegol ar sail reolaidd ac yn gynharach yn y flwyddyn ariannol yn newid o gymharu â blynyddoedd blaenorol ac ymddengys ei fod yn adlewyrchu nod i fod yn fwy tryloyw o ran y ffordd y caiff y GIG ei ariannu. Wrth gyfleu ei phenderfyniad, roedd Llywodraeth Cymru yn ofalus i bwysleisio mai diben yr arian oedd mynd i'r afael â phroblemau ariannu hanesyddol unwaith ac am byth. Ar ôl iddi ddarparu'r arian hwn, tanlinellodd Llywodraeth Cymru ei bod yn disgwyl i fyrddau iechyd gyflawni eu targedau ariannol.

2.12 Fodd bynnag, daeth yn glir na fyddai tri bwrdd iechyd - Aneurin Bevan, Cwm Taf a Phowys - yn llwyddo i gyflawni eu targedau ariannol o hyd ac y byddai angen mwy o arian arnynt. Yn wahanol iawn i flynyddoedd blaenorol, darparodd yr Adran £12.4 miliwn arall ar ffurf arian gwrthbwyso hy, blaenswm ar flynyddoedd i ddod, er mwyn sicrhau bod y byrddau iechyd hyn yn cyflawni eu targedau ariannol. Bydd yr arian a gânt yn 2012-13 yn cael ei leihau'n briodol.

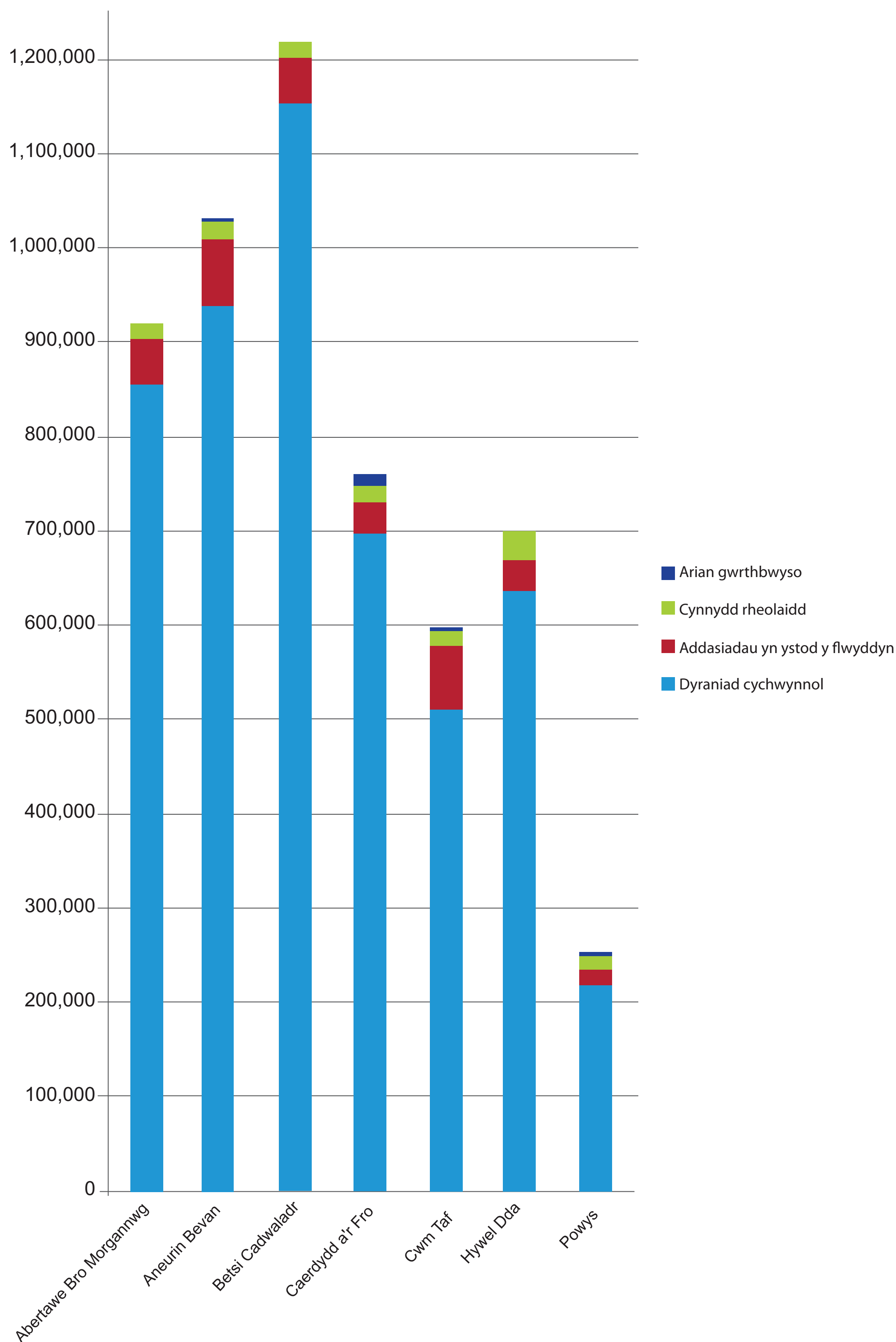
2.13 Dengys Ffigur 14 isod sut y rhannwyd yr arian hwn ar ffurf graff. Dim ond 0.4 y cant o gyllid cyffredinol y flwyddyn oedd yr arian gwrthbwyso ychwanegol a roddwyd i Fyrddau Iechyd Aneurin Bevan, Caerdydd a'r Fro, Cwm Taf a Phowys.

O gymharu pwysau cost, arbedion ac arian ychwanegol awgrymir nad oedd rhai o'r arbedion a nodwyd yn rhai a wnaeth ryddhau arian parod

2.14 Nid yw'r holl arbedion yn lleihad gwirioneddol mewn cost sy'n rhyddhau arian parod. Weithiau, mae arbedion yn creu capasiti ychwanegol a ailfuddsoddir mewn meysydd eraill, yn hytrach na'i fancio fel lleihad cost galed. Mae ein gwaith ni'n hunain dros y blynyddoedd yn archwilio arbedion effeithlonrwydd wedi dangos ei bod yn aml yn anodd iawn nodi'n glir a yw arbedion a nodwyd yn arbedion effeithlonrwydd neu'n doriadau, ac a ydynt yn arbedion sy'n rhyddhau arian parod neu'n enillion o ran cynhyrchiant.

2.15 Nid ydym wedi ceisio dilysu'r £285 miliwn o arbedion a nodwyd gan gyrff y GIG. Fodd bynnag, drwy gymharu'r bylchau ariannu amcangyfrifedig ar ddechrau'r flwyddyn (Paragraffau 2.3 i 2.4 a Ffigur 9) a'r arian ychwanegol a roddwyd yn ystod y flwyddyn, mae modd creu dangosydd bras o'r rhaniad posibl rhwng arbedion sy'n rhyddhau arian parod a'r mathau eraill o arbedion. Dengys Ffigur 15 fod yr arbedion sy'n rhyddhau arian parod a oedd yn ofynnol yn ystod y flwyddyn yn cyfrif am rhwng £309 miliwn a £413 miliwn o'r arbedion a nodwyd. Mae hefyd yn awgrymu, unwaith y caiff arbedion untro o £38 miliwn (gweler Ffigur 11) eu heithrio, i'r arbedion rheolaidd cynaliadwy fod rhwng £271 miliwn a £375 miliwn. Ceir diffyg sylfaenol o £125 miliwn y mae angen mynd i'r afael ag ef o hyd yn 2012-13.

Ffigur 14 - Dyraniad cyllid byrddau iechyd 2011-12 mewn £'000oedd



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ddata dyrannu'r GIG

2.16 O'r holl gategorïau o arbedion, ymddengys mai moderneiddio'r gweithlu sydd fwyaf tebygol o gynnwys arbedion nad ydyn t yn rhyddhau arian parod. Awgryma ein profiad o archwilio arbedion effeithlonrwydd yn y gorffennol fod meysydd fel caffael yn dueddol o fod yn gliriach o ran p'un a gafodd nwyddau a gwasanaethau eu prynu'n rhatach ai peidio. Yn aml, mae'n anos trosi arbedion o ran y gweithlu yn arbedion arian parod; mae'n anodd yn aml ryddhau arian parod o welliannau sy'n rhyddhau cyfran o amser staff. Yn hytrach, caiff yr amser hwnnw ei ailfuddsoddi mewn gweithgarwch arall yn aml. Mae monitro data ar gostau a lefelau'r gweithlu yn awgrymu bod arbedion yn y maes hwn wedi cael eu hailfuddsoddi mewn meysydd eraill. Gorwariodd pump o'r saith bwrdd iechyd ar gyflogau, rhai ohonynt gryn dipyn. Gyda'i gilydd, gwariodd byrddau iechyd £83 miliwn yn fwy ar gyflogau na'r hyn a gynlluniwyd ar ddechrau'r flwyddyn a chynyddodd cyfanswm bil cyflog y GIG ar gyfer gofal eilaidd £48.8 miliwn (2 y cant) o 2010-11 i 2011-12. Cynyddodd nifer y staff a gyflogir yn y GIG, o 78,041 cyfwerth ag amser cyflawn yn 2010-11 i 78,602 yn 2011-12, yn hytrach na lleihau fel y gellir ei ddisgwyl yn sgil yr arbedion a nodwyd. Nid yw mwy o staff o reidrwydd yn arwydd o gostau uwch, gall fod yn rhatach penodi staff newydd a lleihau'r defnydd o staff asiantaeth drud. Bu rhywfaint o gynnydd cyffredinol o ran lleihau'r ddibyniaeth ar staff asiantaeth, gydag amrywiadau rhwng cyrff y GIG, ond dim ond un bwrdd iechyd (Powys) sydd wedi cyflawni'r targed i gadw gwariant asiantaeth i 0.8 y cant o'r bil cyflog drwy gydol y flwyddyn. Llwyddodd dwy o'r tair o ymddiriedolaethau'r GIG i gyflawni'r targed hefyd.

Ffigur 15 - Dadansoddiad dynodol o arbedion sy'n rhyddhau arian parod yn seiliedig ar amcangyfrifon pwysau cost

	Amcangyfrifon y Fframwaith Pum Mlynedd	Amcangyfrifon y Cytundeb Cyllid Cenedlaethol
Bwlch ariannu amcangyfrifedig ar ddechrau'r flwyddyn ariannol	£279 miliwn	£383 miliwn
Yn ogystal â'r diffyg sylfaenol a ddygwyd ymlaen	£187 miliwn	£187 miliwn
Cyfanswm y bwlch ariannol	**£466 miliwn**	**£570 miliwn**
Llai arian ychwanegol a ddarparwyd gan gynnwys arian gwrthbwyso	£157 miliwn	£157 miliwn
Arbedion rhyddhau arian parod gofynnol	**£309 miliwn**	**£413 miliwn**
Arbedion rheolaidd dynodol sy'n rhyddhau arian parod (rhyddhau arian parod llai arbedion eraill yn Ffigur 11)	£271 miliwn	£375

Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ddata dyrannu a ffurflenni monitro'r GIG

Mae Llywodraeth Cymru wedi newid ei dull gweithredu i ddarparu £63 miliwn o'r arian ychwanegol hwn ar sail reolaidd a defnyddio arian gwrthbwyso i atgyfnerthu neges fwy llym i gyrff y GIG

2.17 Rhaid i holl gyrff y GIG gyflwyno adroddiadau monitro misol manwl erbyn degfed diwrnod gwaith y mis canlynol. Mae'r adroddiadau yn gofyn am wybodaeth fanwl am y sefyllfa ariannol hyd yn hyn a rhagolygon tan ddiwedd y flwyddyn ar gyfer nifer o feysydd gan gynnwys tanwario neu orwario yn erbyn arian a ddyrannwyd a chynlluniau arbed.

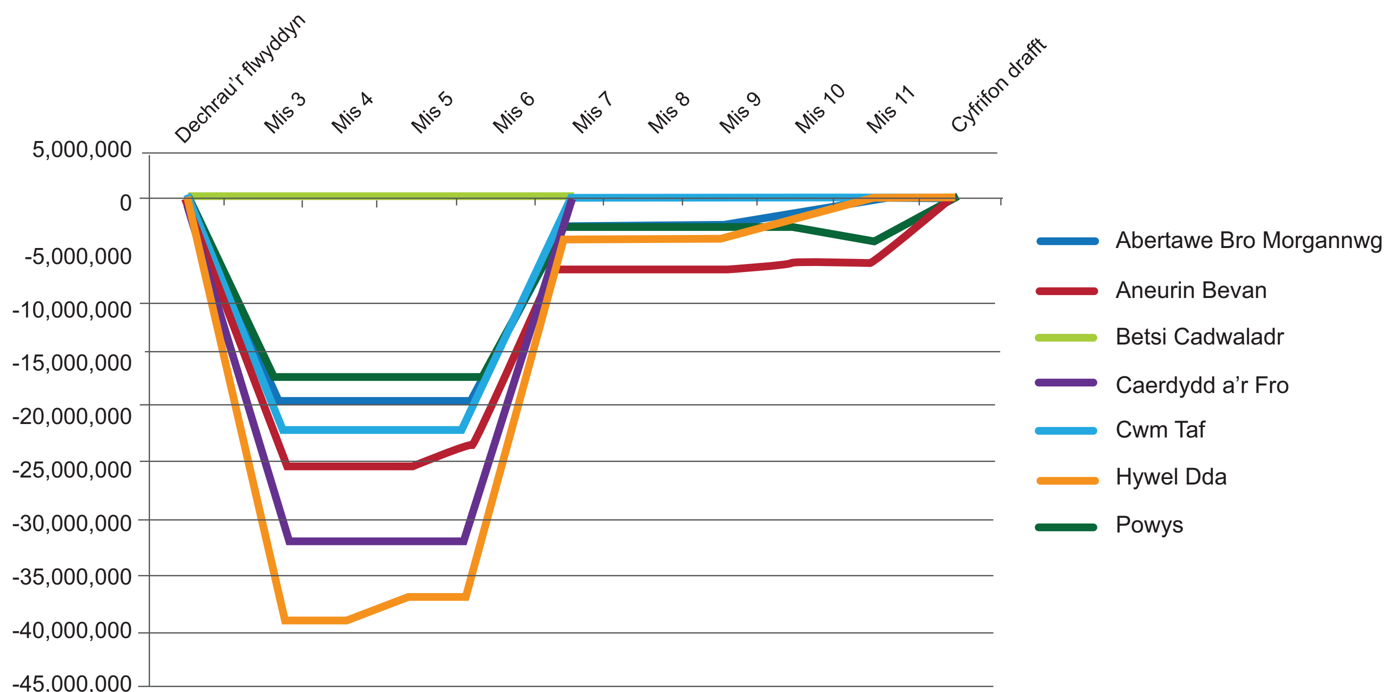
2.18 Mae'r rhagolygon a ddangosir yn Ffigur 16, a nodwyd drwy gydol y flwyddyn gan fyrddau iechyd, yn gyson â'r dyraniad ariannol a nodir yn yr adran uchod. Yn ôl y byrddau iechyd, cafwyd cyfanswm gorwario wedi'i ragamcanu o £155 miliwn ym mis 3 heb braidd dim newid i'r amcangyfrif hwn tan fis 7, pan gafwyd y swm ychwanegol o £133 miliwn a £12 miliwn mewn arian gwrthbwyso, gan leihau'r alldro rhagamcanol i £16 miliwn. Yn dilyn rhagor o arian gwrthbwyso ym mis 12 sef £12.4 miliwn, llwyddodd yr holl fyrddau iechyd i fantoli'r gyllideb yn eu datganiadau ariannol drafft.

2.19 Defnyddiodd Llywodraeth Cymru ragamcanion gwell y ffurflenni monitro i'w helpu i nodi problemau ariannol yn gynharach. Ym mis 6, aseswyd y sefyllfa ariannol a chadarnhawyd y byddai byrddau iechyd yn cael £133 miliwn yn ychwanegol ac y byddai Bwrdd Iechyd Prifysgol Caerdydd a'r Fro yn cael £12 miliwn mewn arian gwrthbwyso ym mis Hydref 2011. Cafodd pob bwrdd iechyd £17 miliwn heblaw am Fyrddau Iechyd Hywel Dda a Phowys a gafodd £33 miliwn a £15 miliwn yn y drefn honno. Cafodd y dyfarniad ei wneud gan ystyried meintiau cymharol byrddau iechyd a graddau'r risg ariannol a oedd yn cael ei rheoli, gyda chymorth penodol yn cael ei roi i Hywel Dda yn unol â'i becyn pedair blynedd o gymorth ariannol meinhaol.

