THE NATIONAL ASSEMBLY FOR WALES: AUDIT COMMITTEE

REPORT 00-04 – Presented to the National Assembly on 13th July, 2000 in accordance with section 102(1) of the Government of Wales Act 1998


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ANNEXES

Annex A : Relevant proceedings of the Committee – Minutes of Evidence (Thursday 6th April 2000)

Annex B : Information from the Assembly’s Director of NHS, Wales on the issue of data matching between the NHS and the Department of Social Security

Annex C : Letters to the Committee from Sir John Bourn, Auditor General for Wales on clinical negligence

Annex D: The Audit Committee
Introduction

1. The National Health Service (NHS) in Wales spent some £2.4 billion in 1998-99. During that year, it operated through 5 health authorities and 26 NHS trusts. On 1 April 1999, the 26 NHS trusts were reconfigured to 16, and on 1 April 2000 to 15 NHS trusts. The National Assembly for Wales’ NHS Directorate now has overall responsibility for the health service in Wales.

2. The NHS in Wales is funded primarily by payments to the five Welsh health authorities, which in turn made payments to NHS trusts under agreements for hospital and other services (£1,485 million). For primary health care services, health authorities made payments to fundholding and on behalf of non-fundholding General Practitioners (£747 million) and also payments to Dentists (£61 million) and Opticians (£18 million).

3. The Summarised Accounts of the NHS in Wales are completed by aggregating the accounts of the underlying NHS bodies, and represent the mechanism by which the overall results of the NHS in Wales are reported. The Report of the Comptroller and Auditor General on the 1998-99 accounts provides an update on the financial health of the NHS in Wales and the main issues affecting that position. The 1998-99 Accounts and the Comptroller and Auditor General’s Report were laid before Parliament as they related to the financial year prior to the establishment of the National Assembly for Wales. The Chairman of the House of Commons Committee of Public Accounts (PAC) agreed that the Assembly’s Audit Committee could take evidence on this matter. We are grateful to the Committee of Public Accounts for an early opportunity to examine this important area of expenditure in Wales.

4. From 1999-2000, responsibility for the audit of the NHS (Wales) Summarised Accounts transfers to the Auditor General for Wales. The accounts for the year and the Auditor General’s Report on them will be presented to the Assembly.

5. We took evidence from Mr Peter Gregory, the Director of the Assembly's NHS Directorate and Accounting Officer for the NHS (Wales) Summarised Accounts, who was accompanied by Mrs Sarah Beaver, the head of the Assembly’s NHS Finance Division. A transcript of this evidence is at Annex A. We also received written evidence from Mr Gregory (Annex B), and from Sir John Bourn, the Auditor General for Wales (Annex C). We would like to thank Mr Gregory for the positive and constructive way in which he responded to the Committee’s questions.

6. In this report, we examine the National Health Service in Wales under five main headings:
   ° The overall financial health of the NHS in Wales;
   ° The financial health of the five Welsh health authority areas;
   ° Clinical negligence;
   ° Fraud; and
   ° The cost of primary care drugs.

The overall financial health of the NHS in Wales

8. In 1998-99, the NHS in Wales recorded an overall deficit of £21.8 million. This increased the total accumulated deficit from £32.1 million to £53.9 million at 31 March 1999. For 1999-2000, two of the five health authorities and 10 of the 16 NHS trusts operating in that year were forecasting further deficits. The net forecast aggregate deficit for 1999-2000 was £20 million, which would increase the accumulated deficit of the NHS in Wales to some £73.9 million at 31 March 2000. Mr Gregory told us that this deficit position and the financial problems of the NHS generally are not unique to Wales, but are common to healthcare systems elsewhere in the developed world.

9. However, other factors have also influenced this position. In early 1999, the then Secretary of State for Wales commissioned a ‘Stocktake’ of the financial health of the NHS in Wales. The Stocktake Report, issued in June 1999, concluded that there was no single explanation for the financial problems existing within the NHS in Wales.

10. In addition to the local performance of health authorities and NHS trusts, the Accounting Officer suggested to us that the following factors contributed at a national level to the financial problems in Wales:

   ° There had been a tightening of the financial environment during the mid to late 1990s, coupled with a requirement for the NHS to meet targets for cash releasing efficiency savings which were in practice difficult to achieve;

   ° Resource and efficiency pressures within the Welsh Office Health Department resulted in a downsizing of that department, including its monitoring function, and making the performance of its strategic management role less effective. Relationships between the Welsh Office and NHS bodies became more difficult as a consequence. The Stocktake Report recommended the strengthening of the Assembly’s NHS Directorate to allow an integrated approach to the monitoring of financial performance, value for money and delivery of NHS objectives in Wales. Mr Gregory told us that a recent review had prompted an increase in staff resources, and that this problem had now been alleviated.

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2 C&AG’s Report, paragraph 4.6
3 C&AG’s Report, paragraphs 4.19 and 4.20
4 Q18
5 Q2
6 C&AG’s Report, paragraphs 4.31 to 4.33
7 Q3
8 Q7 and 8
9 Q8
The NHS internal market, based on competition and a purchaser/provider split, had been beneficial in focussing operational responsibility at the local level. However, it had also created difficulties in the working relationships between health authorities and NHS trusts, and Mr Gregory told us that he considers that the removal of competition from the NHS was contributing to a significant improvement in this regard.

The programme of NHS trust reconfiguration had been introduced to give a more efficient provision of patient care. Mr Gregory expected this to achieve significant savings, but told us that it would initially involve a cost to the NHS in Wales of approximately £4 million, contributing in the short-term to the financial deficit. The NHS Directorate expects that reconfiguration will result in savings of £4 million in 2000-01, rising after three years to a £6 million annual recurrent saving.

11. One key mechanism for monitoring the financial performance of NHS trusts in Wales is the three financial objectives set for each NHS trust by the Assembly’s NHS Directorate (formerly the Welsh Office Health Department). These objectives are:

- To break-even over the three-year period 1997-98 to 1999-2000;
- To achieve a ‘Capital Cost Absorption Rate’ (that is, to cover the notional cost of financing its capital assets after allowing for depreciation) of exactly six per cent annually; and
- To remain within the prescribed External Financing Limit.

12. For 1998-99, the Comptroller and Auditor General reported that 25 of the 26 NHS trusts failed to meet one or more of their three key financial objectives, including four who failed all three objectives. Fourteen trusts failed the interim break-even target and 21 failed to meet the exact 6 per cent Capital Cost Absorption Rate. Four trusts exceeded their External Financing Limit, although Mr Gregory told us that three of these were only marginal failures. Mr Gregory explained to us that all these failures resulted from the difficulties NHS trusts faced in operating within their financial environment.

13. A further financial duty for all NHS bodies is the requirement to settle all their bills within 30 days of receipt of a valid invoice, in accordance with the CBI Supplier Payment Code of Practice. The aggregate performance of the health

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10 Q4
11 Q15
12 Foreword to the NHS Summarised Accounts for Wales, 1998-99, paragraphs 20-23
13 C&AG’s Report, paragraph 4.15 and Q23
14 Q23
authorities against this target remains poor, with only 85 per cent of invoices being paid within the 30-day period, although these did represent some 97 per cent of invoices by value. Of the NHS trusts, 16 improved their performance during 1998-99, but at nine trusts the prompt payment levels worsened – and one trust (Glan Hafren NHS Trust) paid only 26 per cent of its bills within 30 days.  

14. The Accounting Officer informed us that the Assembly have monitored supplier payment performance at health authorities and NHS trusts on a monthly basis, and have been looking for improvements in that position. He told us that he was not satisfied with the current levels of performance, and intended to include in the annual funding allocation letter issued to each NHS body a requirement for improvements to be made.

15. Our main findings, conclusions and recommendations on the overall financial health of the NHS in Wales are as follows:

(ii) We note that the financial problems facing the NHS in Wales are common to healthcare systems elsewhere in the developed world; and also that these problems are not recent, with financial deficits being reported since the 1980s. In a situation of finite funding, the provision of healthcare will always require a careful balance between need and cost;

(iii) We are concerned at the then Welsh Office's inability to monitor adequately the NHS in Wales as those problems were developing, and also that there had been a deterioration in relationships between the Welsh Office and the various parts of the NHS. We are pleased to hear of recent improvements in this area, and that this problem is now being resolved. We encourage the NHS Directorate to work more closely with health bodies across Wales, providing genuine strategic management and leadership for the service;

(iv) We view the poor performance in 1998-99 of NHS trusts in Wales against their three financial objectives as unacceptable, although we recognise that this was a direct consequence of the constraints of their financial environment. We look to the NHS Directorate to take action to ensure that NHS trusts are able to achieve the forecast savings available from the reconfiguration of NHS trusts in Wales, and note our intention to review closely the success of this programme in due course;

(v) We urge that a more rigorous process be put in place to estimate the costs and savings that might be achieved by structural re-organisations in the NHS:

(vi) We are deeply concerned at the performance achieved by health authorities and NHS trusts in Wales against the prompt payment target.

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15 C&AG's Report, paragraphs 4.23 to 4.30

16 Q28
We urge the NHS Directorate to take appropriate action to ensure that all NHS bodies comply with the CBI Supplier Payment Code of Practice, acting in accordance with Government policy in this regard.

The financial health of the five Welsh health authority areas

16. The C&AG’s Report contained an analysis of the 1998-99 deficit incurred by NHS bodies in Wales between the five health authority areas, and identified a wide variation in financial performance. The Accounting Officer put to us several factors, at the health authority area level and also amongst individual NHS bodies, which he believed to have contributed to this variation.

17. At the health authority area level, he suggested that factors influencing performance included the resource allocation formula, the proportion of GP fundholder practices, and the extent to which each area was dependent on services procured externally. Within NHS trusts, factors such as the level of competition for particular services offered and the funding required to support the more specialised functions of certain NHS trusts contributed significantly to their financial performance. Mr Gregory also suggested to us that a range of personnel factors might also impact on the performance of each health authority area. The nature of the working relationship between the health authority and its local NHS trusts, the differing experiences of senior executives and Board members, and variations in their levels of commitment to financial control all contribute to the reported differences in financial performance across the five health authority areas.

18. The Committee questioned Mr Gregory in further detail on the financial performance of each of the five health authority areas: Dyfed Powys, Bro Taf, Gwent, Iechyd Morgannwg and North Wales.

Dyfed Powys health authority area

19. The Dyfed Powys health authority area reported a net deficit of some £11.5 million in 1998-99, which represented over half of the all-Wales deficit. The former Welsh Office had provided a total of £12.5 million in brokerage (short-term funding to meet cash-flow difficulties) to Dyfed Powys Health Authority. In setting out the role of the NHS Directorate in supporting the financial recovery of Dyfed Powys Health Authority, Mr Gregory explained that his decision to transmit this additional funding payable to the local NHS trusts through the Health Authority meant that the NHS trusts were dependent in terms of funding on one paymaster. As a result, those NHS trusts continued to report a more favourable financial position, whilst the Health Authority reported an increasing

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17 C&AG’s Report, paragraph 4.6 and Figure 2

18 Q30

19 C&AG’s Report, Appendix B, paragraphs B.1 and B.3
accumulated deficit 20.

20. In summarising the recovery process for the Dyfed Powys area, the Accounting Officer commented that Recovery Plans had been agreed between the Health Authority, the NHS Directorate and each of Powys Healthcare, Ceredigion and Mid Wales and Pembrokeshire and Derwen NHS Trusts. In respect of the fourth trust in this area, Carmarthenshire NHS Trust, however, Mr Gregory expressed his reservations concerning its forecast financial position, and informed us that he was not confident that a suitable recovery strategy had yet been devised 21.

**Bro Taf health authority area**

21. In his Report, the C&AG had stated that the financial position of Bro Taf Health Authority was forecast to deteriorate sharply, with a deficit of £6.1 million forecast for 1999-2000 and a further significant deficit expected in 2000-01 22. Mr Gregory was able to report a revised forecast to us for 2000-01 which was significantly improved, reducing the original forecast deficit of £17.4 million to only a marginal deficit for that year. This was in part as a result of additional financial assistance from the NHS Directorate to alleviate specific cost pressures. These included the teaching function of the University Hospital of Wales within the Cardiff and Vale NHS Trust, and the additional capital costs arising from the new Royal Glamorgan Hospital 23.

**Gwent health authority area**

22. The Gwent health authority area reported an overall deficit of £0.4 million for 1998-99, which was the lowest deficit of the five Welsh health authority areas 24. The Gwent area contains only three NHS trusts, and Mr Gregory suggested to us that this relative lack of complication had aided relationships between the commissioning authority and the trusts 25. He told us that the area had experienced financial difficulties in the past, but that these had been addressed and resolved by effective financial management undertaken in partnership between the various NHS bodies concerned. He noted also that the Gwent area had experienced one per cent greater growth in funding than its worst-performing counterpart, which had also contributed to the area’s ability to cope with cost pressures 26.

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20 Q36
21 Q37
22 C&AG’s Report, Appendix A, paragraph A.2
23 Q41 and 43
24 C&AG’s Report, Appendix C, paragraph C.1
25 Q46
26 Q46 and 47
23. The financial difficulties experienced by this health authority area centred largely on the large deficits incurred by the former Morriston Hospital NHS Trust, which totalled some £7.2 million at 31 March 1999. Mr Gregory told us that these deficits had been substantially reduced during the 1999-2000 financial year. He believed that the astute leadership of the management team now in place following its merger with the Swansea NHS Trust, together with the resulting synergies, had played a significant role in this achievement.

24. The C&AG noted in his Report that although the North Wales Health Authority itself was the only one in Wales to report a surplus in 1998-99, the area as a whole recorded a deficit of £1.8 million. The Accounting Officer cited to us a number of reasons for the relatively strong financial position of North Wales Health Authority. For example, the area benefited from the current resource allocation formula, with funding to the area being higher than the Welsh average. Mr Gregory also pointed to the relative lack of complexity of the healthcare environment in North Wales, reflected in the simpler healthcare system required compared, for example, with that of south Wales. Relationships between the health authority and its various trusts were comparatively straightforward and there was a clear demarcation of each trust's area of responsibility, which is not true of south Wales. In conclusion, Mr Gregory reported that financial management within the area’s NHS bodies was of a high standard.

25. Our main findings, conclusions and recommendations on the financial health of the five Welsh health authority areas are as follows:

(i) We note the complex range and inter-relationship of the factors that directly influence the performance of each of the five health authority areas;

(ii) We concur with Mr Gregory that the isolation of the NHS Trusts within Dyfed Powys from the debts of the health authority was not an effective method of financial control. In the event that NHS trusts require additional financial assistance from the Assembly in future, we recommend that the NHS Directorate consider carefully the way in which such funding is routed, so as to ensure that it is utilised effectively and for its intended purposes, having regard to the need for transparency and

27 C&AG’s Report, Appendix D, paragraphs D.3 and D.4
28 Q49 and 50
29 C&AG’s Report, Appendix E, paragraph E.1
30 Q53
31 Q54
openness;

(iii) Whilst we note the planned recovery agreed with the Dyfed Powys Health Authority and three of the four NHS trusts in that area, we share Mr Gregory’s concerns regarding the financial performance of Carmarthenshire NHS Trust, both in terms of its current financial position and also the failure to achieve an agreed recovery plan for that trust. We urge that the NHS Directorate work closely with both the trust and Dyfed Powys Health Authority to rectify urgently any failings in their Recovery Plan; and

(iv) We consider that the existing resource allocation mechanism has outlived its usefulness and does not adequately address the various and differing cost pressures that affect NHS bodies across Wales. We therefore urge the NHS Directorate, in close consultation with the Health and Social Services Committee, to act speedily on the results of the ongoing review of the funding formula and to put in place a system that accommodates such factors and provides for fair and equitable annual financial settlements.

Clinical negligence

26. Clinical Negligence is a breach of duty by healthcare practitioners in the performance of their duties in the NHS. The Comptroller and Auditor General reported that the total forecast maximum cost of claims for clinical negligence rose sharply during 1998-99, from £145 million to £214 million at 31 March 1999 (this estimate includes both probable and possible payments). The Accounting Officer suggested to us that this increase was due to two factors: the increasing propensity of individuals to seek legal redress; and the rising levels of compensation payable in such cases.

27. Prior to taking legal action in cases of alleged clinical negligence, patients may seek redress through the NHS Complaints Procedure and, if still dissatisfied, then bring their complaint before the Health Service Ombudsman for Wales. Mr Gregory reported that at the final stage of the Complaints Procedure, when these cases are considered by an independent review panel, a common weakness identified is the poor quality of communication between clinician and patient. He suggested that one important criterion affecting an individual’s decision to make a formal claim for compensation is the manner in which their complaint may have been handled, and the degree of openness encountered in disclosing the facts of the patient’s case to them.
28. The issue of clinical negligence is closely linked to the concepts of clinical effectiveness and clinical governance, within the context of improving the quality of care within the NHS. Mr Gregory outlined a number of mechanisms which support this objective, including the National Institute of Clinical Excellence, tasked with the review of the clinical and cost-effectiveness of new and existing treatments, and the Commission for Health Improvement responsible for the review of the quality of care. He also noted that the Welsh Risk Pool is responsible for the ‘Risk Managers Network’, whose membership includes representatives from all NHS bodies in Wales, and which discusses possible improvements in the management of incidents and disseminates examples of best practice.

29. The Welsh Risk Pool has also taken the lead in promoting effective risk management across the NHS in Wales, including a series of Risk Management Standards applicable to both health authorities and NHS trusts. In 1998-99, however, the Comptroller and Auditor General found that only ten of the 21 member bodies submitted a self-assessment of their performance against these standards. The Welsh Risk Pool has also taken the lead in promoting effective risk management across the NHS in Wales, including a series of Risk Management Standards applicable to both health authorities and NHS trusts. In 1998-99, however, the Comptroller and Auditor General found that only ten of the 21 member bodies submitted a self-assessment of their performance against these standards.

30. Our main findings, conclusions and recommendations on the issue of clinical negligence are as follows:

(i) There appear to us to be two main areas of focus in controlling the growing incidence and cost of clinical negligence in the NHS in Wales: the prompt and cost-effective handling of existing outstanding claims, and the effectiveness of risk management procedures to avoid new claims arising in the first place. We consider that the NHS Directorate has made insufficient progress in both these areas, and stress the potential for improvement through responding to future relevant findings of both the National Institute for Clinical Excellence and the Commission for Health Improvement. We strongly recommend that the NHS Directorate take action to identify and disseminate examples of best practice in financial management across NHS Wales;

(ii) We are deeply concerned to note that only half of the NHS bodies in Wales submitted self-assessments, reporting compliance with the Risk Management Standards, although we recognise the impact that trust reconfiguration at that time may have had on this poor level of response; and
(iii) We also consider that the procedures for complaint by patients or their relatives in the event of an unsatisfactory clinical outcome could and should be improved. We believe that more open and early communication between clinicians and patients is the key to resolving many negligence claims and preventing the need for legal action. Greater transparency in the disclosure of medical details to a complainant should become the standard and we encourage the NHS Directorate to address this issue in part through changes in the education and training of medical staff.

Fraud

31. The incidence of fraud within the NHS is a key concern, resulting in a significant loss of resources that could otherwise be spent on patient care. Although an All-Wales Anti-Fraud Working Group exists, with a remit to develop a fraud strategy and to disseminate examples of best practice in tackling fraud across Wales, the Accounting Officer acknowledged that little progress had been made in addressing fraud in Wales. In 1998-99, detected fraud in Wales totalled only £102,000; whereas based on England's detected fraud for that year in respect of prescription charge evasion alone, a proportionate estimate for the likely fraud in Wales for this same type would be some £8-10 million. Mr Gregory told us that the level of detected fraud was clearly significantly understated, and reflected the limited work undertaken to date in this area.

32. Mr Gregory informed us of the negotiations underway with the Directorate of Counter Fraud Services, the body within the NHS Executive responsible for tackling fraud and corruption within the NHS in England, which were exploring the possibility that its remit might be extended to cover Wales. Subsequent to this Committee hearing, the First Secretary has announced that those negotiations have been completed, and the NHS in Wales will now be included with the work of the Directorate of Counter-Fraud Services.

33. Our main findings, conclusions and recommendations on the issue of fraud are as follows:

(i) We are very concerned at the lack of progress to date in tackling fraud in the NHS in Wales. We therefore welcome the recent announcement by the First Secretary that the monitoring of fraud and corruption within the NHS in Wales will fall within the extended remit of the Directorate of Counter Fraud Services;

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38 C and AG's report, para 5.21
39 Qs 72 and 73
40 Q 74
41 Assembly press Notice (referncce WOO 345-hlt) issued on 10th April 2000
We are astonished that levels of detected fraud are so low (£102,000 in 1998-99; £950,000 (estimate) in 1999-2000), and agree with the NHS Directorate that this can only represent a small fraction of the actual total. We consider that significant improvements are needed in the detection and prevention of fraud. We urge the NHS Directorate to tackle this problem as a matter of urgency, and in particular to consider the potential use of "spend to save" incentives which would allow any savings generated to be released directly for patient care; and

We also observe that actions taken in tackling fraud to date have generally addressed primary care only, and that only recently has the All-Wales Anti-Fraud Working Group considered the issue of fraud within the secondary care sector. We encourage the NHS Directorate also to address the risks of fraud within the secondary care sector, taking due account of the relative inherent risks of fraud arising.

The cost of primary care drugs

34. The Comptroller and Auditor General reported that the cost of drugs prescribed by GPs in Wales, which for 1998-99 totalled some £318 million, has risen annually at a rate in excess of inflation. Also, per capita rates of prescribing are significantly higher in Wales than in England, even in areas of comparable deprivation.

35. Mr Gregory told us that the Assembly has been trying to control these costs, including through the recent appointment of a ‘Task and Finish Group’ established to consider the scope for improving the efficiency and effectiveness of prescribing in Wales. This Group is due to report its findings in June 2000, and is expected to produce a strategy for dealing with this issue over the next three to four years.

36. Our main findings, conclusions and recommendations on the issue of the cost of primary care drugs are as follows:

(i) We note the recent steep increases in the cost of primary care drugs, and acknowledge the steps taken by the NHS Directorate to mitigate this, including the appointment of the Task and Finish Group. We strongly recommend that the Group’s findings are reviewed as a matter of priority and, where appropriate, implemented by the NHS Directorate at the earliest opportunity; and

(ii) Other options are also available to tackle the rising costs of primary care drugs, and we urge the NHS Directorate to develop a coherent strategy, including the consideration of issues such as the greater use of generic

\[42\] C & AG's report paragraph 8.2 to 8.4

\[43\] Qs 84 and 85
drugs, joint formula redevelopments, prescribing incentive schemes and the incidence of repeat prescribing

Summary of Recommendations

37. In the light of our findings and conclusions, we make the following recommendations:

On the overall financial health of the NHS in Wales

(i) We encourage the NHS Directorate to work more closely with health bodies across Wales, providing genuine strategic management and leadership for the service;

(ii) We look to the NHS Directorate to take action to ensure that NHS trusts are able to achieve the forecast savings available from the reconfiguration of NHS trusts in Wales, and note our intention to review closely the success of this programme in due course;

(iii) We urge the NHS Directorate to take appropriate action to ensure that all NHS bodies comply with the CBI Supplier Payment Code of Practice, acting in accordance with Government policy in this regard;

On the financial health of the five Welsh health authority areas

(iv) In the event of NHS trusts requiring additional financial assistance from the Assembly in the future, we recommend that the NHS Directorate channel that support directly to the trusts concerned;

(v) In respect of the Carmarthenshire NHS Trust, and its current financial difficulties, we urge that the NHS Directorate work closely with both the trust and Dyfed Powys Health Authority to rectify urgently any failings in their Recovery Plan particularly in regard to the level of realism in the Plan and to ensure protection of patients’ services.

(vi) The existing resource allocation mechanism has outlived its usefulness and does not adequately address the various and differing cost pressures that affect NHS bodies across Wales. We therefore urge the NHS Directorate, in close consultation with the Health and Social Services Committee, to act speedily on the results of the ongoing review of the funding formula and to put in place a system that accommodates such factors and provides for fair and equitable annual financial settlements;

On clinical negligence

(vii) As regards the management of clinical negligence by the NHS in Wales, we strongly recommend that the NHS Directorate take action to identify and disseminate examples of best practice in financial management across NHS Wales;
Greater transparency in the disclosure of medical details to a complainant should become the standard. We encourage the NHS Directorate to address this issue in part through changes in the education and training of medical staff and to take a leadership role in developing a culture of openness and good communication;

**On fraud**

The total cost of fraud in the NHS in Wales is not known, and significant improvements are needed in the detection and prevention of fraud. We urge the NHS Directorate to tackle this problem as a matter of urgency, and in particular to consider the potential use of "spend to save" incentives which would allow any savings generated to be released directly for patient care;

The main focus in tackling fraud to date has been in the primary care sector. We encourage the NHS Directorate to address the risks of fraud within the secondary care sector as well, taking due account of the relative inherent risks of fraud arising;

**On the cost of primary care drugs**

We recognise that the NHS is taking steps to control the increasing cost of primary care drugs. The Task and Finish Group is investigating this area, and we strongly recommend that the Group’s findings are reviewed as a matter of priority and, where appropriate, implemented by the NHS Directorate at the earliest opportunity;

Other options are also available to tackle the rising costs of primary care drugs, and we urge the NHS Directorate to develop a coherent strategy, including the consideration of issues such as the greater use of generic drugs, joint formula redevelopments, prescribing incentive schemes and the incidence of repeat prescribing.