2.20 Hefyd, drwy ddarparu arian 'gwrthbwyso', yn hytrach na rhoi arian ychwanegol, cadwodd Llywodraeth Cymru at ei nod o beidio â rhoi rhagor o arian mewn ffordd na welwyd mewn blynyddoedd blaenorol. Mae'r defnydd o arian gwrthbwyso, sydd, i bob diben, yn galluogi byrddau iechyd i fantoli'r gyllideb dros sawl blwyddyn, yn mynd i'r afael yn rhannol â'r her a berir gan reolau cyfrifyddu sy'n ei gwneud yn ofynnol i fantoli'r gyllideb bob blwyddyn.

2.21 Mae Llywodraeth Cymru wrthi'n adolygu cynlluniau ariannol y pedwar bwrdd iechyd yr oedd angen arian gwrthbwyso arnynt ar ddiwedd y flwyddyn. Mae hefyd yn gwneud gwaith ym Myrddau Iechyd Betsi Cadwaladr a Hywel Dda. Bwriad Llywodraeth Cymru yw sicrhau y bydd yr adolygiadau hyn yn helpu byrddau iechyd i atgyfnerthu eu gwaith cynllunio a rheoli ariannol. Mae hefyd yn bwriadu sicrhau y bydd yr adolygiadau yn pwysleisio atebolrwydd byrddau iechyd am reoli eu cyllid.

Ffigur 16 - Alldro rhagamcanol byrddau iechyd yn ystod 2011-12



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o ffurflenni monitro 2011-12

2.22 Yn ystod y flwyddyn, cafwyd rhai anawsterau gyda gwybodaeth fonitro Llywodraeth Cymru. Gwnaeth sawl bwrdd iechyd gynnwys arbedion mawr o brosiectau canolog ym mis olaf y flwyddyn ariannol. O ganlyniad, roedd y ffurflenni monitro ar gyfer y flwyddyn gyfan yn dangos bod gan gyrff y GIG fwy o ddiffyg na'r hyn a ddigwyddodd mewn gwirionedd. Lle y bo modd, dylai'r arbedion hyn gael eu proffilio dros y flwyddyn er mwyn hwyluso gwaith monitro a chynllunio. Hefyd, efallai nad yw pob bwrdd iechyd yn gweithredu yn yr un modd, gyda rhai yn bod yn fwy gofalus ac eraill yn cynnwys rhagolygon mwy optimistaidd. Er enghraifft, roedd Bwrdd Iechyd Betsi Cadwaladr yn darogan y byddai'n mantoli'r gyllideb ym mhob mis o'r flwyddyn, er bod ganddo ddiffyg yn ystod y flwyddyn a'i fod wedi cael £17 miliwn arall ym mis Hydref. Roedd Bwrdd Iechyd Cwm Taf yn darogan y byddai'n mantoli'r gyllideb ym mis 11, ond roedd angen iddo gael arian gwrthbwyso ar ddiwedd y flwyddyn.

Rhan 3 – Mae arwyddion calonogol o ddiwygiadau hirdymor i fynd i'r afael â heriau ariannol yn y dyfodol nas gwelwyd erioed o'r blaen ond mae bylchau ariannu byrdymor yn achos pryder o hyd

3.1 Mae'r rhan hon o'r adroddiad yn ystyried y pwysau ariannol sy'n wynebu'r GIG yn ystod y cyfnod tan ddiwedd yr Adolygiad o Wariant (2014-15). Yn arbennig, mae'n edrych ar y pwysau byrdymor sydd ar y GIG i fantoli'r gyllideb yn y flwyddyn ariannol hon (2012-13). Mae hefyd yn nodi'r sefyllfa ariannol tan 2014-15, yn seiliedig ar gyllideb Llywodraeth Cymru, ynghyd â'r heriau tymor hwy sy'n wynebu'r GIG wrth iddo ddechrau ar gyfnod o ddiwygiadau mawr i'r ffordd y darperir gwasanaethau.

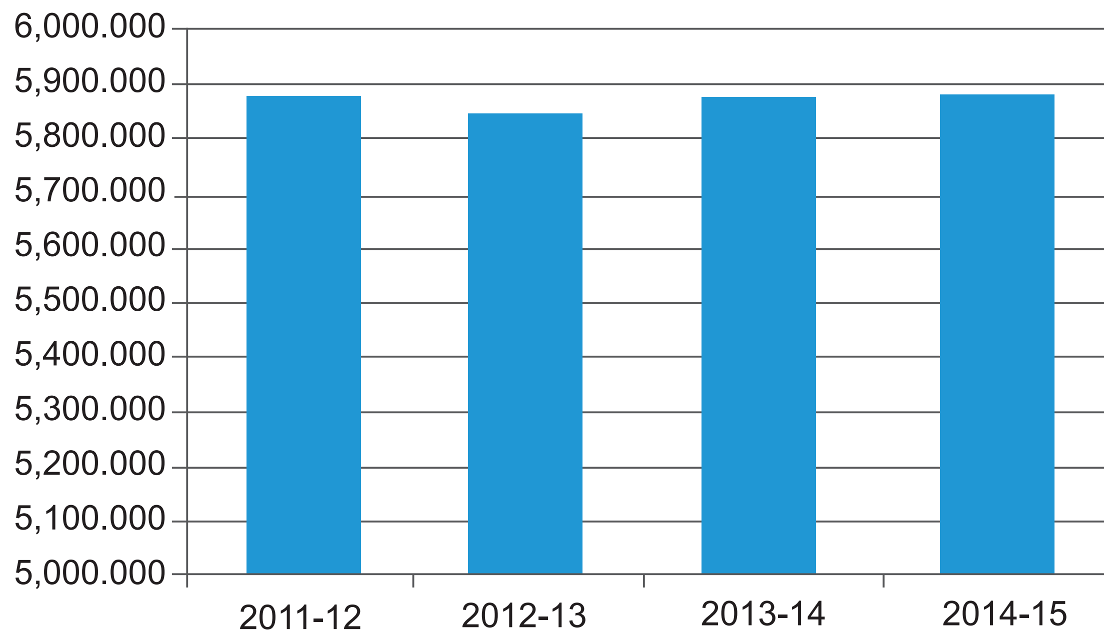
Mae'r GIG yn wynebu toriadau termau real tan 2014-15 gyda bwlch ariannu sylweddol sy'n tyfu

Mae'r GIG yn wynebu heriau ariannol nas gwelwyd o'r blaen gyda thoriadau termau real i gyllidebau iechyd bob blwyddyn tan 2014-15

3.2 Dengys Ffigur 17 y newidiadau i'r gyllideb refeniw iechyd mewn termau arian parod rhwng 2011-12 a 2014-15. Mae'r ffigurau hyn yn cynnwys arian rheolaidd ychwanegol a ddyrannwyd gan Lywodraeth Cymru yng Nghyllideb Derfynol Rhagfyr 2011. Cytunodd Llywodraeth Cymru ar arian rheolaidd ychwanegol ar gyfer y gyllideb refeniw iechyd ym mis Rhagfyr 2011. Drwy gytuno ar yr arian hwn, derbyniodd Llywodraeth Cymru y dylai'r GIG fod yn fwy cynaliadwy ac y dylai dyraniadau cyllidebol atodol nad oeddent yn rheolaidd gynt gael eu gwneud yn rheolaidd. Serch hynny, ar ôl cyfrif am chwyddiant, mae gostyngiad termau real bob blwyddyn yn y gyllideb refeniw iechyd (Ffigur 18). Erbyn 2014-15, mae'r gyllideb refeniw yn debygol o fod tua 10 y cant yn is mewn termau real na 2010-11. Fel y nodwyd gennym yn *Darlun o Wasanaethau Cyhoeddus 2011*, mae'r GIG yng Nghymru yn wynebu'r setliad ariannol llymaf yn ystod y cyfnod hwn o blith unrhyw un o wledydd y DU[8].

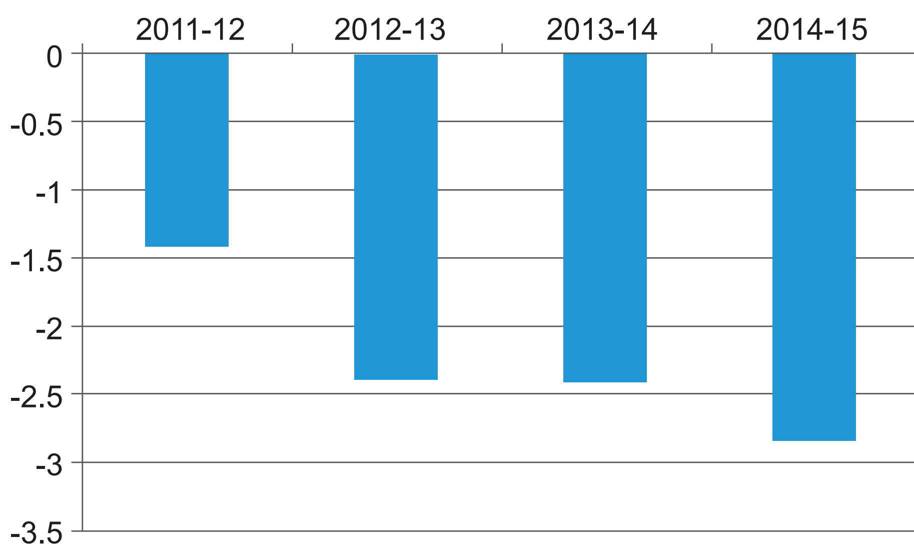
8 Mae Ffigur 18 yn wahanol i'r ffigurau a ddefnyddiwyd yn *Darlun o Wasanaethau Cyhoeddus 2011*. Er mwyn sicrhau cysondeb yn yr adroddiad hwn, cynhwysir yr holl arian refeniw iechyd yng nghyllideb Llywodraeth Cymru. Yn *Darlun o Wasanaethau Cyhoeddus*, dim ond y llinell 'Cyflenwi'r GIG' yn y gyllideb a ddefnyddiwyd. Hefyd, mae Ffigur 18 yn ystyried effaith cyllidebau atodol ac rydym wedi defnyddio set fwy diweddar o ddatchwyddwyr CMC i gyfrifo effaith chwyddiant wrth bennu'r cyllidebau termau real.

Ffigur 17 - Cyllidebau refeniw iechyd (£)



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau Llywodraeth Cymru
Noder: Mae'r ffigur ar gyfer 2011-12 yn seiliedig ar Gyllideb Derfynol 2011-12, a gyhoeddwyd ym mis Chwefror 2011, yn ogystal ag arian ychwanegol a nodir mewn cyllidebau atodol. Mae'r ffigurau ar gyfer 2012-13 i 2014-15 yn seiliedig ar y ffigurau yng Nghyllideb Derfynol 2012-13 a gyhoeddwyd ym mis Rhagfyr 2011.

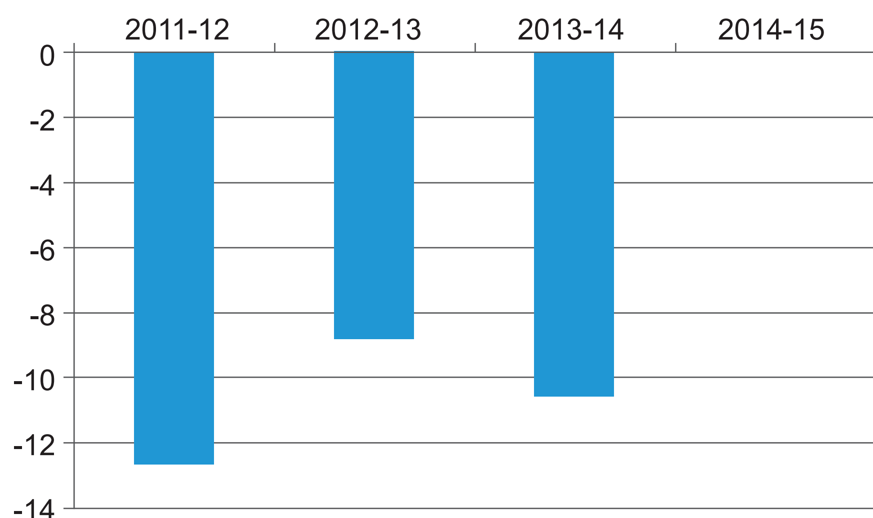
Ffigur 18 - Gostyngiad mewn termau real bob blwyddyn i gyllidebau refeniw iechyd (%)



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau Llywodraeth Cymru
Noder: Mae'r ffigur ar gyfer 2011-12 yn seiliedig ar Gyllideb Derfynol 2011-12, a gyhoeddwyd ym mis Chwefror 2011, yn ogystal ag arian ychwanegol a nodir mewn cyllidebau atodol. Mae'r ffigurau ar gyfer 2012-13 i 2014-15 yn seiliedig ar Gyllideb Derfynol 2012-13 a gyhoeddwyd ym mis Rhagfyr 2011.

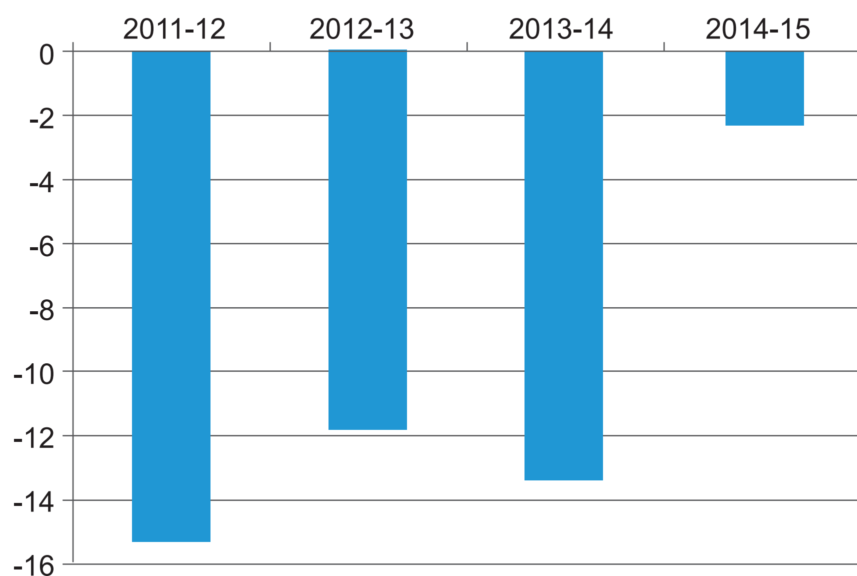
3.3 Fel rhannau eraill o'r gwasanaeth cyhoeddus, gwariant cyfalaf sy'n gweld y toriadau mwyaf. Cyfalaf yw'r arian y mae cyrff y GIG yn ei ddefnyddio i greu neu ddatblygu seilwaith, megis ysbytai, meddygfeydd ac asedau eraill. Dengys cyllideb Llywodraeth Cymru fod y cyllidebau cyfalaf ar gyfer iechyd, mewn termau real, yn lleihau bob blwyddyn heblaw am 2014-15 (Ffigur 19). Mewn termau real, gwelir gostyngiad bob blwyddyn (Ffigur 20) a bydd y gyllideb gyfalaf ar gyfer iechyd oddeutu £1.1 biliwn (36 y cant) yn is yn 2014-15 na 2010-11.

Ffigur 19 - Gostyngiad mewn termau arian parod i'r gyllideb gyfalaf ar gyfer iechyd o flwyddyn i flwyddyn (%)



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau Llywodraeth Cymru

Ffigur 20 - Gostyngiad mewn termau real i'r gyllideb gyfalaf ar gyfer iechyd o flwyddyn i flwyddyn (%)



Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru o gyllidebau Llywodraeth Cymru

Mae bwlch mawr rhwng yr arian sydd ei angen i fodloni'r galw disgwyliedig a phwysau cost a chyllidebau gwirioneddol

3.4 Mae'r Fframwaith Pum Mlynedd yn nodi'r galw amcangyfrifedig a'r pwysau o ran chwyddiant sy'n wynebu'r GIG tan 2014-15. Mae'r Fframwaith Pum Mlynedd yn nodi sefyllfaoedd 'cost isel' a 'chost uchel'. Ers i'r rhagolygon gael eu cynhyrchu, diwygiwyd rhagolygon chwyddiant am i fyny gryn dipyn. Felly, mae'r sefyllfa 'cost uchel' yn debygol o adlewyrchu'n well y pwysau cost gwirioneddol ar y GIG, ond gall hyd yn oed y sefyllfa cost uchel danddatgan y bwlch ariannu gwirioneddol. Mae Ffigur 21 yn diweddaru'r sefyllfa a nodwyd yn ein hadroddiad, *Darlun o Wasanaethau Cyhoeddus 2011*, i gynnwys y ffigurau o gyllideb 2012-13 derfynol Llywodraeth Cymru ac ystyried arian ychwanegol o gronfeydd wrth gefn yn 2010-11 a 2011-12. Gan ddefnyddio 2010-11 fel llinell sylfaen, amcangyfrifwn fod y GIG yn wynebu bwlch ariannu a fydd oddeutu £873 miliwn erbyn 2014-15.