**Summary**

38. The National Health Service is our most precious institution. Its reputation has suffered in recent years, and this has been due in no small part to poor financial performance. This cannot be allowed to continue.

39. The National Health Service must rebuild its reputation by delivering high standards of healthcare for the people of Wales within the resources made available to it by the National Assembly. We therefore urge the Assembly’s NHS Directorate and health service managers, clinicians and staff to do all they can to promote good financial management, including taking more proactive steps to minimise the incidence and cost of clinical negligence, reduce the level of fraud, and secure value for money. In particular, we expect to see a swift end to the continuing spiral of financial deficits that have been reported by health authorities and NHS trusts in recent years.

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Cynulliad Cenedlaethol Cymru
Pwyllgor Archwilio

The National Assembly for Wales
Audit Committee

The National Health Service in Wales
Y Gwasanaeth Iechyd Gwladol yng Nghymru

Cwestiynau 1-86
Questions 1-86

Dydd Iau 6 Ebrill 2000
Thursday 6 April 2000
Dechreuodd y cyfarfod am 9.33 a.m.
The meeting began at 9.33 a.m.

[1] Janet Davies: I welcome everyone to this meeting. The purpose of the meeting is to take evidence in connection with the report by the Comptroller and Auditor General, NHS (Wales) Summarised Accounts 1998-99, published on 19 March 2000.

This report went to Parliament but the Public Accounts Committee decided to refer it to us as the Assembly’s Audit Committee. I particularly welcome a new member of the Committee, Lorraine Barrett. Jane Davidson has also joined the Committee, but is unable to attend today. She sends her apologies. Dafydd Wigley is expected shortly.

I welcome our witnesses. Will you introduce yourselves?

Mr Gregory: I am Peter Gregory, Director of NHS Wales. Consequently, I am also the accounting officer for moneys voted to the NHS by Parliament in the case of these accounts and, in the case of the last and current financial year, by the Assembly. I am also head of the NHS Directorate in the National Assembly for Wales.

Ms Beaver: I am Sarah Beaver, head of the Assembly’s NHS Finance Division.

Croesawaf ein tystion. A wnewch gyflwyno eich hunain?

Mr Gregory: Peter Gregory, Cyfarwyddwr NHS Cymru wyf i. O ganlyniad, fi hefyd yw'r swyddog cyfrifo ar gyfer unrhyw arian y maes yr Senedd yn achos y cyfrifon hyn a'r Cynulliad, yn achos y flwyddyn ariannol ddiwethaf a'r flwyddyn ariannol gyfredol, yn cytuno ei roi i'r NHS. Fi hefyd yw pennydd Nghyfarwyddiaeth yr NHS yng Nghynulliad Cenedlaethol Cymru.

Ms Beaver: Sarah Beaver, pennaeth Is-adrann Cyllid yr NHS y Cynulliad wyf i.
Janet Davies: We will now have a demonstration of how to use the translation facilities.

There are five parts to this report. The first is concerned with the overall financial health of the NHS in Wales. We have an awful lot to get through in this session, and hope to have a coffee break in the middle, so we will get started straight away.

This question is to Peter Gregory. Part 4 of the Comptroller and Auditor General’s report sets out the worsening financial position in the national health service in Wales. Why is it that overall deficits of around £20 million have occurred in each of the last few financial years?

Mr Gregory: Thank you, Chair. I realise that we have a lot to cover, but this is central to much of what we have to discuss this morning, and as a consequence perhaps I could spend a little time on that question because it is so fundamental. In doing so, I draw the Committee’s attention to the NHS stocktake report, published in July last year. I asked that that be made available to Committee members. I am

Mr Gregory: Diolch, Gadeirydd. Yr wyt yn ymwbyddol bod gennym lawer o waith i’w wneud, ond mae hyn yn ganolog i lawer o’r hyn y maen nhad inni ei drafod y bore yma, ac o’r herwydd efallai y gallwn dreulio ychydig o amser ar y cwestiwn hwnnw gan ei fod mor sylfaenol. Wrth wneud hyn, tynnaf sylw’r Pwyllgor at adrodiad cloriannu’r NHS, a gyhoeddwyd ym mis Gorffennaf y llynedd. Gofynnais
not sure whether they have received it. They have? Good. I think that it would be helpful for Committee members to refer to that document. It was a requirement of the then First Secretary that we examine independently this was done by the Assembly’s Policy Unit the circumstances by which this situation had arisen. The document is a pretty exhaustive account of the reasons and in much of what I have to say I will be relying on the evidence adduced in the stocktake.

The first thing to be said about the general context is that the situation in Wales in respect of financial pressure is not unique in the developed world. Most healthcare systems have come under increasing pressure over the last few years, and we have seen the effects of that in other European countries in terms of turbulence between government and healthcare professionals. That is occasioned by both rising public expectations of what should be available, a number of cost drivers which will doubtless come out during the course of this discussion and iddo fod ar gael i aelodau'r Pwyllgor. Nid wwf yn siwr a vdynt wedi ei dderbyn. Ydynt? Da iawn. Credaf y byddai o gymorth i aelodau o'r Pwyllgor gyfeirio at y ddogfen honno. Fe'i gwnaethpwyd yn ofynnol gan y Prif Ysgrifennydd bryd hynny inni gynnal ymchwiliad annibynnol gwnaethpwyd hyn gan Uned Bolisi'r Cynulliad i'r amgylchiadau a arweiniodd at y sefyllfa hon. Mae’r ddogfen yn rhoi adroddiad eithaf cynhwysfawr o'r rhesymau a byddaf yn dibynnau ar y dystiolaeth a gyflwynwyd yr yr adroddiad cloriannu ar gyfer llawer o’r hyn y byddaf yn ei ddweud.

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a natural desire on the part of Government to drive efficiency and effectiveness in healthcare. In the United Kingdom the situation has reflected all of that and the NHS in Wales is not unique in being confronted with financial difficulty or even with the creation of deficits. There have been deficits in other NHS systems over the last few years. I think that it is true to say that all four national health services in the UK last year recorded or are forecasting income and expenditure deficits.

That is the general picture. To turn to specifics, the NHS in Wales has been confronted with financial difficulty for some time. This is not a new phenomenon. Back in the 1980s there were serious financial difficulties in both Gwynedd and Mid Glamorgan district health authorities, which had to be tackled by effective action by the then Welsh Office. What is, I think, special about the situation with which we are confronted, is that the financial pressures have had such a significant cost a fydd yn dod i’r amllwg, yn ddiwch, yn ystod y drafodaeth hon ac awydd naturiol ar ran Llywodraeth i wthio effeithlonrwydd ac effeithiolrwydd mewn gofal iechyd ymlaen. Mae’r sefyllfa yn y Deyrnas Unedig wedi adlewyrchu hyn oll ac nid yw’r NHS yng Nghymru yn unigryw yn y ffaith ei fod yn wynebu anawsterau ariannol neu hyd yn oed ei fod yn cynhyrchu diffygion. Bu diffygion mewn systemau NHS eraill dros yr ychydig flynnyddoedd diwethaf. Credaf ei bod yn gywir dweud bod pob un o’r pedwar gwasaeth iechyd gwladol yn y DU y llynedd wedi cofnodi diffygion incwm a gwariant neu eu bod yn eu rhagweld.

Dyna’r sefyllfa gyffredinol. I droi at faterion penodol, bu’r NHS yng Nghymru yn wynebu anawsterau ariannol ers tro. Nid ffenomenon newydd mohoni. Yn ôl yn y 1980au, bu anawsterau ariannol difrifol yn awdur dawd i iechyd dosbarth Gwynedd a Morgannwg Ganol ac yr oedd yn rhaid i’r Swyddfa Gymreig ar y prydein byd y cubauch i’w efeithiol i fynd i’r afael â’r rhain. Yr hyn sydd yn arbennig am y sefyllfa yr ydym yn ei hwnebu, yn fy marn i, yw bod y
impact at the national level. That is a distinguishing feature. I also think that it is true to say that the protracted nature of that pressure is also distinctive. In preparation for this hearing I did a little research into the surplus deficit position of the NHS in Wales over the years, and although it has become most acute most recently and that is partly to do with the degree to which liquidity in the system has been absorbed by the need to tackle deficits deficits can be traced back for several years. In other words, the NHS has found it difficult to come to terms with a number of cost drivers in the system.

I will not, Chair, go through all the issues that arise out of the stocktake at this juncture, as I am sure that Committee members will want to tease them out. Suffice it to say that the stocktake’s analysis is that the origins of the problem and the difficulties of successfully addressing it are the consequences of a complex matrix of issues that iterate and interact with one another. There is no single distinguishing feature that you can pluck out and say, ‘well, if only they

pwysau ariannol wedi cael effaith mor sylwedol ar y lefel genedlaethol. Mae honno’n nodwedd unigryw. Yr wnf hefyd o’r farn ei bod yn gywir dweud bod natur estynedig y pwysau hwnnw hefyd yn nodwedd unigryw. Wrth baratoi ar gyfer y gwrandawiad hwn, gwneuthum ychydig o ymchwil i sefyllfa gwarged diffyg yr NHS yng Nghymru dros y blynyddoedd, ac er mai yn ddiweddar iawn y bu’r sefyllfa fwyaf difrifol ac mae hynny’n rhanol oherwydd y graddau y mae’r angen fynd i’r afael â diffygion wedi amsugno hylifedd y system gellir olrhain diffygion ers sawl blwyddyn. Hynny yw, bu’r NHS yn ei chael yn anodd i ddod i delerau â nifer o ffactorau sydd yn llywio cost yn y system.

Ni fyddaf, Gadeirydd, yn trafod pob un o’r materion sydd yn deillio o’r adroddiad cloriannu yn awr, gan fy mod yn siwr y bydd aelodau’r Pwyllgor am eu harchwilio fesul un. Digon yw dweud mai dadansoddiai yr adroddiad cloriannu yw bod gwreiddiau’r problem a’r anawsterau o fynd i’r afael â hi yn llwyddiantus yn deillio o gyfuniad cymhleth o faterion sydd yn ailadrodd ac yn rhychweithio â’i gilydd. Nid oes un ffactor unigryw y gallwch ei dynnu allan a dweud, ‘wel,
had done that, it would have solved the
problem’. There are up to 18 to 20
elements that have resulted in this
outcome. What we have here is a broad
context of financial pressure and
something of a history of difficulty in
tackling the problem, which has
become more acute in recent years. It
is a pretty sophisticated causation.
Perhaps I could stop at that juncture,
and allow other questions.

complex factors, to what extent do you
think that inadequate funding is the
root cause of these recurring deficits?
Or are they due to poor financial
management? You have said that it is a
far more complex issue, but do you
think that these are two important
parts of that complex problem?

Mr Gregory: I think that it is important
for me to say, when talking about
inadequate funding, that whatever the
level of funding, the NHS must manage
within it. At one level, in terms of
financial management, the issue of
inadequacy is irrelevant. Government
the Assembly in the current situation
takes decisions about the allocation of

cyfeirio at ffactorau cymhleth, i ba
raddau y credwch fod ariannu
annigonol wrth wraidd y diffygion hyn
sydd yn allddigwydd? Neu ai rheoli
ariannol gwael sydd wedi eu hachosi?
Yr ydych wedi dweud ei fod yn fater
llawer mwy cymhleth, ond a vydch yn
credu bod y rhain yn ddwy ran bwysig
o’r problem gynhleth honno?