Ffigur 21 - Bwlch ariannu yn seiliedig ar Fframwaith Pum Mlynedd y GIG a llinell 'Cyflenwi'r GIG' o gyllideb Llywodraeth Cymru

Refeniw (miliynau)	2010-11	2011-12	2012-13	2013-14	2014-15
Cyllideb Cyflenwi'r GIG	5,467	5,500	5,492	5,507	5,497
Pwysau cost mewn sefyllfa cost isel	3.7	2.6	2.6	2.6	2.6
Pwysau cost mewn sefyllfa cost uchel	4.4	3.3	3.8	4.1	4.4
Arian sydd ei angen mewn sefyllfa cost isel	*	5,609	5,755	5,905	6,058
Arian sydd ei angen mewn sefyllfa cost uchel		5,647	5,862	6,102	6,371
Bwlch ariannu cronnol mewn sefyllfa cost isel	*	-109	-263	-398	-561
Bwlch ariannu cronnol mewn sefyllfa cost uchel	*	-147	-370	-595	-873
Bwlch ariannu o flwyddyn i flwyddyn mewn sefyllfa cost isel		-109	-154	-135	-163
Bwlch ariannu o flwyddyn i flwyddyn mewn sefyllfa cost uchel		-147	-223	-225	-278

Ffynhonnell: Dadansoddiad Swyddfa Archwilio Cymru yn seiliedig ar ragolygon a ffigurau Fframwaith Pum Mlynedd y GIG o gyllidebau terfynol a chyllidebau atodol Llywodraeth Cymru. Roedd ffigur cyllideb Cyflenwi'r GIG a gyhoeddwyd ar gyfer 2010-11 yn £5.506 miliwn ond fe'i haddaswyd i £5,467 miliwn ar gyfer eitemau nad ydynt yn rhai arian parod. Mae'r ffigurau ar gyfer 2011-12 yn cynnwys yr arian ychwanegol a ddyrannwyd yng nghyllidebau atodol mis Mehefin 2011 a mis Chwefror 2012, a wnaeth helpu i leihau'r bwlch yn ystod y flwyddyn.

3.5 Tra bod y Fframwaith Pum Mlynedd wedi nodi rhagolygon cost a ategir gan ddadansoddiad manwl, yn ddiweddar mae Llywodraeth Cymru wedi bod yn nodi'r pwysau cost ar y GIG gan ddefnyddio set wahanol o ffigurau. Yn ei naratif i'r gyllideb ddrafft, amcangyfrifodd Llywodraeth Cymru bwysau cost dynodol o 4 neu 5 y cant y flwyddyn; gyda'r arbedion angenrheidiol oddeutu £250 miliwn y flwyddyn. Awgryma'r ffigurau hyn fod y GIG yn wynebu her fwy na'r hyn a amlinellwyd yn ein hadroddiad *Darlun o Wasanaethau Cyhoeddus 2011*. Yn arbennig, os yw'r pwysau ariannol ar y GIG yn 2011-12 oddeutu £250 miliwn y flwyddyn, fel y nodwyd yn y Cytundeb Cyllid Cenedlaethol a'r naratif cyllidebol, bydd angen iddo leihau costau tua £1 biliwn rhwng 2010-11 a 2014-15.

Mae'r GIG yn wynebu her fawr i ymdopi o fewn y gyllideb yn y byrdymor

3.6 Mae'r bwlch ariannu o bosibl yn fwy na'r hyn a awgrymir gan y naill amcangyfrif a'r llall. Mae'r ffigurau hynny yn seiliedig ar gyrff y GIG yn dechrau gyda llechen lân. Fodd bynnag, mae pedwar bwrdd iechyd yn dechrau'r flwyddyn mewn sefyllfa lle mae angen iddynt ddod o hyd i tua £24.4 miliwn yn lle'r arian a 'wrthbwyswyd' i 2011-12 o flynyddoedd dilynol. At hynny, mae'r amcangyfrifon yn tybio y bydd cyrff y GIG bob blwyddyn yn gallu cynnal eu holl arbedion o'r flwyddyn flaenorol. Fel y dangosodd Rhan 2, yn 2011-12, bu'n rhaid i gyrff y GIG gynyddu lefel yr arbedion nad ydynt yn rheolaidd ar ddiwedd y flwyddyn. I lenwi'r bwlch a adawyd gan yr arbedion nad ydynt yn rheolaidd, bydd angen i gyrff y GIG arbed £38 miliwn arall.

3.7 Mae'n debygol y bydd y GIG yn ei chael yn fwyfwy anodd i barhau i wneud arbedion mawr mewn meysydd trafodol, megis caffael. Yn dilyn dwy flynedd o bwysau ariannol, mae'n debygol bod llawer o'r arbedion hawdd eu gwneud wedi cael eu gwneud eisoes. Mae'r ffaith bod angen i gyrff y GIG wneud mwy o arbedion nad ydynt yn rheolaidd ar ddiwedd 2011-12 yn arwydd eu bod yn ei chael hi'n anodd i wneud arbedion rheolaidd cynaliadwy yn y byrdymor. Felly, bydd angen i gyrff y GIG ystyried gwneud newidiadau mwy sylfaenol a thrawsnewidiol i wasanaethau er mwyn cyflawni'r arbedion angenrheidiol.

Ceir arwyddion cadarnhaol bod y GIG yn barod i wneud y dewisiadau anodd sydd eu hangen er mwyn cyflawni newid yn yr hirdymor ond ymddengys fod y nod i wella ansawdd a chynnal lefelau gwasanaethau a swyddi yn heriol

Mae'r uchelgais a nodir yn y Fframwaith Pum Mlynedd i gyflawni'r arbedion angenrheidiol tra'n gwella ansawdd a chynnal lefelau gwasanaethau a swyddi yn edrych yn fwyfwy optimistaidd

3.8 Mae Llywodraeth Cymru yn pwyso ar fyrddau iechyd ac ymddiriedolaethau i gyflawni eu cynlluniau arbed. Mae'r Fframwaith Pum Mlynedd yn nodi uchelgais i'r GIG gyflawni'r arbedion angenrheidiol ar yr un pryd â gwella ansawdd a chynnal lefelau gwasanaethau a swyddi. Yn ymarferol, nid yw'r nod hwnnw yn rhoi fawr ddim cwmpas i'r GIG weithredu i leihau costau.

3.9 Mae'r Fframwaith Pum Mlynedd yn gadarn o ran nodi bod yn rhaid rhoi blaenoriaeth i ansawdd er gwaetha'r pwysau ariannol. Nid yw'n dderbyniol darparu gwasanaethau o ansawdd is, sydd â chanlyniadau gwaeth neu fwy o ddigwyddiadau andwyol a heintiau. Mae hefyd yn hunan-andwyol gan fod ansawdd is o bosibl yn arwain at fwy o alw i unioni'r

camgymeriadau yn ogystal â hawliadau esgeulustod clinigol efallai. Fodd bynnag, mae angen gwrthbwyso cyflymdra a graddau'r gwelliant o ran ansawdd â'r buddsoddiad sydd ei angen i gyflawni'r gwelliant hwnnw. Mae felly yn gadarnhaol, yn ystod 2011-12, er gwaethaf y pwysau ariannol, i'r GIG wneud gwelliannau mewn amryw feysydd ansawdd, gan gynnwys lleihau nifer yr heintiau a geir mewn ysbytai.

3.10 Ar y cyfan, ymddengys fod cyrff y GIG wedi cynnal lefelau gwasanaeth, a fesurir yn ôl faint o amser y mae pobl yn aros am driniaeth ddewisol. Mae cyfran y cleifion sy'n aros mwy na 26 wythnos am driniaeth wedi aros yn weddol gyson dros y flwyddyn ddiwethaf sef 6 y cant (yn erbyn targed o 5 y cant) ac mae nifer y cleifion sy'n aros mwy na 36 wythnos wedi lleihau o 5,077 yn 2010-11 i 1,614 yn 2011-12. Hefyd, llwyddodd cyrff y GIG i gynnal perfformiad o ran faint o amser y mae pobl yn aros am driniaeth mewn adrannau damweiniau ac achosion brys gydag 89 y cant o gleifion yn aros llai na phedair awr yn 2011-12 o gymharu ag 88 y cant yn 2010-11.

3.11 Yn ystod 2011-12, cynyddodd nifer y staff cyfwerth ag amser cyflawn a oedd yn gweithio yn y GIG, ond nid yw'r fath sefyllfa yn debygol o barhau. Gyda chyflog yn cyfrif am gryn dipyn o wariant y GIG, costau staff yw'r maes mwyaf o gost i'r GIG ac yn y maes hwn mae'r gorwario mwyaf hefyd. Er gwaethaf rhewi cyflogau ac arbedion staffio a nodwyd drwy foderneiddio'r gweithlu, mae costau staffio net wedi cynyddu'n sylweddol uwch na'r cynllun. Mae'n anodd gweld sut y gall y GIG fodoli o fewn ei adnoddau a chyflawni'r uchelgais o gynnal lefelau swyddi mewn blynyddoedd i ddod. Wedi dweud hynny, nid yw lleihau costau staff o reidrwydd yn golygu diswyddo pobl. Ond gall olygu ystyried lleihau rhai oriau staff, gwneud mwy o ddefnydd o oriau hyblyg ac ailgynllunio gwaith fel bod modd i lai o bobl ei reoli neu fod staff ar raddau is yn gwneud hynny.

3.12 Wrth i'r GIG fynd i'r afael â'r her o leihau ei gostau staffio, bydd angen iddo wneud hynny mewn ffordd bendant er mwyn rheoli risgiau i lefelau ac ansawdd gwasanaethau. Y risg, heb ddull gweithredu strategol, yw bod byrddau iechyd ac ymddiriedolaethau yn mynd ati ar sail ad hoc, drwy rewi ymgyrchoedd recriwtio a rheoli swyddi gwag, gan anelu'n bennaf at wneud arbedion byrdymor yn hytrach nag edrych ar y system gyfan wrth reoli'r effaith ar gleifion. Yn wir, gall y fath gamau hyd yn oed gostio mwy lle maent yn arwain at sefyllfa lle mae cyrff y GIG yn gorfod recriwtio staff locwm ac asiantaeth drutach er mwyn llenwi'r bylchau. Yn ddiweddar, mae Llywodraeth Cymru wedi lansio fframwaith newydd ar gyfer y gweithle, sef *Gweithio'n Wahanol - Gweithio Law yn Llaw*, a ategir gan waith cynllunio'r gweithlu lleol. Mae'r fframwaith hwnnw'n cydnabod yr angen i weithredu ar sail system gyfan. Yn arwyddocaol, nid yw'n ailadrodd uchelgais y Fframwaith Pum Mlynedd i gynnal lefelau swyddi. Mae'n pennu nod penodol i leihau costau rheoli a hefyd yn nodi'r her o sicrhau bod costau'r gweithlu yn fforddiadwy.

3.13 Mae cyrff y GIG wrthi'n llunio cynlluniau gwasanaeth a chyllid tair blynedd i sicrhau y gellir ateb yr her ariannol a nodwyd. Bydd yn bwysig sicrhau bod y cynlluniau hyn yn gadarn ac y gellir eu cyflawni. Yn arbennig, bydd angen i'r cynlluniau gysylltu'r cynlluniau cyflenwi cyllid a gwasanaeth â chynlluniau gweithlu cadarn er mwyn rheoli'r risgiau y gall newidiadau yn y gweithlu eu cael ar lefelau ansawdd a gwasanaethau.

Mae'r GIG wedi ei chael yn anodd trawsnewid gwasanaethau yn ôl y gofyn yn y gorffennol ond mae arwyddion ei fod bellach yn barod i wneud y dewisiadau anodd sydd eu hangen er mwyn sicrhau bod y GIG yn gynaliadwy yn ariannol ac er mwyn gwella ansawdd gwasanaethau

3.14 Yr ateb cynaliadwy i'r heriau ariannol sy'n wynebu'r GIG yw trawsnewid y ffordd y caiff gwasanaethau'r GIG eu darparu. Fel mae'r adroddiad hwn wedi'i ddangos, mae peth amheuaeth ynghylch a yw'r cynlluniau arbedion lleol yn cyflawni'r arbedion sydd eu hangen i dywys y GIG drwy gyfnod o gyfyngiadau o ran arian cyhoeddus nas gwelwyd o'r blaen. Mae'r potensial mawr i ryddhau arbedion a hefyd, yn fwyaf pwysig, wella gofal, i'w weld mewn ad-drefnu patrwm a dulliau darparu gwasanaethau iechyd.

3.15 Yn ein hadroddiad, *Darlun o Wasanaethau Cyhoeddus 2011*, edrychwn ar hanes y GIG o ddiwygio gwasanaethau a'r anawsterau mae wedi'u hwynebu yn y gorffennol. Ers i ni gyhoeddi ein hadroddiad, bu sawl datblygiad sylweddol. Yn arbennig, cyhoeddodd Llywodraeth Cymru *Law yn Llaw at Iechyd: Gweledigaeth 5 Mlynedd ar gyfer y Gwasanaeth Iechyd Gwladol yng Nghymru* ym mis Tachwedd 2011. Mae'r weledigaeth yn ailategu rhai o brif elfennau diwygiadau a nodwyd yn flaenorol yng ngweledigaethau Llywodraeth Cymru ar gyfer y GIG, gan gynnwys:

- ffocws ar gadw pobl allan o'r ysbyty drwy waith ataliol ym maes iechyd;
- trin cleifion yn y gymuned ac yn eu cartrefi eu hunain;
- datblygu canolfannau rhagoriaeth ar gyfer gofal arbenigol fel bod arbenigedd ar gael yn yr un lle; ac
- integreiddio gwasanaethau iechyd a gofal cymdeithasol.

3.16 Y gwahaniaeth allweddol rhwng yr ymgyrch ddiwygio bresennol ac ymdrechion blaenorol yw'r gydnabyddiaeth gynyddol nad yw'r sefyllfa sydd ohoni yn fforddiadwy. Mae *Law yn Llaw* at Iechyd yn nodi'n glir bod angen 'mynd ati'n ddiflino i geisio cyflawni gwerth am arian'. Fel rhan o'r broses o gyflawni hyn, bydd Llywodraeth Cymru yn llunio fframwaith ariannol newydd i gefnogi gwaith cynllunio ariannol. Mae Llywodraeth Cymru wedi ymrwymo i adolygu'r gyfundrefn ariannol, ac mae'n bwriadu sicrhau y bydd yn eang ac yn arwain at wella system ariannol gyfan y GIG. Hefyd, bydd holl gyrff y GIG yn creu system gyllidebu lle mae'r ochr glinigol yn chwarae mwy o ran yn y broses o wneud penderfyniadau ariannol. Mae system o'r fath yn welliant. Mae penderfyniadau a gweithredoedd clinigol yn llywio llawer o'r costau yn y GIG. Felly, drwy gynnwys clinigwyr mewn penderfyniadau ariannol ac annog mwy o berchenogaeth o'r heriau ariannol dylai helpu i ddatblygu diwygiadau cynaliadwy.

3.17 Wrth symud ymlaen, mae'r GIG hefyd yn wynebu her o ran dod o hyd i'r arian i'w helpu i ad-drefnu gwasanaethau. Gyda thoriadau termau real o 36 y cant mewn arian cyfalaf yn y cyfnod gwario presennol, bydd angen i'r GIG ddod o hyd i ffyrdd o ddefnyddio'r asedau sydd ganddo eisoes mewn ffyrdd newydd er mwyn adlewyrchu patrymau newydd o ddarparu gwasanaethau. Bydd hefyd angen iddo ystyried dulliau amgen o ariannu cyfleusterau newydd sydd eu hangen i gyflwyno'r gwasanaethau ar eu newydd wedd. Ers 2007, bu gan Lywodraeth Cymru foratoriwm ar ddefnyddio'r Fenter Cyllid Preifat yn y GIG, felly nid yw hynny'n opsiwn i ariannu cyfleusterau newydd. Fodd bynnag, rhydd Cynllun Buddsoddi Seilwaith Cymru a gyhoeddwyd yn ddiweddar fframwaith ar gyfer penderfyniadau buddsoddi cyfalaf yn y dyfodol a bydd angen i'r Adran sicrhau bod unrhyw gynigion ariannu newydd yn gyson â'r blaenoriaethau a nodir yn y cynllun.

3.18 Mae'r GIG yn wynebu heriau penodol oherwydd, yn wahanol i lywodraeth leol, ni all cyrff y GIG fenthyg arian i ariannu datblygiadau cyfalaf ac ad-dalu'r arian hwnnw o refeniw. Beth bynnag, mae'r pwysau ar refeniw yn golygu y byddai cyrff y GIG yn ei chael yn anodd dod o hyd i'r arian refeniw i ad-dalu'r arian a gafodd ei fenthyg, er y gallent o bosibl ddefnyddio arbedion a wnaed gan y ffyrdd newydd o weithio. Mae rhywfaint o arian ar gael drwy raglen Buddsoddi i Arbed Llywodraeth Cymru, ond mae'n gymharol fach o gymharu â maint yr heriau. Yn 2010-11, roedd Buddsoddi i Arbed y GIG tua £7.5 miliwn, gyda £3 miliwn yn ymwneud â chynllun gadael yn gynnar gwirfoddol, ac yn ddiweddar cyhoeddodd y Gweinidog Cyllid £6.6 miliwn ar gyfer 2011-12.

3.19 Wynebir hefyd her refeniw o ran ariannu'r ffyrdd newydd o ddarparu gwasanaethau. Ar rai adegau yn y gorffennol, gwnaed newidiadau drwy gyflwyno gwasanaeth newydd i redeg ochr yn ochr â'r gwasanaeth presennol. Yn y dyfodol, efallai y bydd y wasgfa ar arian refeniw yn golygu nad yw'r opsiwn hwn yn ymarferol a bydd angen i gyrff y GIG baratoi i reoli'r risgiau sy'n gysylltiedig â rhoi'r gorau i wasanaeth presennol a newid i ffordd newydd o weithio. Bydd yn hanfodol cynnwys clinigwyr a sicrhau eu bod yn chwarae rhan arweiniol yn y gwaith o gyflawni'r fath newidiadau anodd a helpu cleifion i ddeall y dulliau gweithredu newydd ac addasu iddynt.

3.20 Bydd sefydliadau'r GIG yn camu ymlaen gyda chynlluniau ar gyfer diwygio'r ffordd y caiff gwasanaethau eu sefydlu a'u darparu. Mae Llywodraeth Cymru wedi sefydlu fforwm clinigol cenedlaethol i adolygu'r cynlluniau. Unwaith y cytunir arnynt, y brif her yw cyflawni'r newid angenrheidiol a dangos yr arweinyddiaeth ofynnol er mwyn cynnwys staff a'r cyhoedd yn y gwaith o helpu'r GIG i fod yn gynaliadwy. Cyn gwneud y newidiadau sydd eu hangen ar y system gyfan, bydd angen cael cefnogaeth eang gan sectorau eraill, yn arbennig llywodraeth leol a'r sector gwirfoddol, yn ogystal â chefnogaeth a chyfranogiad y cyhoedd, cleifion a'u cynrychiolwyr. Fel y dywedwn yn ein hadroddiad, *Darlun o Wasanaethau Cyhoeddus 2011*, bydd angen i'r GIG achub ar y cyfle a gynigir gan y cylch gwleidyddol newydd yn dilyn etholiadau'r Cynulliad yn 2011 ac etholiadau llywodraeth leol yn 2012, i fwrw ati gyda'r newidiadau anodd sy'n angenrheidiol.

Atodiad 1 – Dulliau archwilio a nodiadau technegol

Dulliau

Dadansoddi data: Mae'r adroddiad hwn yn bennaf seiliedig ar ddadansoddiad o'r wybodaeth ariannol o gyllidebau cyhoeddedig, a'r ffurflenni monitro y mae cyrff y GIG yn eu rhoi i Lywodraeth Cymru bob mis. Mae hefyd yn defnyddio data ariannol arall, gan gynnwys:

- data Llywodraeth Cymru ar yr arian a roddwyd i gyrff y GIG ar ddechrau'r flwyddyn ac ar ddiwedd y flwyddyn;
- cyfrifon archwiliedig cyrff y GIG; a
- *Public Expenditure Statistical Analysis* (PESA) Trysorlys EM.

Adolygu dogfennau: Wrth ddehongli'r data ariannol rydym hefyd wedi defnyddio dogfennau strategol cyhoeddedig sy'n ymwneud yn benodol â'r GIG yng Nghymru. Yn eu plith mae Fframwaith Pum Mlynedd y GIG a *Law yn Llaw at Iechyd: Gweledigaeth 5 Mlynedd ar gyfer y Gwasanaeth Iechyd Gwladol yng Nghymru*'.

Nodiadau technegol

Cyllidebau iechyd: Mae'r ffigurau cyffredinol a ddefnyddir yn yr adroddiad hwn yn ymwneud â 'chyllidebau refeniw iechyd' neu 'gyllidebau cyfalaf iechyd'. Mae'r term hwn yn cyfeirio at yr holl refeniw neu arian cyfalaf a nodwyd yng nghyllideb Llywodraeth Cymru a ddyrennir i iechyd. Nid yw'n cynnwys unrhyw ran o'r gyllideb adrannol a roddir yn benodol i wasanaethau cymdeithasol neu wasanaethau plant.

Termau real: Mae'r adroddiad hwn yn cynnwys ffigurau ar y gyllideb 'termau real'. Mae 'termau real' yn gofyn am gynnwys chwyddiant yn y dadansoddiad. Yn achos cyllidebau'r sector cyhoeddus, mae'n arfer a dderbynnir i ddefnyddio cyfres datchwyddo CMC Trysorlys Llywodraeth y DU, sy'n nodi'r gyfradd chwyddiant yn y gorffennol ac yn rhagamcanu'r gyfradd chwyddiant yn y blynyddoedd i ddod. Ar gyfer yr adroddiad hwn rydym wedi defnyddio'r set o ddatchwyddwyr a gyhoeddwyd gan y Trysorlys ym mis Rhagfyr 2011. Nodir y ffigurau chwyddiant ar gyfer y blynyddoedd a drafodir yn yr adroddiad hwn isod.

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

Bylchau ariannu: Mae'r adroddiad hwn yn cynnwys dadansoddiad o'r bylchau ariannu a wynebir gan y GIG, yn seiliedig ar ragolygon o'r pwysau cost yn y GIG. Fodd bynnag, mae peth ansicrwydd ynghylch y pwysau hynny. Rydym wedi defnyddio dwy brif ffynhonnell: Fframwaith Pum Mlynedd y GIG a'r Cytundeb Cyllid Cenedlaethol, sy'n nodi pwysau cost penodol a chyffredinol bob blwyddyn yn seiliedig ar gymysgedd o ddata cenedlaethol a lleol. Mae'r rhagolygon hyn yn cwmpasu amrywiaeth o elfennau manwl, gan gynnwys cyflog ac elfennau eraill ac maent yn ystyried mynegeion chwyddiant penodol y GIG. I gyfrifo bylchau ariannu, rydym wedi defnyddio llinell Cyflenwi'r GIG o'r gyllideb iechyd. Defnyddiwn y rhan hon o'r gyllideb am ei bod yn cwmpasu cyllid gwasanaethau'r GIG y mae'r pwysau cost yn gymwys iddo.

Byrddau iechyd: Yn gyfreithiol, gelwir y byrddau iechyd yn fyrddau iechyd lleol. Fodd bynnag, ers eu had-drefnu mae Llywodraeth Cymru wedi caniatâu iddynt gyfeirio at eu hunain fel byrddau iechyd - dyma a wna'r adroddiad hwn.

Atodiad 2 – Perfformiad ariannol cyrff y GIG yn 2011-12

Mae'r atodiad hwn yn manylu ar berfformiad ariannol cyrff unigol y GIG a gellir ei ddarllen ochr yn ochr â Rhan 2 o'r prif adroddiad.

Yn 2011-12, cafwyd bwlch ariannu yn ystod y flwyddyn oedd rhwng £280 miliwn a £380 miliwn ar ddechrau'r flwyddyn

Mae Rhan 2 o'r prif adroddiad yn asesu bod bwlch ariannu'r GIG yn ystod y flwyddyn rhwng £280 a £380 miliwn yn seiliedig ar ddata Llywodraeth Cymru. Ar ddechrau'r flwyddyn, amcangyfrifodd cyrff unigol y GIG fwlch o £279 miliwn yn ystod y flwyddyn, a oedd ar begwn isaf ein cyfrifiadau. Roedd gan gyrff y GIG hefyd ddiffyg sylfaenol o £187 miliwn o 2010-11. Er mwyn pontio'r bwlch yn ystod y flwyddyn a dileu'r diffyg sylfaenol, nododd cyrff y GIG gyfanswm bwlch ariannu o £466 miliwn.

Cyflwynodd cyrff y GIG gynlluniau arbed i helpu i bontio'r bwlch ariannu a nodir eu targedau arbedion cychwynnol yn unol â ffurflenni monitro misoedd 1 i 3 yn Arddangosyn 1 isod.

Arddangosyn 1 - Targedau arbed cychwynnol cyrff y GIG ar gyfer 2011-12

Corff y GIG	Targed arbedion cychwynnol (£ miliwn)
Abertawe Bro Morgannwg	43
Aneurin Bevan	52
Betsi Cadwaladr	57
Caerdydd a'r Fro	53
Cwm Taf	26
Hywel Dda	43
Powys	13
Ymddiriedolaeth GIG Felindre	2
Iechyd Cyhoeddus Cymru	3
Ambiwlans Cymru	7
Cyfanswm	**300**

Nododd cyrff y GIG arbedion sylweddol o £285 miliwn yn 2011-12 ond cafwyd £157.4miliwn ychwanegol oddi wrth Lywodraeth Cymru er mwyn ymdrin â phwysau cost a mantoli'r gyllideb

Yn ystod y flwyddyn ariannol, yn ôl yr arfer, gwnaed addasiadau amrywiol i'r dyraniad gan yr Adran i adlewyrchu arian a ddaeth o gyllidebau rhaglen canolog a diwygiadau i amcangyfrifon o ddarpariaethau a chostau cyfalaf penodol.

Hefyd, mae cyrff y GIG wedi nodi iddynt wneud arbedion sylweddol yn ystod y flwyddyn fel y nodir yn Arddangosyn 2.

Arddangosyn 2 - Arbedion a nodwyd gan gyrff y GIG

Corff y GIG	Targed arbedion cychwynnol (£ miliwn)	Targedau arbedion terfynol (£ miliwn)	Arbedion a nodwyd (£ miliwn)
Abertawe Bro Morgannwg	43	43	37
Aneurin Bevan	52	52	49
Betsi Cadwaladr	57	58	45
Caerdydd a'r Fro	53	59	59
Cwm Taf	26	31	27
Hywel Dda	43	43	43
Powys	13	13	13
Ymddiriedolaeth GIG Felindre	2	2	2
Iechyd Cyhoeddus Cymru	3	3	3
Ambiwlans Cymru	7	8	8
Cyfanswm	**300**	**312**	**285**

Felly, byddai'r bwlch ariannu amcangyfrifedig yn ystod y flwyddyn o £279 miliwn wedi cael ei gwmpasu gan arbedion a nodwyd o £285 miliwn. Roedd hyn yn gyflawniad sylweddol ond nid oedd yn ddigon i gwmpasu'r bwlch ariannu yn ei grynswth sy'n cynnwys y diffyg sylfaenol. Nid yw'r arbedion a nodwyd wedi cael eu harchwilio ychwaith ac efallai na fydd llawer ohonynt yn rhyddhau arian parod ond byddant yn cynrychioli enillion effeithlonrwydd neu fesurau osgoi costau, yn hytrach na gostyngiad gwirioneddol mewn gwariant. Mae'n ddarlun cymhleth a heb ystyried yr arbedion a nodwyd, roedd yn glir yn ystod y flwyddyn ariannol y byddai angen i fyrddau iechyd gael mwy o arian i gyflawni eu targedau ariannol.

Cytunodd Llywodraeth Cymru y byddai £133 miliwn yn cael ei ddyrannu ym mis Hydref 2011, y byddai £103 miliwn yn rheolaidd (hy, yn cael ei gynnwys mewn dyraniadau ariannol mewn blynyddoedd i ddod), er mwyn cydnabod y pwysau cost ar fyrddau iechyd. Cytunwyd y byddai cronfeydd canolog wrth gefn yn ariannu £93 miliwn o'r cynnydd hwn - £63 miliwn yn rheolaidd a £30 miliwn fel rhan o'r pecyn meinhaol i Hywel Dda - gyda'r £40 miliwn oedd yn weddill yn cael ei ddarparu gan yr Adran.

Hefyd, cafodd Bwrdd Iechyd Caerdydd a'r Fro £12.25 miliwn yn ychwanegol, gyda £12 miliwn yn arian gwrthbwyso i'w ad-dalu o ddyraniadau adnoddau 2012-13 a 2013-14 yn gyfartal. Drwy gael y cymorth hwn, ynghyd ag arbedion ychwanegol arfaethedig o £2.5 miliwn, roedd modd i'r bwrdd iechyd hwnnw fantoli'r gyllideb. Yn gyfnewid am y cymorth hwn, gofynnwyd i'r bwrdd iechyd sefydlu a chynnal tîm 'trosglwyddo' penodedig, a chyflwyno cynllun ariannol ac iddo broffil ar gyfer misoedd 9 i 12 erbyn diwedd mis Tachwedd 2011 a chynllun ariannol ac arbedion ar gyfer 2012-13 erbyn diwedd mis Chwefror 2012.

Erbyn diwedd mis Chwefror 2012, roedd yn dal i fod yn amlwg i nifer o fyrddau iechyd a'r Adran, hyd yn oed ar ôl cael arian ychwanegol ym mis Hydref, a chyflawni arbedion sylweddol, na fyddai rhai byrddau iechyd yn llwyddo i gadw eu gwariant net o fewn eu terfynau adnoddau diwygiedig o hyd.

Ar 6 Mawrth 2012, ysgrifennodd y Gweinidog Iechyd, Gwasanaethau Cymdeithasol a Phlant at gadeiryddion y byrddau iechyd yn cynnig cymorth ariannol pellach. Byddai'r cymorth hwn yn cael ei roi ar ffurf 'blaenswm' yn erbyn dyraniad adnoddau 2012-13 bwrdd iechyd, gan gynyddu'r terfyn adnoddau i lefel a fyddai'n galluogi byrddau iechyd i gyflawni eu targedau ariannol statudol. Derbyniodd tri bwrdd iechyd y cynnig hwn: Aneurin Bevan (£4.5 miliwn), Cwm Taf (£4 miliwn) a Phowys (£3.9 miliwn). O ganlyniad, ni fyddant yn gallu defnyddio'r cyfleuster hwn eto yn 2012-13.

Mae Prif Weithredwr GIG Cymru wedi comisiynu adolygiadau allanol o drefniadau rheoli ariannol pob bwrdd iechyd a gafodd y cymorth hwn. Hefyd, caiff gwaith ei wneud gyda Byrddau Iechyd Betsi Cadwaladr a Hywel Dda i'w helpu gyda'u cynlluniau ariannol.

Cafodd y dyraniad ychwanegol ym mis Hydref i Fwrdd Iechyd Caerdydd a'r Fro, a'r dyraniad ym mis Mawrth i Fyrddau Iechyd Aneurin Bevan, Cwm Taf a Phowys eu gwneud yn benodol i sicrhau eu bod yn cyflawni eu targedau ariannol. I bwysleisio hyn, mae'r Archwilydd Cyffredinol wedi cyflwyno adroddiad sylweddol (ochr yn ochr â'i farn archwilio) ar gyfrifon y byrddau iechyd hynny.

Ceir crynodeb o'r arian ychwanegol a gafodd pob un o gyrff y GIG yn ystod y flwyddyn yn Atodiad 3.

Arddangosyn 3 - Crynodeb o'r arian ychwanegol a gafwyd yn 2011-12

Bwrdd iechyd	Hydref 2011 (cynnydd rheolaidd)	Tachwedd 2011 (i gyflawni targed ariannol yn bennaf)	Mawrth 2012 (i gyflawni targed ariannol)	Cyfanswm yr arian
Abertawe Bro Morgannwg	£17 miliwn	-	-	£17 miliwn
Aneurin Bevan	£17 miliwn	-	£4.5 miliwn	£21.5 miliwn
Betsi Cadwaladr	£17 miliwn	-	-	£17 miliwn
Caerdydd a'r Fro	£17 miliwn	£12 miliwn	-	£29 miliwn
Cwm Taf	£17 miliwn	-	£4.0 miliwn	£21 miliwn
Hywel Dda	£33 miliwn	-	-	£33 miliwn
Powys	£15 miliwn	-	£3.9 miliwn	£18.9 miliwn
Cyfanswm	**£133 miliwn**	**£12 miliwn**	**£12.4 miliwn**	**£157.4 miliwn**
Cronfeydd canolog wrth gefn	£93 miliwn	-	-	£93 miliwn
Adran	£40 miliwn	£12 miliwn	£12.4 miliwn	£64.4 miliwn
Cyfanswm	**£133 miliwn**	**£12 miliwn**	**£12.4 miliwn**	**£157.4 miliwn**

Mae Llywodraeth Cymru wedi newid ei dull gweithredu i ddarparu £63 miliwn o'r arian ychwanegol hwn ar sail reolaidd a defnyddio arian gwrthbwyso i atgyfnerthu neges fwy llym i gyrff y GIG

Cyflwynodd pob bwrdd iechyd ei alldro ragamcanol am y flwyddyn yn fisol i Lywodraeth Cymru. Dangosir y patrwm rhagamcanu yn Ffigur 16 yn y prif adroddiad ynghyd â'r lleihad yn y rhagolwg gorwario mawr ar ddechrau'r flwyddyn ym mis 7 pan ddyrannwyd yr arian rheolaidd ychwanegol ym mis Hydref. Gwelir lleihad pellach mewn rhagolygon gorwario ar ddiwedd y flwyddyn wrth i arian mis Mawrth gael ei adlewyrchu.