Mr Gregory: Credaf ei bod yn bwysig
imi ddweud, wrth siarad am ariannu
annigonol, waeth beth fo lefel yr
ariannu, mac’n rhaid i’r NHS reoli o
fewn y lefel honno. Ar un lefel, o ran
rheoli ariannol, nidyw’r mater o
ariannu annigonol yn berthnasol.
Mae’r Llywodraeth y Cynulliad yn y
sefyllfa bresennol yn gwneud
resources between programmes and those programmes are expected to keep within their cash limits. At the all-Wales level that is in fact what we have done. However, there is then the issue of the relationship between the resources provided and need and cost in the healthcare system. That is a very big debate and it is one that can only really be satisfactorily answered through the kind of review of the resource allocation process upon which the Health and Social Services Committee is just about to embark. We can elaborate on that, Chair, but it is pretty deep water.

Looking at what the stocktake has said, and from my experience of this situation, I think that, in terms of adequacy, the allocations made to the NHS in recent years not last year or this year, but in previous years have generally been tighter than hither to. There was a definite tightening of the financial environment in the mid to late 1990s. Allied to that was a requirement, which goes back several years, for the NHS to achieve cash releasing efficiency savings. Those savings were at levels 3 per cent for two years, and 2.7 per cent for the
following year, in the mid 1990s that
the NHS found extremely difficult to
achieve in year.

I think that the final element, in talking
about adequacy, is that the relationship
between the NHS and the Welsh Office
during most of the 1990s certainly until
the mid to late 1990s was founded on
the operation of an internal market in
healthcare. That, for reasons which I
am happy to elaborate on, made it
more difficult to establish an open and
mutual assessment of real cost. In
other words, it was not very easy to
establish between ourselves and the
NHS a clear notion of what the true
level of cost was in the NHS. If you add
it all up tightening financial
allocations, relatively high levels of
assumed efficiency plus differences of
view about the realism of cost
assumptions made in the allocations
you have a pretty formidable set of
challenges in terms of financial
management. I think that, if you look
at the levels of efficiency expected, look
at the way the deficits arose and add in
all the other factors, you will see a
degree of correlation between those

Credaf mai’r elfen olaf i’w nodi, wrth
drafod digonolrwydd, â bod y
berthynas rhwng yr NHS a’r Swyddfa
Gymreig yn ystod yr rhan fwyaf o’r
1990au yn bendant hdy at ganol a
diwedd y 1990au yn seiliedig ar
weithredu marchnad fewnol mewn
gofal iechyd. Yr oedd hynny, am
resymau yr wyf yn fodlon ymhelaethu
arnynt, yn ei gwneud yn anos pennu
asesiad agored o’r nauill ochr a’r llall
o’r costau gwirioneddol. Hynny yw,
nid oedd yn hawdd iawn inni a’r NHS
bennu amcan clir o lefel wirioneddol
costau yn yr NHS. Os ydych yn
ystyried pob peth tynhau dyrianaidau
a’r ariannol, lefelau cymharol uchel o
effeithlonrwydd tybiedig ynghyd â
gwahaniaeth barn ynglyn â realaeth y
tybiannau cost a gafwyd yn y
dyrianaidau dyna ichi gyfres o heriau
eithaf anodd o ran rheoli ariannol. Yn
fy marn i, os ystyriwch y lefelau
effeithlonrwydd a ddigwylwyd
edrych ar y modd y cynyddodd y
diffygion ac ychwanegu’r holl
factors and the way in which the
deficits occurred.

that the new structure helps to
overcome some of the factors?

Mr Gregory: I think that it goes a very
substantial way towards doing so. I
want to make it clear, Chair, that I am
not making a party political point in
saying this. I believe that although
there were the difficulties that I
described with the internal market, it
brought some benefits in terms of
focusing operational responsibility at
the local level. However, I am quite
clear that the complexity of the
financial management arrangements
created by the internal market
particularly, if I may say so, a
contracting relationship, which by its
nature is likely to be competitive, but
also the creation and development of
general practitioner fundholding and
the way in which that took
responsibility for financial allocation
away from health authorities to an
extent, but without giving fundholders
responsibility for the totality of the

felly bod y strwythur newydd yn
cynorthwyo i oresgyn rhai o’r
ffactorau?
expenditure inevitably had the effect of making financial management more difficult and more complex to achieve.

We are still working out the present arrangements. I will not pretend that we have everything buttoned down. However, I am quite clear that there has been a very significant transformation in the relationship between what is now the Assembly and the NHS in respect of the openness and candour with which we look at the real level of cost in the NHS. I am quite confident that, if directors of finance in the NHS and Sarah Beaver were to compare notes on the levels of cost implied by current levels of activity, drug increases and so on, their estimates would be pretty close. In fact, we have done such an exercise. I think that we were a couple of million out it was at that sort of level.

That changes the nature of the relationship in two ways. First, it means that we are all using the same information to make an appreciation about the choices that have to be made. It makes a very significant transformation to prioritisation between programmes between meeting

crynswth wedi arwain yn anochel at wneud rheoli ariannol yn anos a mwy cymhleth i’w gyflawni.

Yr ydym yn parhau i weithio ar y trefniadau presennol. Ni honnaf ein bod wedi datrys popeth. Fodd bynnag, yr wwf yn gwbl sicr bod y berthynas rhwng y NHS a’r Cynulliad, fel y mae bellach, wedi cael ei thrawsnewid yn sylweddol yn y modd yr ydym yn ystvried lefel wirioneddd costau yn yr NHS mewn ffordd agored a gonest. Yr wwf yn eithaf ffyddiog y byddai amcangyfrifon cyfarwyddwyr cyllid yn yr NHS o lefelau cost y mae lefelau gweithgaredd cyfrifol, cynnydd mewn cyffuriau ac ati yn eu hawgrymu yn eithaf tebyg i amcangyfrifon Sarah Beaver petaent yn cymharu eu ffigrwyr. Yn wir, yr ydym wedi cynnau ymarfer o’r fath. Credaf mai ychydig o filiynau oedd rhyngym cymharu yr oedd ar y math hwnnw o lefel.

Mae hynny’n newid natur y berthynas mewn dwy ffordd. Yn gyntaf, mae’n golygu bod pwb yn defnyddio’r un wybodaeth i bws o a mesur y dewisiadau y mae’n rhaid eu gwneud. Mae’n trawsnewid y modd y caiff blenoriaethau rhwng rhaglenni eu pennu yn sylweddol rhwng cwrddd â
real cost or putting money into service development. However, it also means that, if we are looking at cost in a more open and realistic way, that has consequences for the extent to which we can make decisions about finance. That may seem a slightly arcane point. However, the truth of the matter is, I think, that in the past there has been a sense in which Government and I am talking about UK national Government has had its own calculations, for instance, about inflation related to gross domestic product, and has made its own assumptions about inflation in the NHS, which have not been sufficiently sensitive to local variation. There is significant variation in cost pressures within the NHS. What we have now, I believe, is a very much more open dialogue with the NHS, which exposes those costs much more effectively and allows us to have much greater confidence that we are reflecting the real pressure inside the NHS when we come to make decisions about allocation. It does have the consequence of limiting, to an extent, the money that is then available for service development and central initiatives.

chost wirioneddol neu ddyrannu arian i ddatblygu gwasanaethau. Fodd bynnag, mae’n golygu hefyd bod goblygiadau yng Nghyfrifiannau raddau y gallwn wneud penderfyniadau ynglyn ag arian os ydym yn ystyried cost mewn ffordd fwy agored a realistig.

Efallai bod hynny i’w glywed yn bwyt braidd yn astrus. Fodd bynnag, y gwir amdani, yn fy marn i, yw y bu ymdeimlad yn y gorffennol bod y Llywodraeth a chyfeirio yr wyf at Llywodraeth genedlaethol y DU yn gwneud ei chyfrifon ei hun, er enghraifft, yng Nghymru a chwyddiant yn ymwneud â chynnryrch mewnwlod crynsyth, a bu’n dod i’w chasgliadau ei hun ynglyn â chwyddiant yn yr NHS, heb fod yn ddigon sensitif i amrywiadau lleol. Mae cryn amrywiaeth o ran pwysau costau yn yr NHS. Yr hyn sydd gennym yn awr, yn fy marn i, yw dialog llawer mwy agored â’r NHS, sydd yn amlygu’r costau hynny’n llawer mwy effeithiol ac sydd yn ein galluogi i fod yn llawer mwy fwyddog ein bod yn adlewyrchu’r pwysau gwirionedddol o fewn yr NHS pan fyddwn yn gwneud penderfyniadau ynglyn â dysanu arian. Un o oblygiadau hyn yw ei bod yn cyfyngu, i raddau, ar yr arian sydd ar gael wedyn i ddatblygu
Janet Davies: I realise that we are spending a lot of time on this question, but I think that it is so crucial that we need to establish.

Mr Gregory: It is quite fundamental.

Janet Davies: There are two Members who want to ask something else. Brian will ask his questions first, then Peter.

Brian Gibbons: Yes, two things. The one thing that you did not mention is the impact of capital charges on the NHS, because that is all part of the internal market. I wonder if you would like to say what effect you thought capital charges had. Did they serve a useful function? Do they still serve a useful function? And to whom do capital charges the money go back?

The second thing is that the stocktake said that one of the criticisms was that the Welsh Office at the time was not sufficiently equipped to be able to monitor what was going on because of the downsizing of the activities going on there. Do you think that the ability of the Assembly centrally to do that has improved and, if so, how has that
Mr Gregory: If capital charges work efficiently, their impact should be neutral. It is only to the extent that they do not operate neutrally that they cause difficulties. I think that it is entirely appropriate that the NHS should be required to take decisions about expenditure, particularly about investment, and the utilisation of physical resources. It should be required to do that on the basis of a proper economic appraisal and appreciation of what those decisions and what that utilisation mean. Capital charges are a way of achieving that. I think that they have had a significant benefit in that respect, because they force people to understand that keeping a hospital half empty has a particular effect. It represents an opportunity cost.

I think that difficulties could arise in two ways. One is the extent to which capital charges properly reflect the real costs of utilisation or initiatives. I am not arguing that the capital charges regime itself is absolutely perfect. There may come a time when we need to look at it. The other thing is that the
capital charges regime can have unintended effects in 'destabilising' is too strong a word, but in adding to the volatility of NHS finance. We have seen that with the opening of the Royal Glamorgan Hospital. That has had a significant effect a capital charges effect on the Pontypridd and Rhondda NHS Trust and on Bro Taf Health Authority. In the allocations that we are making this year, we are having to take steps to try to neutralise that effect because it would otherwise mean that patient care services would have to be reduced in order to fund the balance. I think that what I am saying here is that, in principle, you need some such mechanism to make sure that decisions about investment and utilisation are taken with a proper economic appreciation but that there are attendant difficulties in that. Some of those can actually be quite severe year on year.

On the Welsh Office’s role in all of this, in the 1980s and into the 1990s, the Welsh Office I was involved in this with my predecessor, John Wyn Owen had developed a particular approach to the general management function in Y mater arall yw y gall y drefn taliadau cyfalaf esgor ar effeithiau annisgwyl wrth mae ‘dadsefydlogi’ yn air rhy gryf, ond wrth ychwanegu at gyfnwedioldeb cyllid yr NHS. Yr ydym wedi gweld hynny yn sgil agor Ysbty Brenhinol Morgannwg, Mae hvnnwy wedi cael effaith sylweddol effaith taliadau cyfalaf ar Ymddiriedolaeth NHS Pontypridd a’r Rhondda ac Awdurddod Iechyd Bro Taf. Wrth ddyranu arian eleni, mae’n rhaid inni gymryd camau i niwtraiddio’r effaith honno neu fel arall byddai’n golygu y byddai’n rhaid cwtogi ar wasanaethau gofal i gleifion er mwyn ariannu’r gweddill. Credaf mai’r hyn yr wyf yn ei ddweud yma yw bod angen, y ran egwyddor, rhyw fecanwaith o’r fath i sirchau y caiff penderfyniadau ynglŷn â buddsoddiad a defnydd eu gwneud yng ngoleuni arfarniad economiadd priodol ond bod anawsterau ynglŷn wrth hynny. Mae rhai ohonynt yn gallu bod yn eithaf llym fflywyddyn ar ôl blwyddyn.

Ynglŷn â rôl y Swyddfa Gymreig yn hyn o beth, yn yr 1980au ac ar ddechrau’r 1990au, yr oedd y Swyddfa Gymreig yr oeddwn yn cyrffodi rhai yn hyn gyda’m rhagfalfaenydd, John Wyn Owen wedi datblygu ymagwedd
the NHS. That was one that was based upon the notion of the NHS being a corporate entity and also that that corporate enterprise was to improve health in Wales. Strange although it may seem, both of those were actually rather idiosyncratic at the time. They have become common currency since.