Cafodd yr arian ychwanegol ym mis Tachwedd 2011 a mis Mawrth 2012 ei ddarparu fel 'blaenswm' o arian blynyddoedd i d dod ac felly bydd yr arian sydd ar gael yn y dyfodol yn lleihau'n briodol. Mae hyn yn newid penodol yn y modd y mae'r Adran yn gweithredu. Ni fydd byrddau iechyd yn cael arian i'w helpu i gyflawni eu targedau ariannol heb fod amodau ynghlwm mwyach. Yn hytrach bydd angen i'r sawl sy'n ei gael ei dalu'n ôl, i bob pwrpas drwy gael llai o arian cyfatebol mewn blynyddoedd dilynol. Hefyd, ni fydd y sawl sy'n cael arian ym mis Mawrth yn gallu gofyn am arian gwrthbwyso'r flwyddyn nesaf.

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

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

8 July 2012

Dear Darren,

PROGRESS IN DELIVERING THE WELSH HOUSING QUALITY STANDARDS

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

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

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

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

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

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

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

Best wishes

DANNY ALEXANDER

Dyfodol Cynaliadwy
Sustainable Futures

Cyfarwyddwr Cyffredinol • Director General

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

Mr Darren Millar
Chair
Public Accounts Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
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CF99 1NA

11 July 2012

Dear Mr. Millar

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

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

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

   Answer:

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

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

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

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Continued…

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

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

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

Answer:

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

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

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

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

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

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

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

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

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

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

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

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

Answer:

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

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

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

Answer:

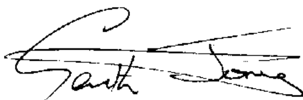
The Housing White paper has given a clear commitment to collaborative working with Value Wales to develop a clear framework for assessing value for money and ensuring the wider community benefits, including jobs and training opportunities, are embedded in public sector procurement practice.

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

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

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

Yours sincerely



Gareth Jones
Director General – Sustainable Futures.

REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL

HC 192
SESSION 2012–13

29 JUNE 2012

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

Our vision is to help the nation spend wisely.

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

Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 28 June 2012

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

Amyas Morse
Comptroller and Auditor General
National Audit Office

27 June 2012

HC 192 London: The Stationery Office £16.00

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

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

The National Audit Office study team consisted of:
Jamie Hart, William Palmer and Lee Summerfield under the direction of Laura Brackwell, with assistance from Richard Alcorn, Thibault Dornon, Rachael Foster, Joe Perkins and Jack Sharples.

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

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Key facts

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

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

NOTES

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

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

Summary

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

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

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

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

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

Figure 1
Indicators for comparing the health services

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

Source: National Audit Office

Health outcomes

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

Spending on health services

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

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

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

Population health needs

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

Policy and funding priorities

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

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

Health service delivery and performance

Organisation of health services

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

Cost and volume of health service resources

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

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

Efficiency and productivity in the use of health service resources

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

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

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

Quality and effectiveness of healthcare

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

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

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

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

Concluding comments

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

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

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

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

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

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

Part One

Health outcomes and spending

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

Health outcomes

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

Figure 2
Life expectancy

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

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

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

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

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

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

Spending on health services

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

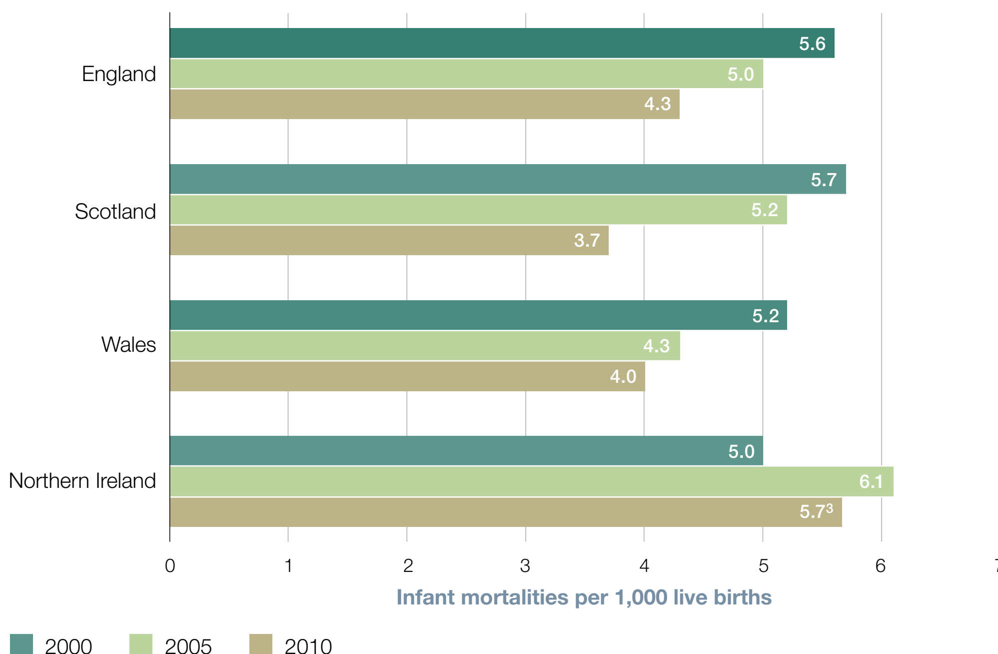
1.7 Looking forward, according to government spending plans, Wales is predicting the lowest increase per person over the four years to 2014-15 – remaining almost constant in cash terms and equating to an average annual fall of 2.3 per cent in real terms. In comparison, real terms spending is expected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

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

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

Figure 3

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



NOTES

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

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

3 Data for Northern Ireland for 2010 are provisional.

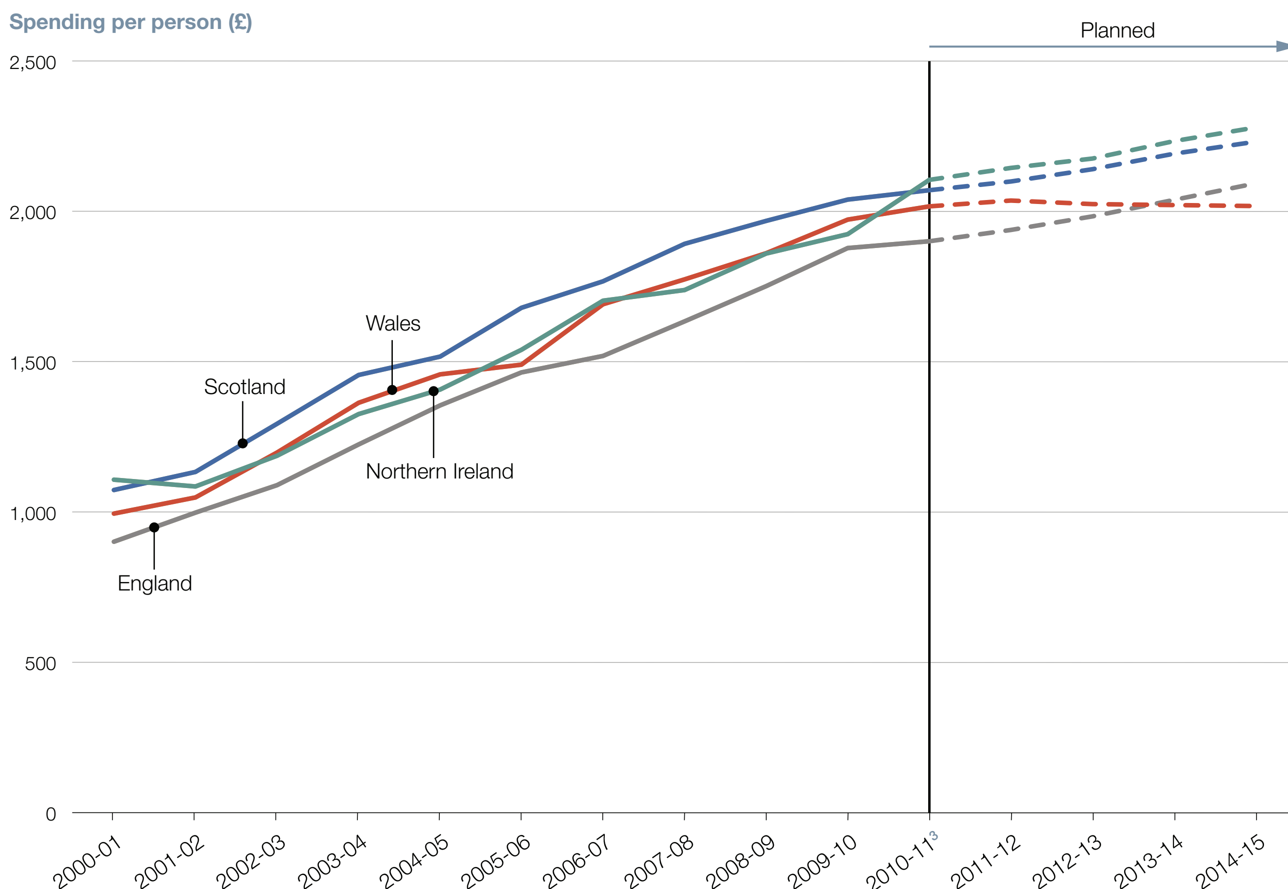
Source: Office for National Statistics; Statistics for Wales

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

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

Figure 4

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



NOTES

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

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

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

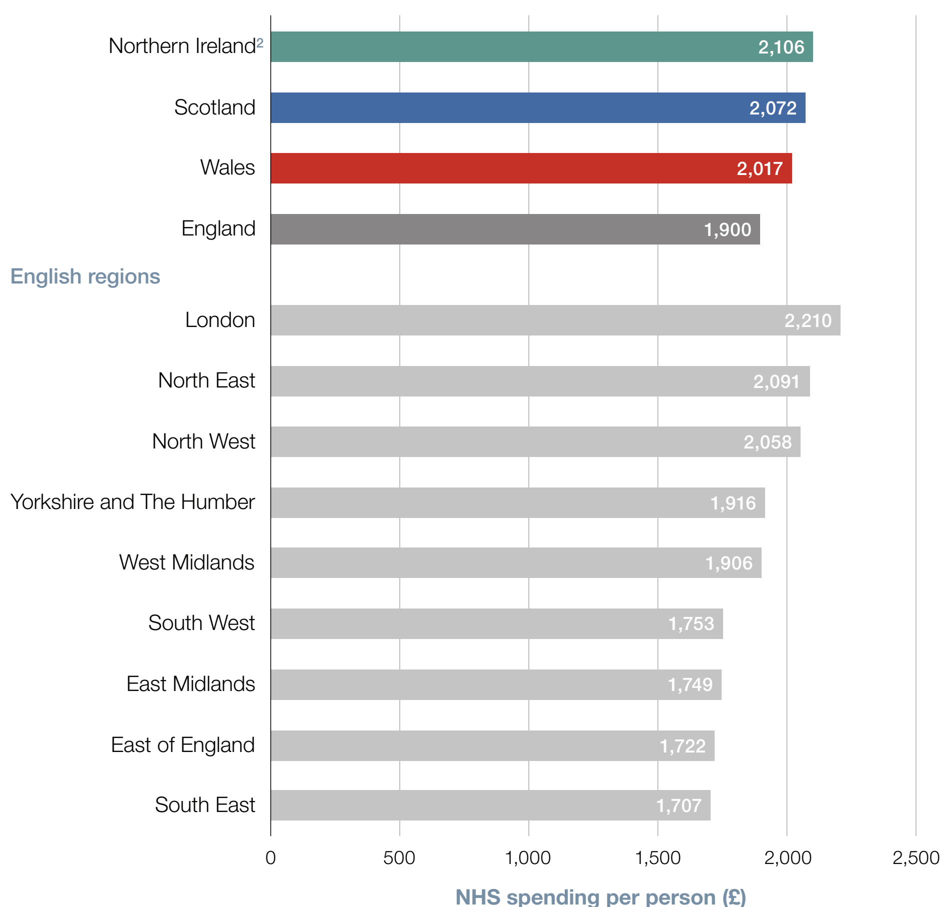
Source: HM Treasury; Scottish Government; Wales Audit Office analysis of Welsh Government data; Northern Ireland Executive

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

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

Figure 5

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



NOTES

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

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

Source: HM Treasury

Population health needs

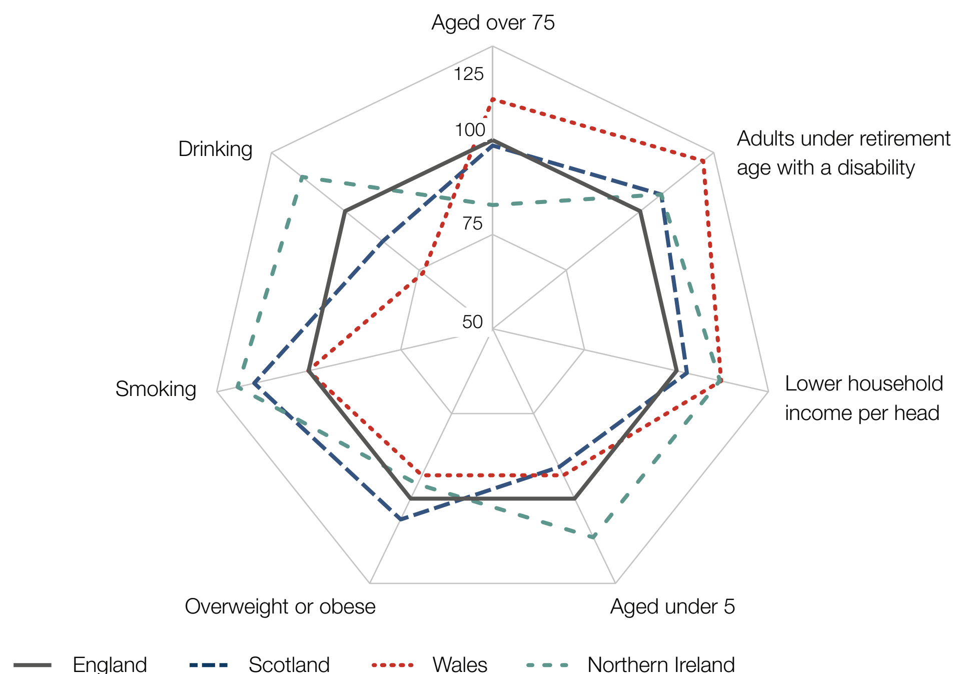
1.11 Many factors affect population health needs and the demand for healthcare. These factors, which are to some extent interrelated, include:

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

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

Figure 6

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



NOTES

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

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

Indicators

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

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

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

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

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

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

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

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

Figure 7

Estimation of relative health need per person[1]

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

NOTES

1 The figures are relative scores with higher numbers representing higher estimated health needs per person based on data from 2007-08 to 2009-10. Absolute figures are nominal.

2 Population weighted mean average; UK average 0.93.

3 Minimum and maximum relative need for local health areas within each nation for the period in question (152 primary care trusts in England, 14 heath boards in Scotland, 7 health boards in Wales, and 4 health and social care boards in Northern Ireland).

4 The size of local health areas vary (see Figure 9); due to less aggregation, smaller areas are more likely to have extremes of need.

Source: Deloitte analysis for National Audit Office

Policy and funding priorities

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

3 Further information on this methodology is available at: www.nao.org.uk/uk-healthcare-2012.

4 The Northern Ireland Assembly has, however, been suspended for long periods, including from October 2002 to May 2007. During these times the UK Parliament regained full responsibility for devolved matters, including health.