The creation of the internal market had an inevitable consequence for the notion of corporacy and collective enterprise. At the same time, there was in 1994, as you will recall, a very significant drive to reduce management costs. In fact, that was led by Wales and the then Secretary of State for Wales. That meant both reductions in costs inside the NHS, which led to the reorganisation of health authorities, and costs within the Welsh Office. I was in my present job at that time and the costs bore particularly heavily on my part of the office, with the result that we had to undertake a quite significant change in our relationship with the NHS. The stocktake report discusses this to some extent. The effect of that was to substantially withdraw the Welsh Office’s health department, as it then was, from what had been its strategic

bu gobygyiadau anochel ar gyfer y cysyniad o gorfforaetholdeb a chyd-fenter yn sgil creu’r farchnad fewnol. Ar yr un pryd, yn 1994, yr oedd ymgvyrch sylweddol iawn, fel y cofiwch, tuag at leihau costau rheoli. Yn wir, Cymru ac Ysgrifennydd Gwladol Cymru ar y pryd a arweiniodd y gad yn hynny o beth. Golwgai hynny ostyngiadau mewn costau o fewn yr NHS, a arweiniodd at ad-drefnu’r awdurddodau iechyd, a chostau o fewn y Swyddfa Gymreig. Yr oeddwn yn fy swydd bresennol bryd hynny ac yn fy rhan o’r swyddfa yr oedd costau’n hynod o feichus. O’r herwydd bu’n rhaid inni newid ein perthynas â’r NHS gryn dipyn. Mae’r adroddiad clorianu yn trafod hyn i raddau, Effaith hynny fu tynnu adran iechyd y Swyddfa Gymreig, fel yr oedd ar y pryd, i raddau helaeth, oddi wrth ei rôl rheoli strategol, fel yr oedd wedi bod,
management role and to rely, as a consequence, on the NHS itself through the relationship between health authorities and trusts to manage issues such as regional acute services. At one time, those services were led by the Welsh Office. I, at one stage, held the post of manager of regional services. During the course of the period that I am describing, the Welsh Office had to give up its role in that respect and it was passed out to the health authorities who did it collectively. That eventually led to the creation of the special health services commissioning group led by Gillian Todd, which is now responsible for it. That is one example of a number of ways in which the centre was downsized with, ultimately, a significant impact on our ability to strategically manage the NHS.

[8] Brian Gibbons: Has it improved?

Mr Gregory: I am glad to say that it has. The structure of the organisation has been changed. We have been reviewed and I now think that we are in better organisational shape. We have had a significant increase in the

[8] Brian Gibbons: A yw wedi gwella?

Mr Gregory: Mae’n dda gennyf nodi ei bod wedi gwella. Mae strwythur y sefydlad wedi ei newid. Yr ydym wedi cael ein harolygu ac mae ein sefyllfa drefniannol wedi gwella. Cawsom gynnydd sylweddol yn yr adnoddau
resources that are available for staffing, although that is still working through. We have also changed the relationship with the NHS. It is only relatively recently that I have felt it possible, because of the development of a better relationship with the NHS, to assume the kind of what I will describe as a leadership role, for want of a better expression, with the NHS that I believe is necessary. I now meet all NHS chief executives every month for a business meeting that is of the kind that you might imagine that the management board of a large company might have. That relationship is relatively new but it has rebuilt the kind of relationship that used to exist something like eight to 10 years ago.


[10] Peter Black: Yes. I just want to try to clarify some points and ensure that I understand what you are saying. You must excuse me if I simplify this. I have a very simple mind when it comes to these things. It seems to me that you are saying that the creation of an internal market, combined with the downsizing of the central
administration of the national health service at the Welsh Office level, effectively created a very complex financial management structure within the NHS that made it very difficult to manage these deficits. As a result, those deficits were created. Would that be a fair summary?

Mr Gregory: Almost, but not quite in terms of the last bit. I think that you have summarised well what I was trying to say about the relationship and the way in which the financial management system worked. That did not cause the deficit. I think that all of that was one of the reasons why the other causes that I have described in terms of efficiency rising levels of activity and so on were much more difficult to deal with. Listening to the way that you summarised it, I think that, although it is inevitably my responsibility as the accounting officer to ensure the good financial management of the NHS, the kind of leadership role that that implies in terms of leading service development, performance management and all of those issues came not to be expected. So what you have is a complex weave of pressures and causation and, on top of that, a withdrawal from the kind of

gwasanaeth iechyd gwlad ar lefel y Swyddfa Gymreig, wedi arwain at greu strwythur rheoli ariannol cymhleth iawn o fewn yr NHS a oedd yn ei gwneud yn anodd iawn i reoli’r diffygion hyn. O ganlyniad, cynhyrchwyd y diffygion hynny. A fyddai hynny’n grwynode teg?

Mr Gregory: Bron iawn, ond nid yn gyfan gwbl o ran y darn olaf. Credaf eich bod wedi rhoi crynodeb da o’r hyn yr oeddwn yn ceisio ei ddweud ynglyn â’r berthinynas a’r modd yr oedd yr system rheoli ariannol yn gweithredu. Ni achosodd hynny’r diffyg. Credaf fod hynny oll yn un o’r rhesymau pam yr oedd yn llawer anos ymdrin â’r achosion eraill a ddisgrifiais o ran effeithlonrwydd lefelau gweithgaredd yn cynyddu ac ati. Wedi gwrando ar y ffordd y buoch yn ei grynhoi, er mai fy nghyfrifoldeb i wrth reswm fel y swyddog cyfrifo yy sicrhau rheolaeth ariannol dda yr NHS, credaf nad oedd disgwyl bellach y math o ról arweiniol a fyddai ymhlyg wrth hynny o ran arwain datblygiad gwasanaeth, rheoli perfformiad a’r holl faterion hynny. Yr hyn sydd gennych yw pwysau a phroses achos yn cydblethu ac, ar ben hynny, tynnnu’n ôl o’r math o ról rheoli strategol y byddai ei hangen i ymdrin
strategic management role that would have been needed to deal with it effectively, plus, actually, a much more sophisticated financial management system in any event. Those three things came together.

[11] Peter Black: So the situation was that you became aware that these deficits were building up, but you felt unable to do anything about it because you did not have that leadership role?

Mr Gregory: I would not say that we felt that we could not do anything about it. We felt that things needed to be done and, for several years, we sought to do so. There was a context within which that had to be done. I am quite happy to explain to the Committee why that itself was very difficult to achieve. It was not a matter of our abdicating our responsibility. I am describing a general situation within which still as the accounting officer I had to take the action that I felt was necessary. That included requiring from the health authorities and trusts that were clearly in difficulties a financial recovery planning process that would deliver. We had umpteen meetings, discussions...
and rather difficult dialogue between the health department and individual health authorities and trusts about that. Therefore, we felt engaged in trying to tackle the problem but that was against a background of a more sophisticated financial management system and an assumption that strategic management was not the nature of our job.

[12] Peter Black: So you are saying that you tried to tackle the deficits, but the structure that you had to cope with made it almost impossible to do so?

Mr Gregory: No. That sounds like a kind of displacement strategy, which is not what I am about. I think that you have to add into all of this what the political environment was in which this was being acted out. If you look at the way in which deficits rose they started to become acute at the national level from 1995 onwards, and became most evident in around 1996-97 you had, and I am now quoting from the stocktake report, an approach to a general election, a referendum on devolution, elections to the Assembly...
and trust reconfiguration. All of that made the whole context within which any service response to the financial difficulty became more difficult. I think that what happened in Dyfed Powys in that period, where the health authority tried very energetically to respond to the financial difficulties it was facing, was that it fell foul of that political context.

I think that one of my regrets is that we did not foresee in a sufficiently sophisticated way that trying to be energetic and pretty hard-nosed about tackling these problems in the way in which the health authority did the first time round and this was in the run up to the election, and involved a plan that said quite openly that services would have to contract; community hospitals, you may remember, were said to have to close had a dramatic impact on the receptivity of the body politic in the area to the idea that that was necessary. There was a reaction against it and it sent a very powerful message to the rest of the NHS, that if you want to tackle financial problems, contracting services, dealing with it with a service-driven approach would
not actually work. The consequence was that the political response I am using ‘political’ in terms of community and not party politics; the local response would be a better expression would be so antipathetic that it would gridlock. You would never move out of that situation.

It has taken us a long time to overcome that, to re-establish the relations that I described earlier and to start to frame a new approach to tackling difficult issues inside the NHS which others have described as participative governance. That is, a way of going about community involvement in an ownership of problems of the kind that need to be faced in order to deal with financial difficulties. It has taken us a long time to develop that. The experience of Powys is a very good example of the attempt to do that, but even that is not without its difficulties and its traumas.

[13] Janet Davies: Thank you. I have two Members who want to come in on
this, but I really think that we need to move on a bit. Alison, can I ask you to come in?

[14] Alison Halford: Yes. I do not mind who answers these questions, Mr Gregory. It has been touched on already that in 1996-97, as you know, there were five health authorities and 30 trusts. The number of trusts has now been halved to 15, with a view to reducing administration costs. What has been saved by this reconfiguration and is there scope to reconfigure the five health authorities and reduce them in number?

Mr Gregory: I will happily answer both those questions, but can I make one point about the way in which you framed the question? I would want to challenge the notion that trust reconfiguration was simply about saving money. It was not.

[15] Alison Halford: We have the questions to put to you. If you do not like the question, move on to the bit that you do like.

Mr Gregory: Thank you very much. I appreciate that. If I could just

[14] Alison Halford: Cewch. Nid oes gwahaniaeth gennyf pwy sydd yn ateb y cwestiynau hyn, Mr Gregory. Soniwyd eisoes bod pum awdurdod a 30 ymddiriedolaeth yn 1996-97, fel y gwyddoch. Cafodd nifer yr ymddiriedolaethau ei haneru bellach i 15, gyda’r bwriad o leihau costau gweinyddol. Faint o arian a arbedwyd yn sgîl yr ailgyflunio hwn ac a oes lle i ailgyflunio’r pum awdurdod iechyd a lleihau eu nifer?

Mr Gregory: Yr wyf yn fodlon ateb y ddau gwestiwn hynny, ond a gaf wneud un pwynt yng Nghymru i’r modd y lluniasoch y cwestiwn? Hoffwn herio’r syniad mai arbed arian oedd unig nod ailgyflunio’r ymddiriedolaethau. Nid yw hynny’n wir.

[15] Alison Halford: Mae’r cwestiynau gennym ni i’w gofyn ichi. Os nad ydych yn hoffi’r cwestiwn, symudwch i’r rhan yr ydvch yn ei hoffi.

Mr Gregory: Diolch yn fawr iawn. Yr wyf yn gwerthfawrogi hynny. Os caf
elaborate my point, we were very, very clear when we launched trust reconfiguration and we did it in a way that was radically different from the way in which trusts had been formed and the way in which trust reconfiguration was done in the other countries of Great Britain. We did it led by the Welsh Office. This was going back to strategic management; it was the re-engagement of strategic management. We did it principally because we believed that there were patient care advantages in bringing trusts together in the way that we eventually did. I have to say that I would argue that, notwithstanding the difficulties that we had last winter, we would have had very much greater difficulties in handling the pressures, had we not brought trusts together in the way that we did.

Moving on to what has been saved, in the last financial year the trust reconfiguration process actually cost money and was expected to do so. In fact, that was one of the reasons why we had the level of deficit that we did. I believe from memory that the net cost was around £4 million. This year, we

ymhelaethu ar fy mhwynt, yr oedd yn sicr iawn, iawn pan lansiasom ailgyflunio’r ymddiriedolaethau ac fe’i gwnaethom mewn modd a oedd yn hollol wahanol i’r modd y lluniwyd ymddiriedolaethau a’r modd y'u hailgyfluniwyd yng ngwledydd eraill Prydain Fawr. Gwnaethom hynny o dan arweinyddiaeth y Swyddfa Gymreig. Yr oedd hyn yn dychwelwch at reoli strategol; ailglydiwyd mewn rheoli strategol. Fe’i gwnaethom yn bennaf oherwydd ein bod o’r farn fod manteision o ran gofal i gleifion yn deillio o ddod â’r ymddiriedolaeth au ynghyd yn y modd a wnaethom yn y pen draw. Mae’n rhaid imi ddweud y byddwn yn dadlau, er gwaethaf yr anawsterau a gawsom y gaeaf diwethaf, y byddem wedi cael anawsterau llawer dwysach wrth ymdopi â’r pwysau, pe na byddem wedi dod â’r ymddiriedolaethau ynghyd fel y gwnaethom.