Health policy priorities

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

Funding priorities

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

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

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

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

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

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

Figure 8
Public spending on health services, 2010-11

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

NOTE

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

Source: HM Treasury

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

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

Part Two

Delivery and performance of health services

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

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

Organisation of health services

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

Figure 9
Local health areas

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

NOTES

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

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

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

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

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

Competition in health services

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

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

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

Payment frameworks

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

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

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

Cost and volume of health service resources

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

2.11 This section of the report sets out data on:

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

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

Income and number of GPs and dentists

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

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

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

NOTES

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

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

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

Source: The Health and Social Care Information Centre

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

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

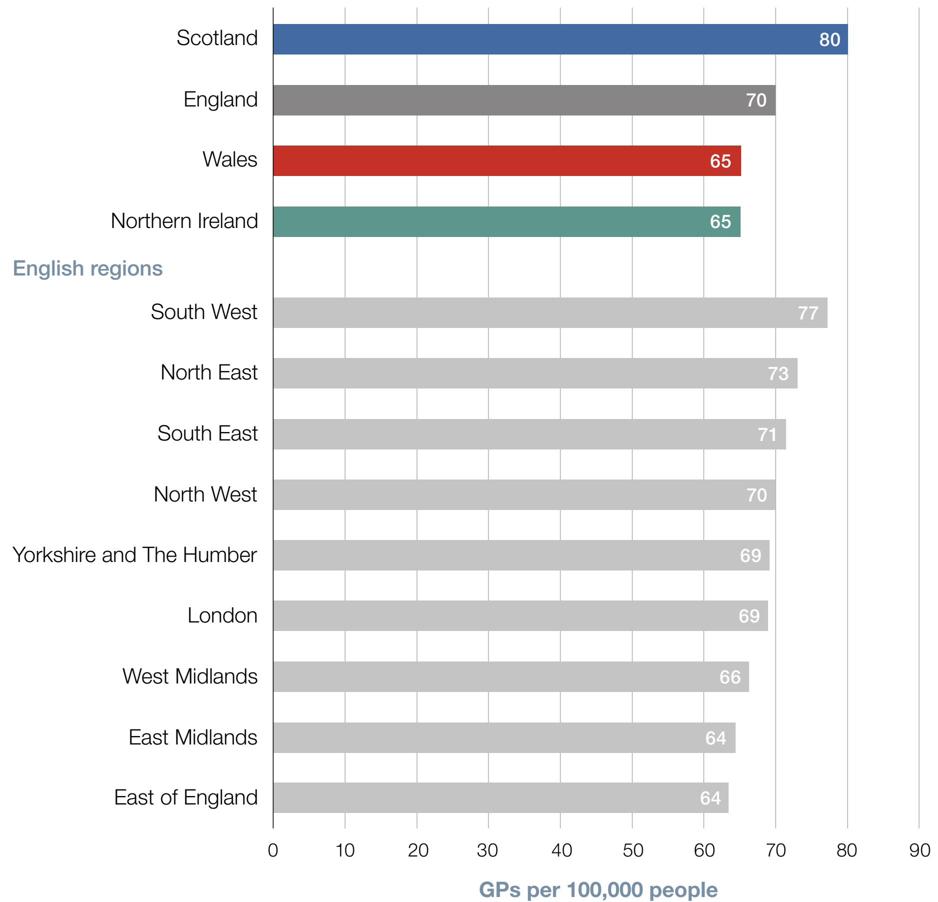
Pay and number of hospital staff

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

8 The Health and Social Care Information Centre.

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

Figure 11
Number of GPs per 100,000 people,[1] by nation and English region, 2009



NOTE

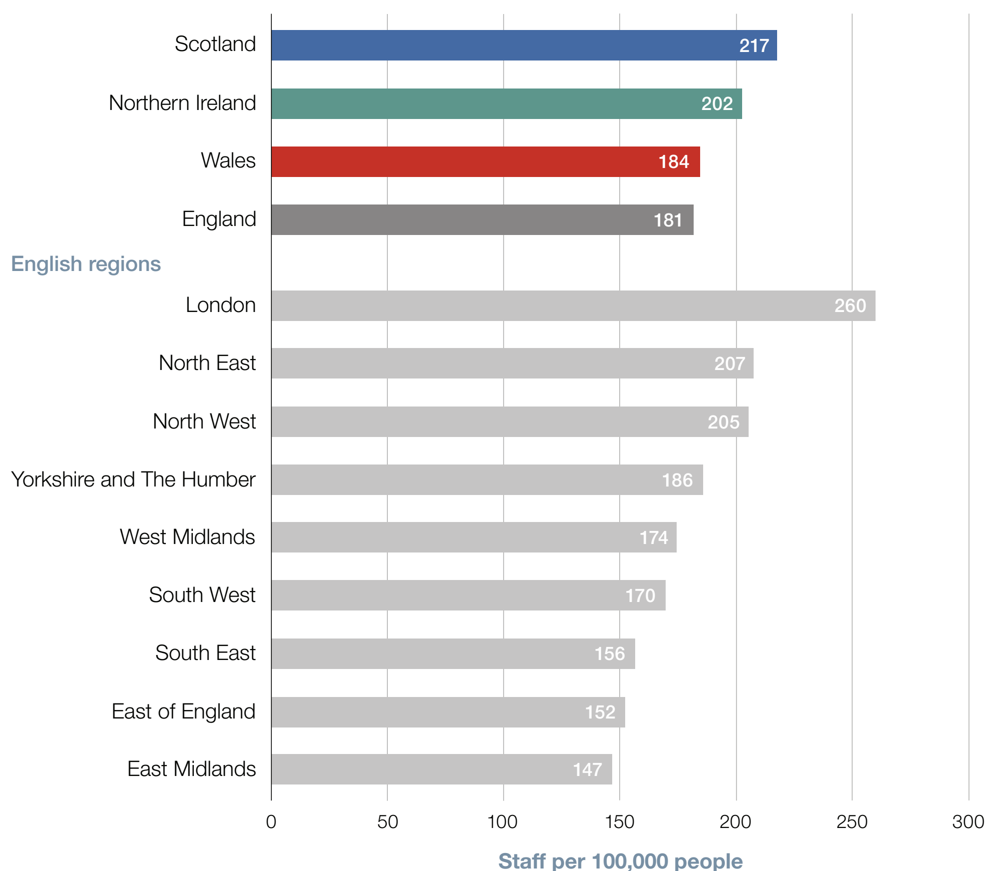
1 Staff numbers are headcount and do not account for the effect of part-time working which may vary across the nations and regions. However, the figures exclude retainees (often GPs working part-time after, for example, returning from maternity leave), locums, GPs in training, and those working only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

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

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

Figure 12

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



NOTES

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

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

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

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

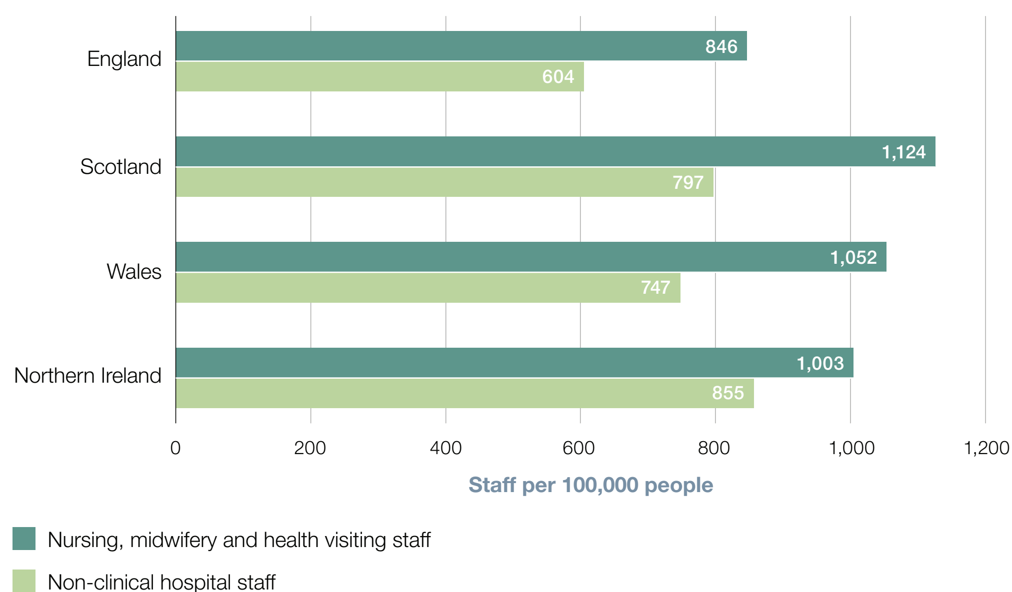
Source: Office for National Statistics; The Health and Social Care Information Centre

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

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

Figure 13

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



NOTES

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

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

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

Source: Office for National Statistics

Non-staff costs

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

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

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

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

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

NOTES
1 Figures relate to NHS prescription items dispensed by community pharmacies, appliance contractors (appliance suppliers in Scotland and in Northern Ireland) and dispensing doctors, and prescriptions submitted by prescribing doctors for items personally administered, known as stock orders in Scotland and Northern Ireland.
2 Refers to net ingredient cost: the cost of medicines before any discounts and does not include any dispensing costs or fees. This is known as gross ingredient cost in Scotland and ingredient cost in Northern Ireland.

Source: Office for National Statistics

10 HM Treasury.
11 Data not available for Northern Ireland.

Efficiency and productivity in the use of health service resources

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

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

2.24 This section of the report sets out data on:

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

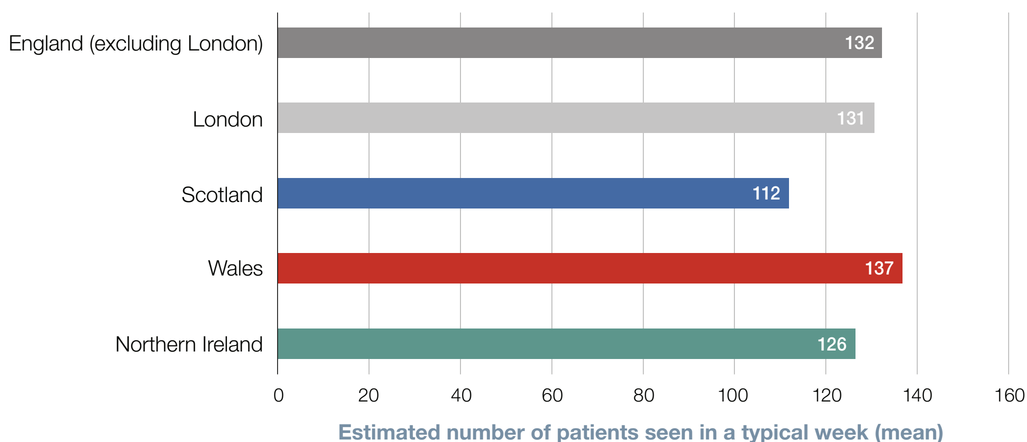
The measures of efficiency presented do not cover certain aspects of healthcare, such as community care, since no comparable activity data are available in these areas. England and Northern Ireland produce a measure of hospital efficiency (known as a ‘reference cost index’), based on the costs of producing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

Utilising staff efficiently

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

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

Figure 15
Estimated number of patients seen per GP in a typical week,[1,2] 2009



NOTES
1 Staff numbers are headcount and do not account for the effect of part-time working which may vary across the nations.
2 Data for London were collected separately to the rest of England and, therefore, London appears separately.

Source: Aston Business School

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

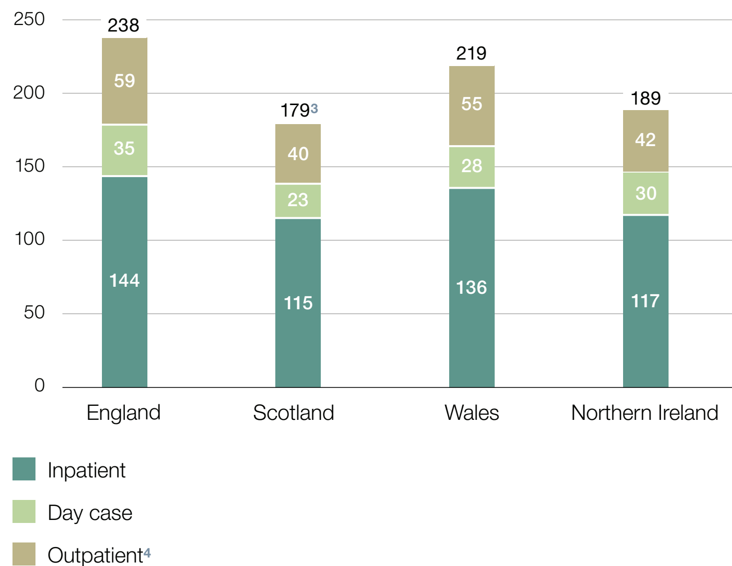
Using hospital beds more efficiently

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

Figure 16

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

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



NOTES

1. Cost-weighted activity index, covering Hospital and Community Health Services including hospital inpatient, day case and outpatient episodes. Weighting based on estimated average cost for inpatient, day case and outpatient activity published in 2008-09 English reference cost data.
2. Detailed notes on the comparability of medical staff numbers are included in Figure 12. Figures include activity from, but exclude staff in, independent and private sector providers of NHS care. Levels of independent and private sector involvement vary by nation (estimated at around 1 to 2 per cent of hospital services in England in 2008-09), with higher involvement likely to inflate performance against this measure.
3. Total activity differs from the sum of the three constituent activities due to rounding.
4. Outpatient activity excludes non-consultant led services, the levels of which will vary between the nations.

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

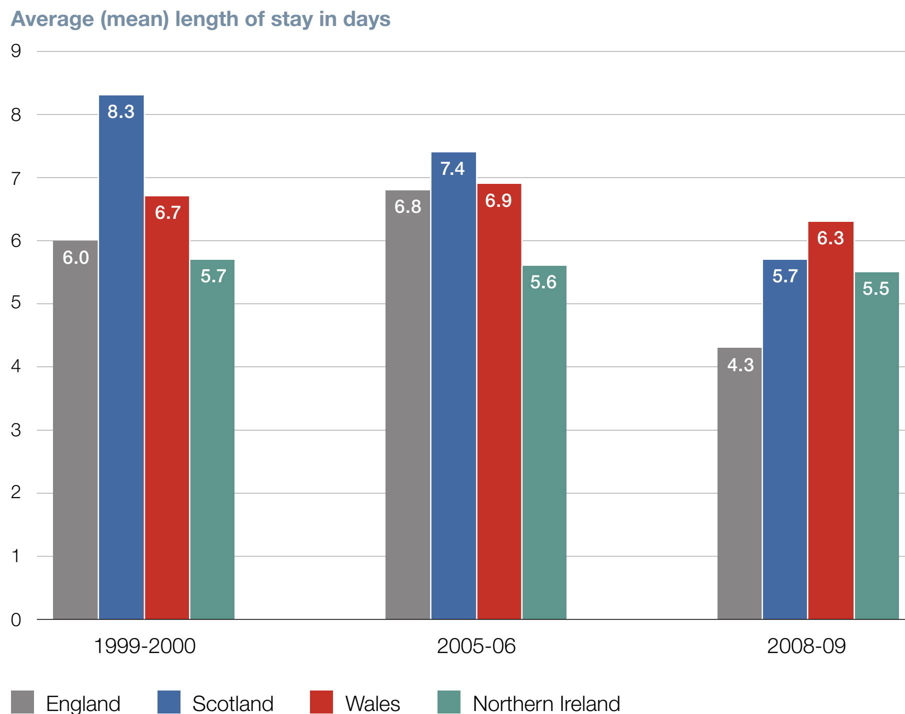
Reducing hospital lengths of stay

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

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

Figure 17

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



NOTES

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

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

Source: Office for National Statistics

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

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

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

Conducting more activity as day cases

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

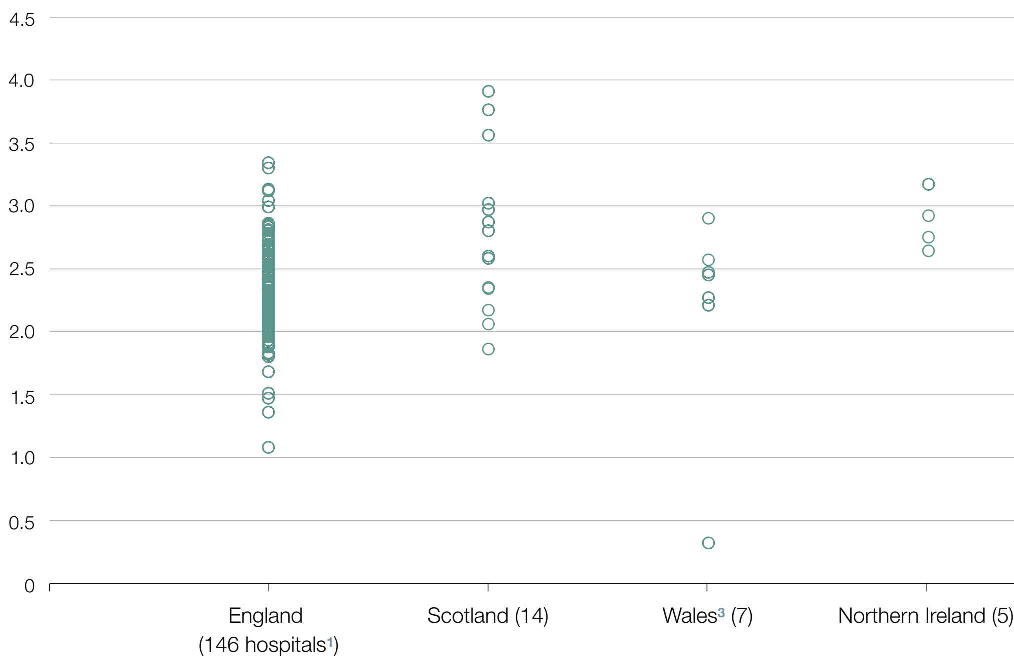
2.34 Comparable data are available on day cases as a proportion of all acute hospital admissions. In 2008-09, Northern Ireland treated the highest proportion of these admissions as day cases (41.8 per cent) (**Figure 19** on page 35). It should be noted, however, that some healthcare provided as day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

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

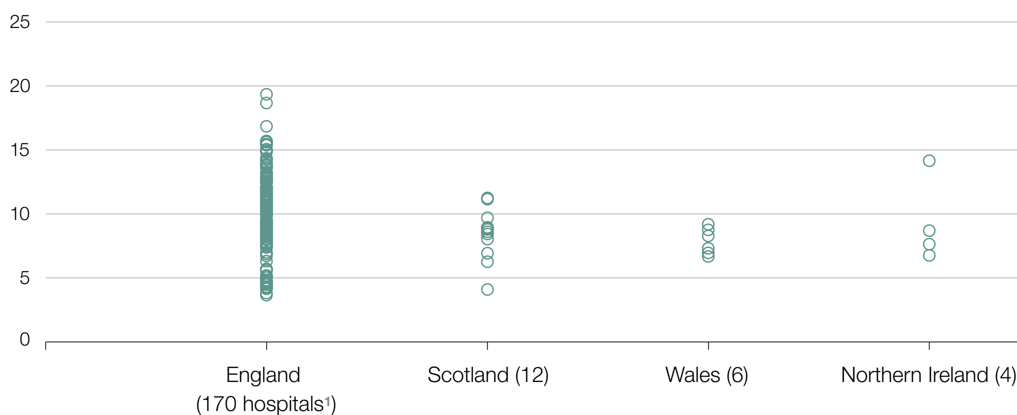
Figure 18

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

Births – mean length of stay, days



Hip replacements – mean length of stay, days



NOTES

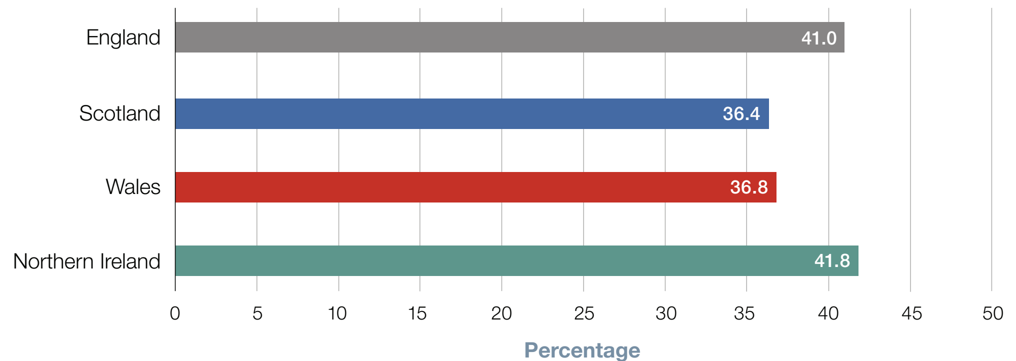
1 Each dot represents a hospital trust, health board or health and social care trust; where more than one hospital have the same performance they may appear as a single dot. Trusts and boards with fewer than 100 cases have been excluded.

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

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

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

Figure 19
Day cases as a proportion of all acute hospital admissions,[1,2] 2008-09



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

Source: Office for National Statistics

Reducing bed numbers

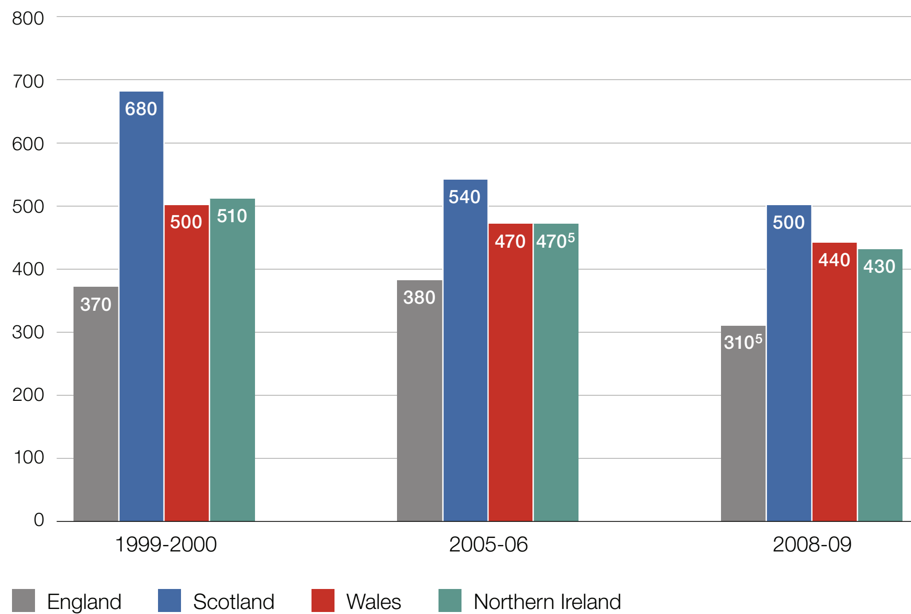
2.35 By conducting more activity as day cases or reducing lengths of stay while maintaining bed occupancy levels, the NHS can reduce the number of beds required to provide the same level of health services and thereby improve efficiency. Across all four nations, bed occupancy rates were similar and did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

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

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

Figure 20

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



NOTES

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

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

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

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

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

Source: Office for National Statistics

Local area efficiency

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

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

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

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

Quality and effectiveness of healthcare

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

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

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

18 The analysis is based on figures for the existing local health areas during the period analysed, 2007-08 to 2009-10 (152 in England, 14 in Scotland, 7 in Wales and 4 in Northern Ireland).

19 S Martin and P C Smith, *A comparison of English primary care trusts,* The Health Foundation, 2010. We extended this methodology to include data from 2007-08 to 2009-10, and to cover all four nations.

Quality of primary care

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

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

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

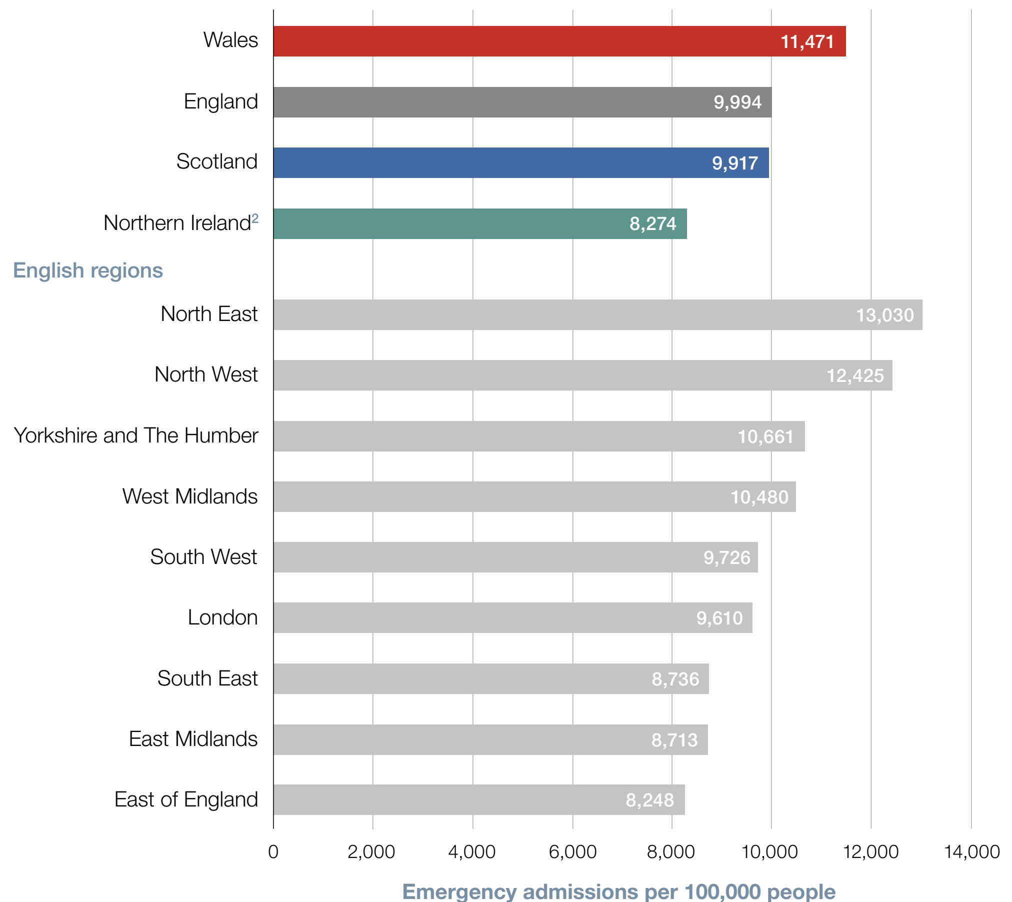
2.43 The number of emergency admissions per 100,000 people has increased in all four nations. Between 2000-01 and 2009-10, the rate of increase was greatest in England – 28 per cent, compared with 9 per cent in Scotland and 3 per cent in Wales. No data were available for Northern Ireland for 2000-01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

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

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

Figure 21

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



NOTES

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

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

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

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

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

Quality of hospital care

Waiting times

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

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

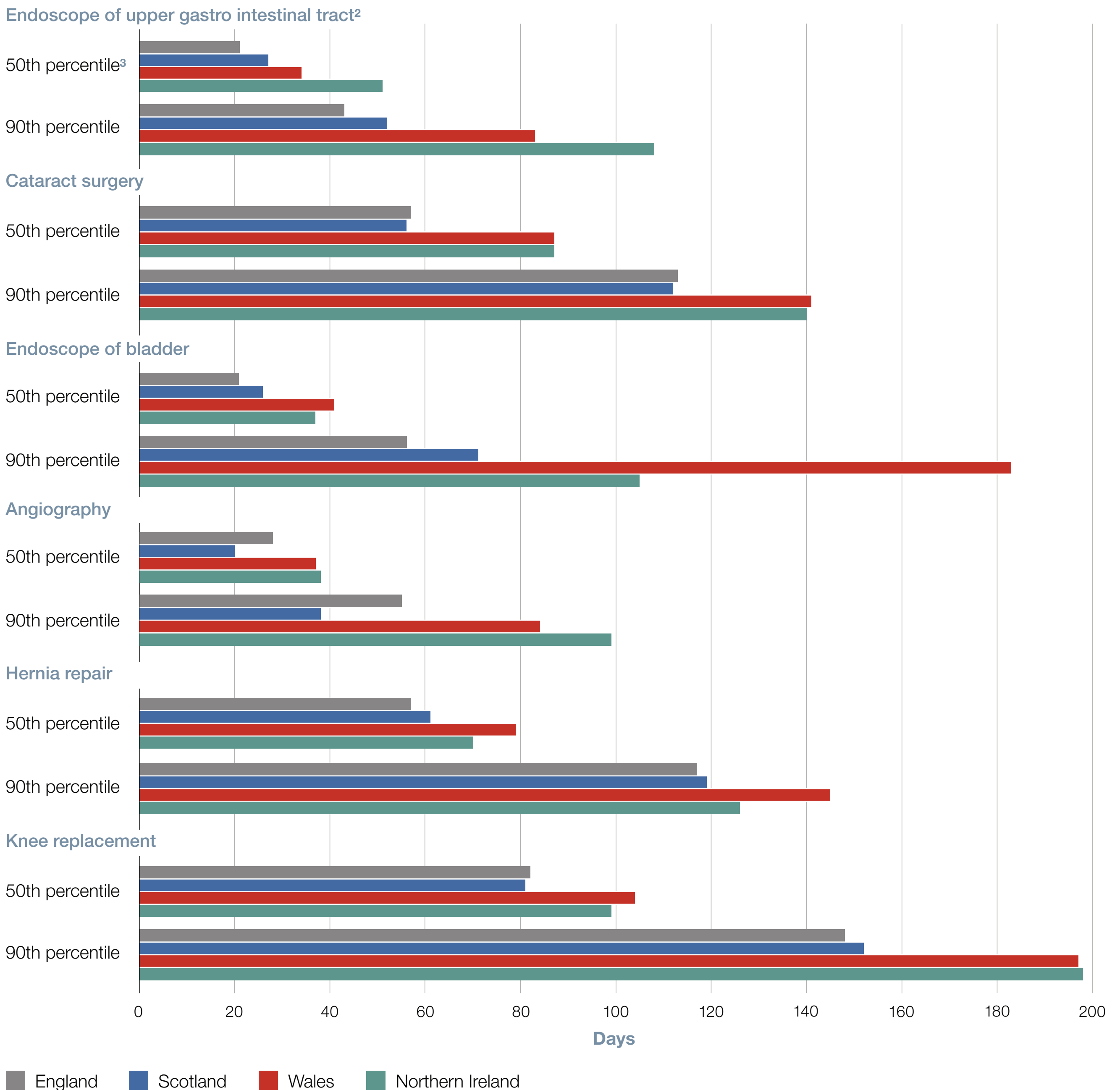
2.49 The waiting time targets/performance standards for elective procedures vary in terms of the time limit for referral to treatment and the required level of achievement. This makes it difficult to compare the nations' performance. England and Scotland were the only nations to achieve their elective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

Rates of healthcare associated infections

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

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

Figure 22
Time waited for selected hospital procedures,[1] 2009-10



NOTES

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

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

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

Source: Office for National Statistics

Figure 23

Performance against waiting time targets/performance standards, 2011

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

NOTES

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

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

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

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

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

Figure 24
Healthcare associated infection rates

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

NOTES

1. Data have yet to be published for Northern Ireland.
2. Unlike Scotland and Wales, the reduction for England was not statistically significant at the 95 per cent confidence level.
3. The reduction for Scotland includes a revision to account for differences in patient exclusion criteria and infection definitions between the two surveys; the unadjusted decrease was 48 per cent. No adjustments are made for the other reductions presented.
4. Different definitions are used for MRSA rates across the four nations and, as a result, we only report changes over time.
5. MRSA annual rates in Northern Ireland are calculated as an unweighted average across the four quarters within the year.

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

Appendix One

Methodology

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

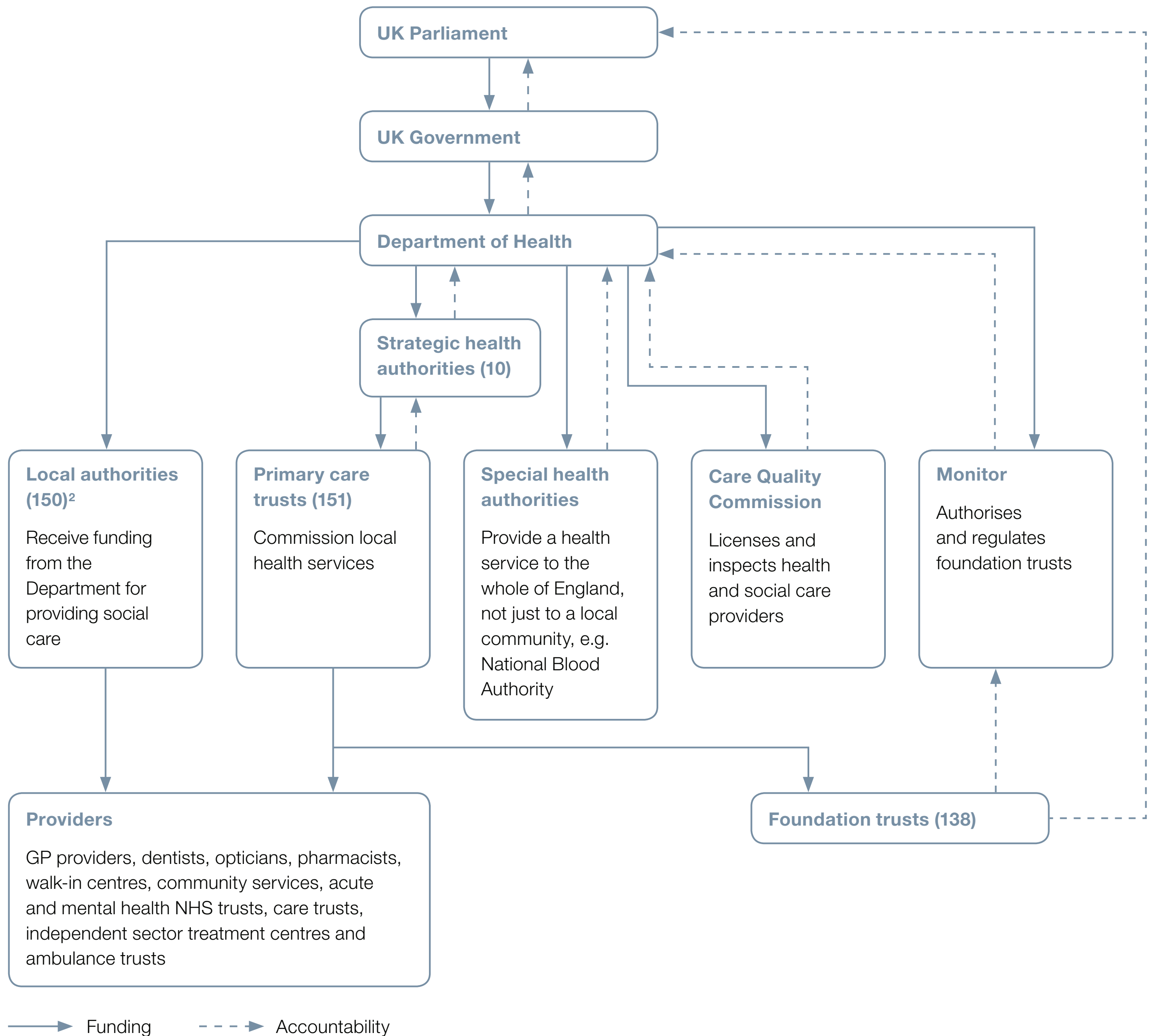
Method	Purpose
Review of literature on UK health comparisons. Key sources of documents included the Office for National Statistics, the Nuffield Trust, the Health Foundation and the King's Fund.	To understand: • the differences in the UK's health structures; • what comparisons are possible; and • known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