Gan symud ymlaen at yr hyn a arbedwyd, yn y flwyddyn ariannol ddiwethaf, yr oedd y broses o ailgyflunio’r ymddiriedolaethau yn costio arian mewn gwirionedd ac yr oedd hynny yn ôl y disgwyl. Yn wir, dyna un o’r rhesymau am lefel y diffyg a gawsom. Yn ôl yr hyn a gofiaf, tua £4
are expecting trust reconfiguration to produce a benefit at around the same level. So, from a cost of about £4 million, we expect it to flip over to a saving of about £4 million. Over three years, we expect to get up to a recurrent saving of something like £6 million a year. That was all set out in the trust reconfiguration process and I will be looking to auditors to confirm that that has happened and is not just assumed to be in the system.

Mr Gregory: Having done it once already, I cannot say that at a personal level I have an enormous amount of appetite for it. In my experience, I have taken the NHS through its biggest structural and policy change probably in its history and certainly since 1974. I think that it is generally

Alison Halford: So having had such a success with the reduction of the trusts, what about the health authorities?

[16] Alison Halford: Felly a chithau wedi cael llwyddiant o’r fath wrth leihau nifer yr ymddiriedolaethau, beth am yr awdurdodau iechyd?

Mr Gregory: Ar ôl gwneud hynny unwaith eisoes, ni allaf ddweud ar lefel bersonol fod llawer o chwant gennyf at hynny. Yn fy mhosodiad, yr wyf wedi arwain yr NHS drwy’r newid mwyaf o bosibl yn ei hanes, yn bendant ers 1974, o ran strwythur a pholisi. Credaf ei fod, yn gyffredinol

[17] Alison Halford: Can I ask you, yes or no?

[17] Alison Halford: A gaf ofyn ichi, ie neu nage?
Mr Gregory: The impact of putting organisations through reorganisation is generally underestimated. I think that part of our deficit problem is down to the fact that trusts have been restructured. I would still defend that decision, but I think that it is part of it. If you put health authorities through another reorganisation at a time of acute pressure and financial difficulty, you will exacerbate those problems.

[18] Alison Halford: That is helpful. I will move on, as we only have a limited amount of time. I am grateful for that answer. The report on which we are working forecasts a deficit for 1999-2000 of £26.2 million. I am sure that you know that figure well. Can you provide an update of this estimate and explain to this Committee what can be done to tackle what appears to be a worsening financial situation?


Mr Gregory: Just as a matter of comparison, the Comptroller and Auditor General’s audited figure for 1998-99 was £21.7 million. Our current forecast for 1999-2000, and I expect it to be £22.5 million. That is a genuine improvement.

to come in at around this figure, is £20 million. Therefore, it is about £6 million less than we told the National Audit Office in December that we thought the figure was.

The answer to the second half of your question, I am afraid, cannot be so brief. I am clear in my own mind that as a result of the measures that we have taken, partly prompted by the stocktake but also by work that Sarah Beaver was already doing in collaboration with the NHS, the position was more or less stabilised this last financial year. It certainly was in terms of financial performance. For this current financial year, 2000-01, we have a highly provisional estimate and you will understand all of the kind of equivocation and caveats that one has to attach to this that the out-turn this financial year without the budget would have been slightly less than £20 million. I guess that it would be somewhere around £18 million. With the budget, for reasons that I can explain, it is very much more satisfactory than that. I would argue, I think, as a consequence, that the measures that we have put in place had done what we had intended in our first
strategy, which was to staunch the flow of blood, if I can put it that way. The second part is how do you put in place measures to put things right. You look at the stocktake report, you go through its analysis of the problems and you make sure that you are successfully tackling each of them. I can take the Committee through that if you would like.

[19] Alison Halford: No. I will stop you there. We are just touching on vast subjects. I have a brief to ask particular questions, so forgive me for being so rude. Should the accumulated deficits of the NHS in Wales be written off and, if so, what is the impact on the Assembly’s available financial resources?

Mr Gregory: Sorry?

[20] Alison Halford: Should the accumulated deficits be written off? If that is your recommendation, what does that mean to the Assembly’s available financial resources?

Mr Gregory: You have to be careful about terminology here.

Alison Halford: A ddylid dileu diffygion cronedig? Os ydych yn argymell hynny, beth fydd yr effaith ar yr adnoddau ariannol sydd ar gael i’r Cynulliad?

Mr Gregory: Mae’n ddrwg gennyf?

Alison Halford: A ddylid dileu diffygion cronedig? Os ydych yn argymell hynny, beth fydd yr golygu i’r adnoddau ariannol sydd ar gael i’r Cynulliad?

Mr Gregory: Mae’n rhaid ichi fod yn ofalus ynglyn à therminoleg yma.
Mr Gregory: I just want the Committee to be clear about what my answer is seeking to achieve. There are two separate financial descriptors here, if I can put it that way. One is deficit, which is, if you like, the difference between the ongoing cost of an organisation and its ongoing income. The other is debt. That is the extent to which it has had to borrow from another party, in this case the Welsh Office or the Assembly, in order to provide cash to bridge between those recurrent income and expenditure deficits. So far as the accumulated deficit is concerned, there is a process by which when new trusts are set up the Comptroller and Auditor General mentions this in his report income and expenditure deficits are written off. That is a process that has occurred recently and should see a modest reduction in the accumulated deficit because of write off. That is a natural process and I do not believe that it is for me to say whether deficits should be written off because there is actually a legal duty
Alison Halford: Somebody has to pay, do they not?

Mr Gregory: There is a legal duty on trusts to break even. That means that if they get into a deficit position, they ultimately have to make a surplus in order to provide the liquidity, as it were, in the system that brings them back into balance. So far as debt is concerned, that is really a political decision for the Assembly and not one for me.

Alison Halford: Mae'n rhaid i rywun dalu, onid oes?

Mr Gregory: Mae dyletswydd cyfreithiol ar ymddiriedolaethau i adennill eu costau. Mae hynny'n golygu, os ydwnt yn cyrraedd sefyllfa diffyg, bod yn rhaid iddynt gynhyrchu gwarged yn y pen draw er mwyn sicrhau hylifedd, fel petai, yn y system, a fydd yn eu cydbwyso o'r newydd. Cyn belled ag y mae dyled dan sylw, penderfyniad gwleidyddol i'r Cynulliad ydyw mewn gwirionedd ac nid imi.

Alison Halford: I will not push any further on that one. I will ask a simpler question, perhaps. The report notes that 25 of the 26 trusts failed on one or more of the three financial objectives that you set them. Four trusts failed on all three financial objectives. Could you please tell us why the performance was so poor?

Mr Gregory: The direct answer to that is because they were coping with the financial difficulties that I described. The consequence of that was that they were unable to meet their duties to

Alison Halford: Ni phwysaf ragor ar hynny. Gofynnaf gwestiwn symlach o bosibl. Mae'r adroddiad yn nodi bod 25 o blith y 26 ymddiriedolaeth wedi methu â chyflawni un neu fwy o'r tri amcan ariannol a bennwyd ar eu cyfer gennych. Methoddd pedair ymddiriedolaeth â chyflawni pob un o'r tri amcan ariannol. A allech ddweud wrthym pam bod y perfformiad mor wael?

Mr Gregory: Yr ateb unioңyrchol i hynny yw oherwydd eu bod yn ymgodymu à'r anawsterau ariannol a ddisgrifiadau. O ganlyniad i hynny, nid oeddent yn gallu cyflawni eu
break even, to return a rate of interest and to contain external financing limits expenditure within the set limits. I must say that the three of the four EFL breaches were highly marginal. They went over if you look in the annex to the summarised accounts by £1,000. That is a reportable offence. I would not say that it is a capital offence. One has to take that into account. As far as the rest are concerned, trusts naturally found it extremely difficult to cope in the financial environment that they faced. The benefit of having a trust financial regime of the kind that we have is that the information you have described is so much clearer. There is no hiding the fact that the great majority of trusts were unable to meet their statutory duty to break even.

[24] Alison Halford: We have mentioned the stocktake a great deal. We were told that the Secretary of State for Wales introduced it in February 1999. It was an interesting report. Do you not think that you should have been proactive and
dyletswyddau i adennill costau, ad-dalu cyfradd llog a chyfyngu gwariant ar derfynau ariannu allanol o fewn y terfynau a bennwyd. Mae’n rhaid imi ddweud y bu tri o blith y pedwar yn torri terfynau ariannu allanol o ychydig iawn yn unig. Aethant £1,000 yn uwch na’r terfyn os edrychwch ar yr atodiad i’r cyfrifon cryno. Mae hynny’n drosedd y gellir ei chofnodi. Nid yw’n drosedd ddihenydd yn fy marn i. Mae’n rhaid vstyried hynny. Cyn belled ag y bo’r gweddi di anod, yr oedd ymddiriedolaethau, wrth reswm, yn ei chael yn anodd dros ben i ymdopi â’r amgylchedd ariannol yr oeddent yn ei wynebu. Y fantais o gael trefn ariannol ymddiriedolaethol o’r math sydd gennym yw bod yr wybodaeth a ddisgrifiwyd gennych yn llawer cliriach. Nid oes modd celu’r ffaith fod y rhan fwyaf o’r ymddiriedolaethau wedi methu â chyflawni eu dyletsywydd statudol i adennill costau.

undertaken such a report yourself rather than leave it to a political master?

Mr Gregory: I think that having political backing for such an exercise was likely to make it more effective. Alun Michael’s intervention at that point was one of the decisive elements in the efforts to achieve financial balance.

[25] Alison Halford: You do not see it as a shortcoming in your own management performance?

Mr Gregory: I would not want to affect to this Committee that as the accounting officer I do not have a responsibility for the situation. I would not want to affect that. On the other hand, given what I have said about the withdrawal from strategic management, and the very significant reduction in staffing, I think that having to have completed this exercise on top of managing the problem was beyond our capacity, frankly. It was for that reason that I so very much welcomed the fact that this was an independent review run by the Policy Unit of the Assembly, as it became.
Alison Halford: I have almost finished. I have a couple more questions. What actions have you been able to take on the main recommendations of the stocktake report?

Mr Gregory: I have gone through the report to tease out every major cause that it ascribes to the deficit. I am confident that in every single respect we are currently undertaking the necessary response to that. There is an awful lot of it. Recognising what you said earlier about time, I am not keen to go through it in detail.

Alison Halford: I am sure that my colleagues will pick up points as necessary. The last question applies to the prompt payment of suppliers. It would appear that the NHS does not have a very good record in paying its suppliers quickly. Have you a comment on that? I can draw your attention to certain paragraphs but it appears that the NHS does not pay quickly. Thus the next question is, does that late payment by national health bodies cause a cash-flow problem for the companies that supply the NHS?
Mr Gregory: I think that the

[28] Alison Halford: Glan Hafren would be an example.

Mr Gregory: Absolutely. That is obviously the most extreme outlier. I think that there are others at the other end of the spectrum. Basically, the point I want to make is that I am not satisfied with the level of performance in this area and we shall be requiring, in the allocation letter that I hope will go out this week, much improved performance by the NHS in this area. So I am not satisfied with it and we have been monitoring this month by month and seeking to improve performance. The fact that we have not had as much effect as I would wish means that we will have to redouble our efforts and make the requirements on the NHS much stricter.

The second part of your question is more difficult. The great majority of health authority payments would actually be within the NHS itself. The issue is really about trusts. That, I think, was the main purpose of your question. In that respect, I would guess that the majority of trusts’ expenditure

Mae’r ail ran o’ch cwestiwn yn anos. Byddai’r mwyafrif helaeth o daliadau’r awdurdodau iechyd o fewn yr NHS ei hun. Mae’r mater yn ymwneud â’r ymddiriedolaethau mewn gwirionedd. Hwnnw, fe gredaf, oedd prif ddiben eich cwestiwn. Yn hynny o beth, byddwn yn dyfalu y

Mae’r ail ran o’ch cwestiwn yn anos. Byddai’r mwyafrif helaeth o daliadau’r awdurdodau iechyd o fewn yr NHS ei hun. Mae’r mater yn ymwneud â’r ymddiriedolaethau mewn gwirionedd. Hwnnw, fe gredaf, oedd prif ddiben eich cwestiwn. Yn hynny o beth, byddwn yn dyfalu y
would be on their own staff and the rest would be on large supplying companies. However, there will be trusts that will have contracts with smaller local companies and it is those in particular that I am concerned about. I have no evidence that companies are being put into difficulty by the NHS and given that the statutory framework within which all of this is acted out now gives companies the right to claim interest beyond the due date and since I am unaware of any interest being claimed my assumption, and it is only that, is that it is not having an effect. Having said that, I am conscious that that is a very generalised remark and someone will soon bring out of his or her pocket an example where I am wrong.

Mr Gregory: Absolutely. As it happens we have a meeting later this month and I was going to refer to this in the course of that.

[29] Alison Halford: Thank you. I imagine that when you have your monthly meetings with your health authorities, this might be a priority

Mr Gregory: Yn union. Fel mae’r ddiwyddiad, yr ydym yn cyfarfodiad o bosibl yn eich cyfarfodydd misol â’ch awdurdodau iechyd

[29] Alison Halford: Diolch. Tybiaf fod hyn yn flaenoriaeth o bosibl yn eich cyfarfodydd misol â’ch awdurdodau iechyd
Janet Davies: We now need to move on to look at the financial health of the five health authority areas and try to bring out some comparisons and differences between them. Looking at that first of all, the report shows the breakdown by health authority area of the £22 million deficit from 1998-99. Why do you think that there is such an apparent variation in the financial performance of the five health authority areas?

Mr Gregory: That is a very tricky question. The evidential basis on which one can make an assessment is not robust. It also depends and I do not wish to make a facetious response on who you ask. Whoever you ask is bound to have the most serious problems of all the trusts or health authorities. I say that slightly facetiously but there is a truth in it, in that everyone sees their particular problems as unique to themselves and much worse than anyone else’s. I think that as in my answer to your first question about the reasons for the overall deficits in the NHS in Wales, I would have to say that this has a number of features. I will go through them very quickly.
There are the effects of differential formula distribution to health authorities, differences in the quality of working relations between health authorities and trusts, the extent to which health authority areas had a high or relatively low percentage of GP fundholder practices and variations in the clinical situations of trusts. Some trusts are in highly competitive healthcare markets if I can use the old jargon and others are not. I think that there were variations in commitment to financial control. There are significant variations in the extent to which health authority areas are dependent on external services and that can have a significant impact on their ability to control the process of contracting. There are, self-evidently, differences of experience among senior executives and board members. Also, some areas are more dependent on the centre for specialised funding than others; that is particularly true of Swansea and Cardiff. There are very great variations in the effectiveness of efficiency measures. Now, if you put that matrix together, I think that you can see that there are a lot of factors that bear down on each health

Mae effeithiau dosrannu i awdurdodau iechyd drwy fformwla wahaniaethol, gwahaniaethau o ran ansawdd y berthynas waith rhwng yr awdurdodau a’r ymddiriedolaethau iechyd, i ba raddau yr oedd gan ardaloedd awdur-dod iechyd ganran uchel neu ganran gymharol isel o feddygfevddeilliaid cronfa ac amrywiadau o ran sefyllfa glinigol yr ymddiriedolaethau. Mae rhai ymddiriedolaethau mewn marchnadoddedd gofal iechyd cystadleuol dros ben os caf ddefnyddio’r hen ieithwedd ac maeraill nad ydynt yn y marchnadodedd hynny. Credaf fod yr ymrwymiad i reolaeth ariannol yn amrywio. Mae amrywiadau sylweddol o ran y graddau y mae ardaloedd yr awdur-dodau iechyd yn dibynnu ar wasanaethau allanol a gall hynny gael effaith sylweddol ar eu gallu i reoli’r broses contractio. Mae gwahaniaethau o ran profiad ymysg uchwraithredwyr ac acelodau bwrdd, wrth reswm. Hefyd, mae rhai ardaloedd yn fwy dibynnol ar y canol ar gyfer ariannu arbenigol nag eraill; mae hynny’n wir am Abertawe a Chaerdydd yn enwedig. Mae effeithirolrwydd mesurau
authority and each trust in different ways. It is not surprising, therefore, that there is that kind of variation. Perhaps I could leave it there for the time being, Chair. I think that that is enough of an introduction to that.

[31] Janet Davies: Perhaps the greatest difference between two health authorities is between Dyfed Powys and Gwent. Do you think that there are any fundamental differences between those two that account for the different reported performances?

Mr Gregory: I think that it would be possible to tease out differences between them in each of the areas that I have described. To give you an example, the first area that I mentioned was the formula distribution. Between 1996-97 and 1998-99, the average growth increase given to Gwent Health Authority over that period in each year, was 4.1 per cent. The average in Dyfed Powys was 3.1 per cent. I am not saying that that effeithlonrwydd yn amrywio’n fawr iawn. Yna, os cyfunwch hynny oll, credaf y gallwch weld bod llawer o ffactorau a fydd yn effeithio ar bob awdurdod iechyd a phob ymddiriedolaeth mewn gwahanol ffwrdd. Nid yw’n syndod, felly, bod amrywiaeth o’r fath yn bodoli. Efallai y tawaf ar y pwnc hwn am y tro, Gadeirydd. Credaf fod hynny’n ddigon o gyflwyniad i hynny.

[31] Janet Davies: Y gwahaniaeth mwyaf o bosibl rhwng dau awdurdod iechyd yw’r gwahaniaeth rhwng Dyfed Powys a Gwent. A oes gwahaniaethau sylfaenol rhwng y ddau awdurdod hynny, yn eich barn chi, sydd yn gyfrifol am y gwahaniaeth yn y perfformiadau a gofnodwyd?

Mr Gregory: Credaf y byddai’n bosibl canfod gwahaniaethau rhwng y ddau ym mhob un o’r meysydd yr wyf wedi eu disgrifo. I roi enghraifft ichi, y fformwla dosrannu oedd y maes cyntaf y cyfeiriais ato. Rhwng 1996-97 a 1998-99, 4.1 y cant oedd y cynnydd twf cyfartal a gafodd Awdudod Iechyd Gwent ym mhob blwyddyn yn ystod y cyfnod hwnnw. Yn Nyfed Powys, 3.1 y cant oedd y cynnydd twf cyfartal. Nid wyf yn dweud mai hwnnw oedd y
is the reason why Dyfed Powys, as a health care system, performed poorly and Gwent performed relatively well, but it seems to me that that is an important piece of information to consider when one is looking at the relativities of performance. If one went through all the other factors, I think that I could tease out ways in which there were differences not always to the benefit of Gwent but there would be differences, and if you add the sum of that up, you arrive at the kind of outcome that we have had.

[32] Janet Davies: Brian, I am going to leave you for the moment.

[33] Brian Gibbons: I have a question directly relevant to that.

[34] Janet Davies: Well, very quickly then.

[35] Brian Gibbons: Cases like Dyfed Powys are already on a higher allocation per capita so that you are almost saying that the more you get, the more you get.

Mr Gregory: Actually, the reverse is true in Dyfed Powys’s case, because

rheswm pam bod Dyfed Powys, fel system gofal iechyd, yn perfformio’n wael a bod Gwent yn perfformio’n gymharol dda, ond yn fy marn i, mae hwnnw’n ddarn pwysig o wybodaeth i’w ystyried wrth bwyso a mesur perfformiad. O ystyried yr holl ffactorau eraill, credaf y gallwn ganfod ffyrdd lle yr oedd gwahaniaethau eraill nid o blaid Gwent bob tro ond yr byddai gwahaniaethau, ac os ydych yn ystyried hyn oll, byddwch yn esgor ar ganlyniad o’r fath yr ydym wedi ei gael.

[32] Janet Davies: Brian, yr wyf am eich hepgor am y funud.

[33] Brian Gibbons: Mae gennyf gwestiwn sydd yn ymwneud yn uniongyrchol â hynny.

[34] Janet Davies: Wel, yn gyflym iawn felly.

[35] Brian Gibbons: Mae achosion fel Dyfed Powys eisoes yn derbyn dyraniad y pen uwch felly yr hyn yr ydych yn ei ddweud bron yr po fwyaf y cewch, mwyaf yr byd y cewch.

Mr Gregory: I’r gwrthwyneb yn achos Dyfed Powys, mewn gwirionedd
had it been kept to the formula allocation, the per capita gap to which you are quite right to draw attention between Dyfed Powys and other health authorities would have narrowed over the period. All that I am saying is that if you add all these factors up and look for differences between different health authority areas, you will see that those differences have an impact on the way in which financial performance occurs in those two areas.

[36] Alun Cairns: I would like to stick with Dyfed Powys Health Authority in the first instance. I understand that the district auditor has issued a report to management on the financial standing of Dyfed Powys Health Authority. What is your view of the financial position of the health authority?

Mr Gregory: I would prefer to talk about the financial health of the NHS in Dyfed Powys. The distinction that I am making is an important one, because the main the almost exclusive cost drivers for the health care system are actually in the trust, not in the health authority. The health authority has a number of roles, one of which is to act as the resource allocator between


Mr Gregory: Byddai’i’n well gennyn drafod iechyd ariannol yr NHS yn Nyfed Powys. Mae’r gwahaniaeth a nodaf yn un pwysig, gan fod y prif ffactorau bron pob un ohonynt sydd yn llwio cost ar gyfer y system gofal iechyd yn ymwneud â’r ymddiriedolaeth mewn gwirioneddd yn hytrach na’r awdurdod iechyd. Mae sawl rôl gan yr awdurdod iechyd. Un
the Assembly and the trusts. So if you are happy with that, I would prefer to talk about the totality of the health care system, rather than the health authority.

The second reason that I say that, is that the situation in Dyfed Powys, in terms of the financial information particularly the information recorded by the Comptroller and Auditor General is different from the rest of Wales for a particular reason. When the financial difficulties of Dyfed Powys as an area were becoming manifest, there was a decision to be taken about how the money to keep services running while recovery was planned was to be provided. Should that be done directly by the Welsh Office to trusts, or should it be done through the health authority? The decision that the then chief executive and I took was that the money should be directed through the health authority. The reason for that was that it was considered that the health authority would be able to exercise more control in its relationship with trusts as a consequence, if it were holding the money and passing it on to o’r rhain yw bod yn ddyrannwr adnoddau rhwng y Cynulliad a’r ymddiriedolaethau. Felly os ydych yn fodlon ar hynny, byddai’n well gennyf drafod y system gofal iechyd yn ei chyfanrwydd yn hytrach na’r awdurdod iechyd.

Yr ail reswm imi ddweud hynny yw bod y sefyllfa yn Nyfed Powys, o ran gwybodaeth ariannol yn enwedig yr wybodaeth a gofnodwyd gan y Rheolwr ac Archwilydd Cyffredinol yn wahanol i weddill Cymru am reswm penodol. Pan ddechreuodd anawsterau ariannol Dyfed Powys fel ardal ddod i’r amlwg, yr oedd yn rhoaid gwneud penderfyniad yngylch sut y gellid darparu’r arian yr oedd ei angen i’r gwasanaethau barhau i weithredu tra’n cynllunio’r broses adfer. A ddylid gwneud hynny’n unio gýrchol gan y Swyddfa Gymreig i’r ymddiriedolaethau, ynten a ddylid ei wneud drwy’r awdurdod iechyd? Penderfynodd y prif weithredwr ar y prydr a minnau y dyliol rhoi’r arian drwy’r awdurdod iechyd. Y rheswm dros hynny oedd ein bod yn ystyrwied y byddai’r awdurdod iechyd o ganlyniad yn gallu arfer mwy o reolaeth yn ei berthynas â’i ymddiriedolaethau pe bai’n dal yr arian a’i drosglwyddo i’r
trusts, rather than the trusts actually having two paymasters and conceivably being able to play them off one against the other.

So the financial information for Dyfed Powys although it is perfectly proper to account for it in the accounts in this way is actually a little misleading because it appears to suggest that the problems of Dyfed Powys lay exclusively in the health authority and they did not. To give you an example, we have made some calculations I am now looking at 1998-99, which is the year in question of a total deficit for the area of something like £11.5 million, which in the accounts is quite properly recorded against the health authority, because that is actually where the money went. Our calculation and I believe that this is accepted locally is that the deficits recorded at trust level, which you will see from the Comptroller and Auditor General’s reports are quite modest, were actually very significant. To give you just one example, our belief was, if you had translated the money given to the health authority and passed on to the trust, into, as it were, deficit incurred by way of funding directly from the Assembly, then Carmarthen’s deficit

ymddiriedolaethau, yn hvtrach na bod gan yr ymddiriedolaethau ddau dâl-feistr ac yn gallu chwarae’r naill yn erbyn y llall efallai.