Appendix Two

Organisation of health services

Organisation of health services

England[1]



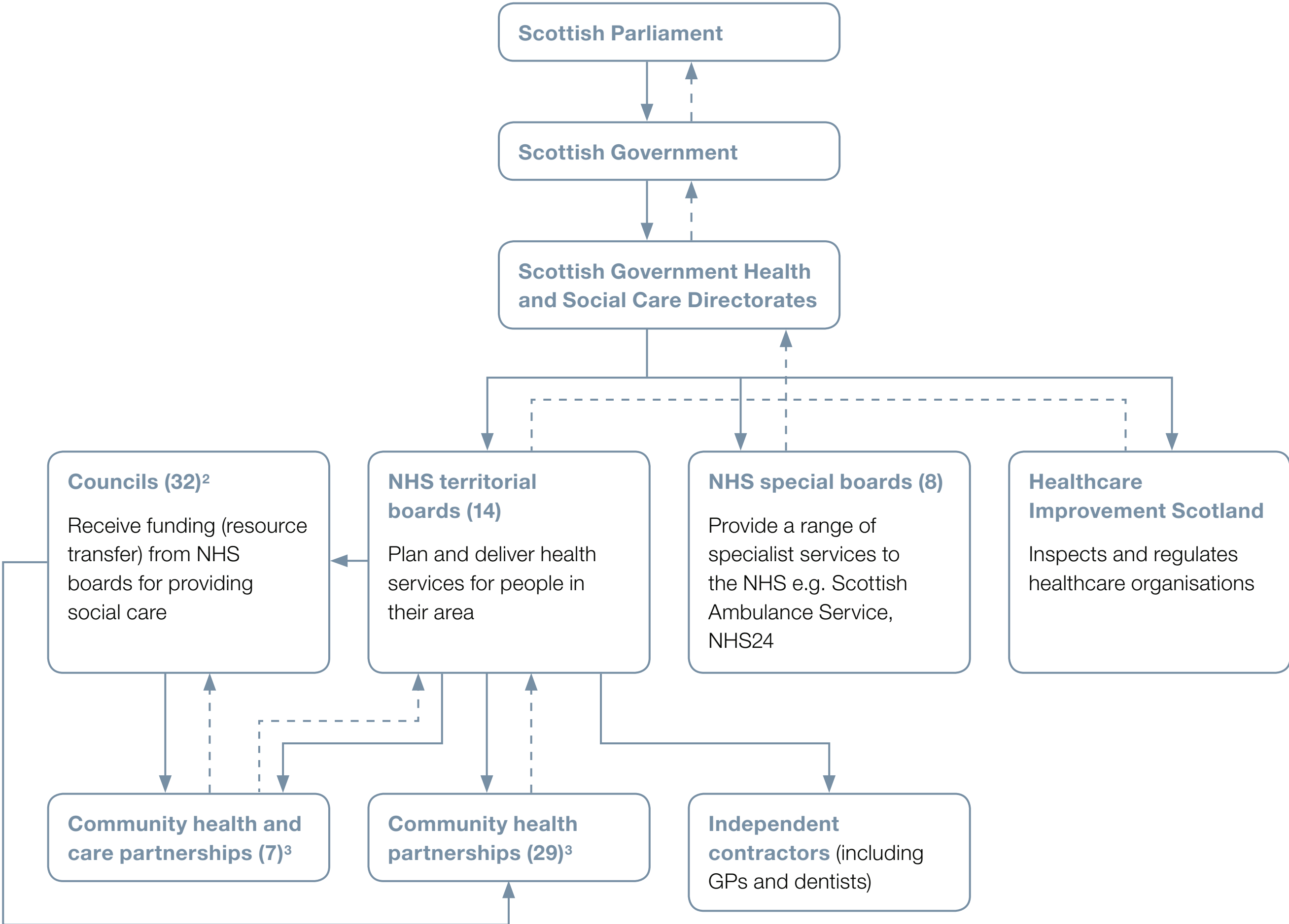
NOTES

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

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

Source: National Audit Office

Scotland[1]



NOTES

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

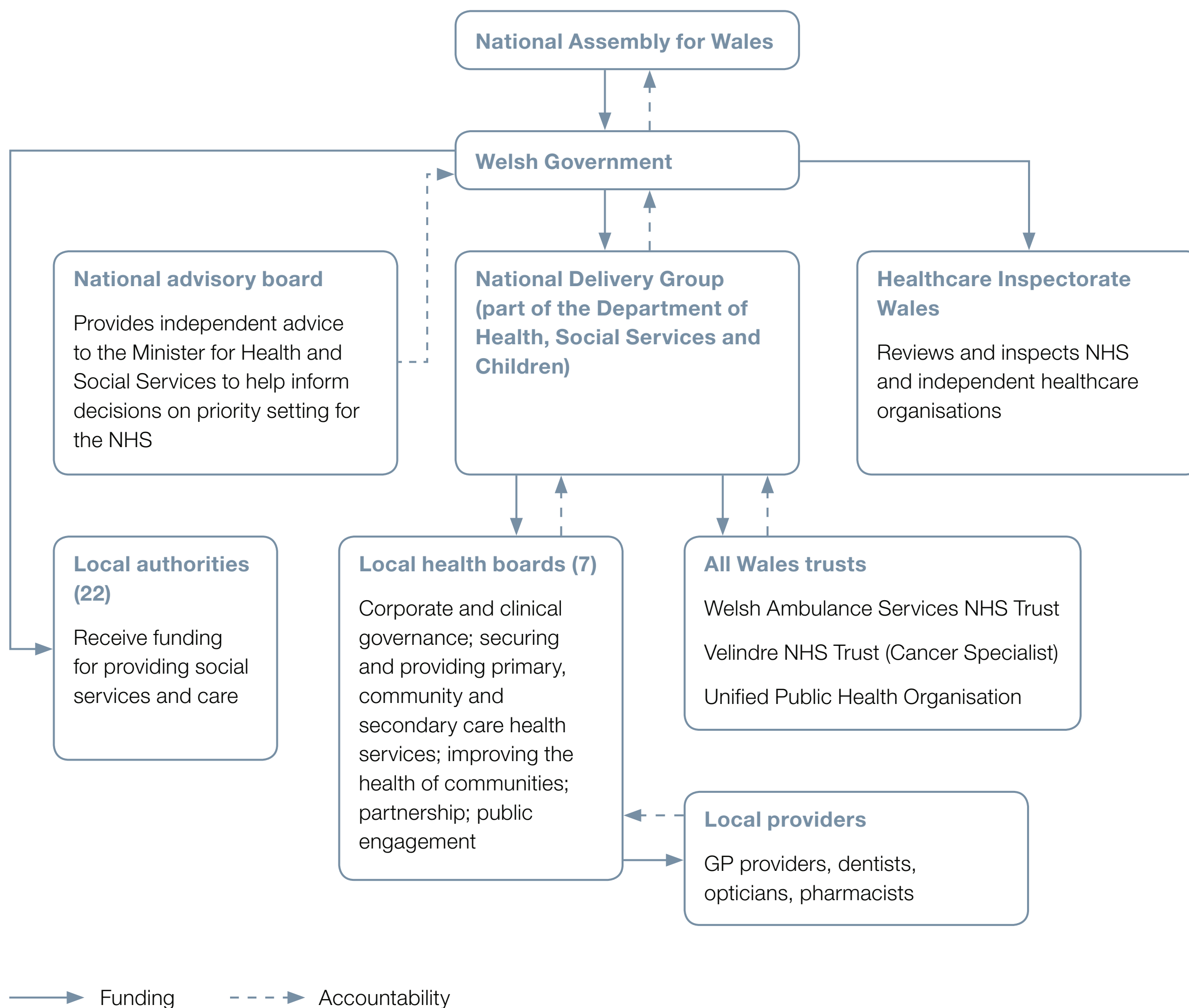
2 The main source of funding for councils is the Scottish Government Communities and Local Government Directorates.

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

Source: Audit Scotland

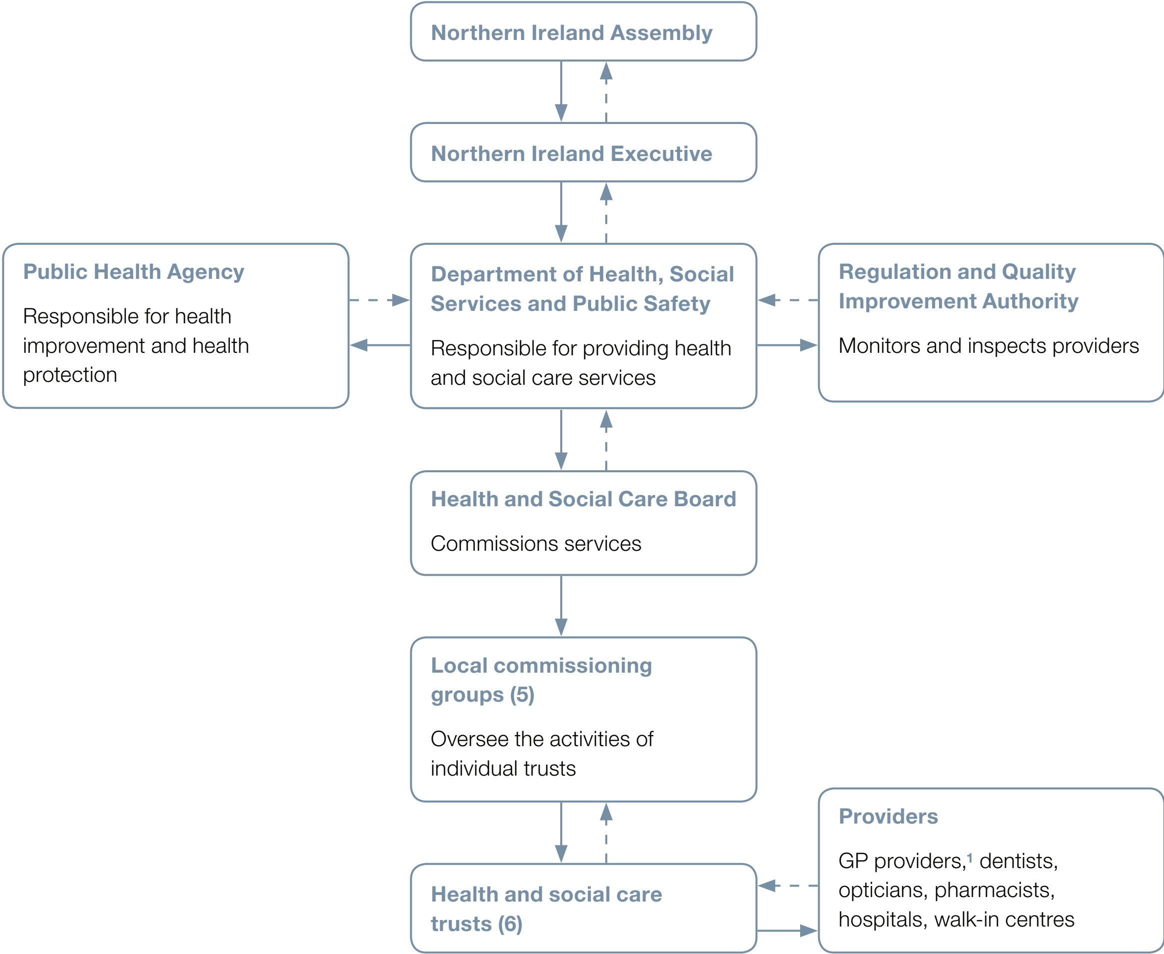
Organisation of health services *continued*

Wales



Source: Wales Audit Office

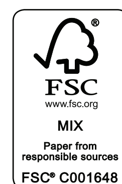
Northern Ireland



NOTE

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

Source: Northern Ireland Audit Office



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Dyddiad:	**Dydd Mawrth, 10 Gorffennaf 2012**
Amser:	**09:00 - 11:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Staff y Pwyllgor:	**Tom Jackson (Clerc)** **Daniel Collier (Dirprwy Glerc)**

1. Ystyried yr adroddiad drafft 'Rheoli Grantiau yng Nghymru'

1.1 Nododd y Pwyllgor ei fod wedi cytuno yn ei gyfarfod diwethaf, ar 3 Gorffennaf 2012, i ddechrau'r cyfarfod hwn yn breifat.

1.2 Trafododd y Pwyllgor y newidiadau i'w adroddiad drafft 'Rheoli Grantiau yng Nghymru' a chytunodd arnynt.

2. Trafod yr adroddiad drafft 'Cynnydd o ran cyrraedd Safon Ansawdd Tai Cymru'

2.1 Trafododd y Pwyllgor ei adroddiad drafft 'Cynnydd o ran cyrraedd Safon Ansawdd Tai Cymru' a chytunodd i'w ystyried ymhellach yn ei gyfarfod ar 17 Gorffennaf 2012.

3. Paratoi ar gyfer tystiolaeth Llywodraeth Cymru ar broses gaffael Llywodraeth Cymru a'r camau a gymerwyd ganddi i waredu hen westy River Lodge, Llangollen

3.1 Trafododd y Pwyllgor y ffordd y mae'n bwriadu ymdrin â'r sesiwn dystiolaeth ddilynol (eitem 5) ar adroddiad Swyddfa Archwilio Cymru 'Proses gaffael Llywodraeth Cymru a'r camau a gymerwyd ganddi i waredu hen Westy River Lodge, Llangollen'.

4. Cyflwyniad, ymddiheuriadau a dirprwyon

4.1 Croesawodd y Cadeirydd yr Aelodau ac aelodau o'r cyhoedd i'r cyfarfod.

5. Proses gaffael Llywodraeth Cymru a'r camau a gymerwyd ganddi i waredu hen westy River Lodge, Llangollen - Tystiolaeth gan Lywodraeth Cymru

5.1 Croesawodd y Cadeirydd y Fonesig Gillian Morgan, Ysgrifennydd Parhaol, Llywodraeth Cymru; James Price, Cyfarwyddwr Cyffredinol, Busnes, Menter Technoleg a Gwyddoniaeth; Arwel Thomas, Dirprwy Gyfarwyddwr, Yr Is-adran Llywodraethu Corfforaethol a Sicrwydd; a David Richards, Cyfarwyddwr Llywodraethu.

5.2 Holodd y Pwyllgor y tystion.

Pwyntiau gweithredu:

Mewn ymateb i'r cwestiynau, cytunodd Llywodraeth Cymru i ddarparu:

- Manylion ar p'un a fyddai uwch reolwyr Llywodraeth Cymru sy'n uwch na lefel ranbarthol wedi bod yn bresennol ar gyfer sesiynau briffio'r cyn Weinidog dros Fenter, Arloesi a Rhwydweithiau ynghylch cynigion i brynu gwesty River Lodge.
- Nodyn ynghylch a oes dyddiad cau wedi'i bennu i waredu hen westy River Lodge.
- Nodyn ynghylch y cynnydd ar gyfer gwerthuso ceisiadau ar ddefnyddio'r safle, gan gynnwys manylion am unrhyw amodau ar adeiladu llwybr troed ar y safle.
- Rhagor o fanylion am Dîm Arweinyddiaeth Eiddo Llywodraeth Cymru.
- Manylion am sut y gwnaeth swyddogion Llywodraeth Cymru yn y gogledd ymdrin â phryderon a godwyd gan Aelod Cynulliad lleol mewn llythyr i'r Gweinidog ynglŷn â chaffael gwesty River Lodge.

6. Papurau i'w nodi

7. Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol:

Trawsgrifiad