Felly mae’r wybodaeth arianol ar gyfer Dyfed Powys er ei bod yn gwbl briodol iddo roi cyfrif amdani yn y cyfrifon yn y modd hwn ychydig yn gamarinol gan ei bod yn awgrymu, fe ymddengys, mai’r awdurddod iechyd a oedd yn gwbl gyfrifol am broblemau Dyfed Powys ond nid yw hynny’n wir. I roi enghraifft ichi, yr ydym wedi cyfrifo ac yr wyf yn awr yn cyfeirio at 1998-99, sef y flwyddyn dan sylw cyfanswm diffyg o dau £11.5 miliwn ar gyfer yr ardal sydd yn cael ei gofnodî yn y cyfrifon gan mai i’w goffrau ef yr aeth yr arian mewn gwirionedd. Yn ôl ein cyfrifon a chredaf fod hyn wedi cael ei dderbyn yn lleol mae’r diffygion a gofnodwyd ar lefel yr ymddiriedolaethau, y gwelwch eu bod yn gympharol Fach yn ôl adroddiadau’r Rheolwr ac Archwilydd Cyffredinol, yn rhai sylweddol iawn mewn gwirionedd. A rhoi un enghraifft yn unig ichi, pe baech wedi trosglwyddo’r arian a roddwyd i’r awdurddod iechyd a’i drosi i’r ymddiriedolaeth fel diffyg a gafwyd,
would have been £3.5 million. So for each of the trusts, although the deficit was carried at health authority level, the financial position was significantly worse. This is a long preamble to answering your question, but unless one understands the background, I do not think that the answer is discernible.

[37] Alun Cairns: In the rest of your answer, can I ask you then, do you consider the isolation of the trusts from the debt an effective method of financial control?

Mr Gregory: No. I think that that is a perfectly fair point to make. I think that, on reflection, while the decision that we took at the time was against a background of difficult relations between the health authority and its trusts we felt that it would be appropriate to strengthen the health authority’s role in all of this and that that was an appropriate way of doing it. I fear that what it did, to some extent, was to engender a sense in the trusts that the financial envelope that they were dealing with was much bigger than it actually was, if you see what I mean.

[37] Alun Cairns: Am weddill eich ateb, a gaf ofyn ichi fel y pwynt holol deg. Wrth edrych yn ôl er bod y penderfyniad a wrengwyd gennym ar y pryd wedi ei wneud yng ngoleuni’r berthynas anodd rhwng yr awdurddod iechyd a’i ymddiriedolaethau credaf inni deimlo y byddai’n briodol atgyfnerthu rôl yr awdurddod iechyd yn hyn o beth a bod hynny yn fodd priodol o wneud hyn ofnaf mai’r hyn a gyflawnodd i raddau oedd rhol amcan i’r ymddiriedolaethau bod yr amlen ariannol yr oeddent yn ymwneud â hi’n llawer mwy nag yr oedd mewn gwirionedd, os deallwch yr
mean, because the money the funding was coming through the system in the normal way, rather than being through an exceptional route of going to the Welsh Office. Although I think that these decisions are very finely balanced, I think, on balance, that it might have been better to have retained the system of dealing directly with trusts and that is what I intend that we should do for the future.

To get to the nub of your question, the budget will obviously make a very significant difference to the situation, but I know that both the Finance Secretary and the Assembly Secretary responsible are determined that we should see better financial performance and you do not do that by writing off everybody’s problems, so Dyfed Powys is still going to have to perform financially.

Looking at the trusts individually, perhaps I could just do a tour and tell you what I think about each one. I think that Powys has made very significant progress, and although we are still in dialogue with them to achieve a recovery plan that works, I would now be very surprised indeed, given the capital investment that we
are giving them, if Powys did not achieve a proper financial balance.

Ceredigion, and Pembrokeshire and Derwen, I am slightly more equivocal about. I have seen figures that demonstrate that they can come back into balance over the next two years. I know that both of the boards are committed to doing so, but I have not yet got the detailed recovery plan that gives me the confidence that they will deliver. I am not saying that they will not, but I need the recovery plan and I need to be able to assure myself that they will. I am a little more equivocal about that.

I have to say that the trust that is of concern to me, and I have said this to its senior staff, is Carmarthenshire. At the moment, Carmarthenshire’s financial performance is significantly off-line, and I am not confident yet that there is a financial plan in place or that one is going to be devised that will produce financial recovery. That is the trust, not just in Dyfed Powys but across Wales as a whole, that causes me the greatest degree of anxiety.

are giving them, if Powys did not achieve a proper financial balance.

Nid wyf yr un mor sicr ynglyn â Cheredigion, a Sir Benfro a Derwen. Yr wyf wedi gweld ffigurau sydd yn dangos eu bod yn gallu adennill cydbwysedd yn ystod y ddwy flynedd nesaf. Gwn fod y ddau fwrdd yn ymrwymedig i wneud hyn, ond nid wyf wedi derbyn y cynllun adfer manwl hvd yn hyn sydd yn fy narbwyllo y byddant yn cyflawni hynny. Nid wyf yn dweud na wnânt, ond mae arnaf eisiau’r cynllun adfer ac mae arnaf eisiau fy sicrhau y byddant yn gwneud hynny. Nid wyf yr un mor sicr.

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Mae’n rhaid imi ddweud mai Caerfyrddin yw’r ymddiriedolaeth sydd yn achosi’r pryder mwyaf imi, ac yr wyf wedi dweud hyn wrth yr uwch aelodau o’i staff. Ar hyn o bryd, mae perfformiad ariannol Sir Gaerfyrddin yn anghyson iawn, ac nid wyf yn argyhoeddig hyd yn hyn bod cynllun ariannol yn ei le neu y bydd cynllun yn cael ei lunio a fydd yn arwain at adferiad ariannol. Honno yw’r ymddiriedolaeth, nid yn unig yn Nyfed Powys ond ledled Cymru, sydd yn...
Mr Gregory: I have already had a meeting which was part of a pattern of meetings and had nothing to do with my appearance here this morning with the chair, the chief executive, the director of finance and the medical director, together with the chair of the health authority, the acting chief executive and the director of finance to review the situation. I told them that I was not satisfied with the recovery plan that they had produced. I also told them that I would be telling you that, so that it did not come as a complete bolt out of the blue. We have postponed meetings that we were to have had with other trusts in the area until the implications of the budget were worked through. Once we know that which I hope will be very shortly I will have another meeting with the trust at which I will expect it to put to me a recovery plan which will work. If that is not forthcoming then we will have to consider other measures which might be put in place to achieve it.
Alun Cairns: You mentioned earlier in your answer to one of my colleagues’ questions that trust reconfiguration was expected to cost some money and that it partly contributed to the deficits. Is that the case in terms of Dyfed Powys Health Authority?

Mr Gregory: It would be true of what is now Carmarthenshire NHS Trust because that brought together two trusts and there were costs in respect of that. I cannot from memory remember what they were but, yes, they would have.

Alun Cairns: So if it was expected to cost money, why was this not planned for, in relation to Dyfed Powys in particular, but also across the whole of Wales?

Mr Gregory: It was planned for in the sense that we knew, and so did the NHS, that these costs would occur. The decision was taken at the time that the costs should fall where they arose, and that as a consequence the trusts and the health authority should between them manage these costs. In fact, that is what has happened. Part of the reason why the income and
expenditure forecast in trusts this last financial year has improved, is that a number of health authorities have been more forthcoming than expected in meeting those costs. However, it was planned. The only issue, which perhaps lay behind your question, is that there was no intention to provide any supplementary funding from the centre from the Assembly to meet those costs.

Alun Cairns: I move now to Bro Taf Health Authority. It is forecasting a deficit of £6.1 million in 1999-2000, which will rise by another £17.4 million taking it to a total of £23.5 million in 2000-01. That trust will then become the worst in Wales. What steps have been taken to address this and how effective do you expect them to be?

Mr Gregory: The first thing to say is that I do not expect the position in Bro Taf to be anywhere as severe as you describe, for a variety of reasons.

Alun Cairns: How severe would you expect it to be?
Mr Gregory: That is rather difficult for me to say.

Mr Gregory: Mae braidd yn anodd imi ddweud.

[43] Alun Cairns: So how do you substantiate that it will not be as severe?

[43] Alun Cairns: Sut y gallwch felly gyfiawnhau dweud na fydd mor ddifrifol?

Mr Gregory: I will now try to do so. There are two reasons. The first is that had we not had the significant increase in financial resources in the budget, I calculate that the overall position of Bro Taf would have improved significantly because we had already reached agreement and this will be implemented in any event to deal with some of the cost pressures affecting Bro Taf which were caused by difficulties with the centre. I will explain that. Bro Taf has been affected by two particular cost pressures which are attributable to decisions by the Welsh Office or the Assembly.

One is the issue that I mentioned when Brian Gibbons asked me about capital charging. That has a significant effect on Bro Taf because of the Royal Glamorgan Hospital. We have an agreement with the NHS that we will allow that to happen but we are also going to take corrective action to neutralise the effect of that. So, that is

Un o’r penderfyniadau yw’r mater y cyfeiriaais ato pan gefais fy holi gan Brian Gibbons ynglyn â thaliadau cyfalaf a godir. Bu hynny’n cael effaith sylweddol ar Bro Taf oherwydd Ysbyty Brenhinol Morgannwg. Yr ydyn wedi cytuno â’r NHS y byddwn yn caniatáu i hynny ddiogewyd ond yr ydyn hefyd yn bwriadu cymryd camau unioni i
I think that all of those measures will reduce the position very significantly. I should say that I think that the £23 million was hopelessly overstated. I do not believe that that was a robust figure. I think that a more robust figure would have been somewhere like £16 million and, as a consequence of the measures we were proposing to take, that would again have come down to something like £7 million. I am not in a position to tell you what the impact of the budget will be in detail because we simply have not had the time to work it through with health authorities and trusts. However, I am confident the position in Bro Taf in 2000-01 will see a significant improvement again, though I think it will still be to an

Credaf y bydd yr holl fesurau hynny yn lleihau sefyllfa’r diffyg i raddau helaeth iawn. Dylwn nodi mai goramcangyfrif llwyrgedd y £23 milion, yn fy marn i. Ni chredaf fod y ffigur hwnnw yn un cadarn. Byddai £16 milion yn ffigur cadarnach, yn fy marn i, ac o ganlyniad i’r mesurau yr oeddwm yn bwriadu eu cymryd byddai’r ffigur hwnnw wedi disgyn eto i £7 milion yn fras. Nid wyf mewn sefyllfa i ddweud wrthych pa effaith a gaiff y gyllideb yn fanwl gan nad ydym wedi cael digon o amser mewn gwririonedd i’w chyfrifio gyda’r awdurddodau a’r ymddiriedolaethau iechyd Fodd bynnag, yr wyf yn hyderus y bydd sefyllfa Bro Taf yn gwella’n sylwedol unwaith eto yn

a significant benefit. The second is that we are also doing the same with a number of issues that arise in respect of the operation of the teaching trust what is now Cardiff and Vale NHS Trust. For instance, the special increment for training staff has in the past, in my judgment, not been accurately funded. We have an agreement with the trust to resolve that.
extent, although only marginally, in deficit.

2000-01, ond y bydd yn parhau i fod â rhywfaint o ddiffyg, er dim ond yn ffiniol, yn fy marn i.

[44] Alun Cairns: Are you saying that the extra money provided by the budget will be to clear that suspected £7 million deficit?

[44] Alun Cairns: A ddywedwch y bydd yr arian ychwanegol a ddarperir yn y gyllideb yn cael ei ddefnyddio i adadlu’r diffyg o £7 miliwn a amheuir?

Mr Gregory: I think that I must make it absolutely clear that the decisions that have been taken by the Secretary for Health and Social Services and the Finance Secretary have been decidedly not to bail out deficit areas. Inevitably, however, in order to reflect pressures across the NHS as a whole, the uplifts have had an effect of benefit to areas in deficit. However, I have no doubt that both Dyfed Powys and Bro Taf on the basis of the calculations that we can make at the moment will be faced with a collective deficit next year and both will still have to undertake measures to constrain costs and to address underlying problems. That will also be true for the succeeding year.

Mr Gregory: Credaf fod yn rhaid imi ei gwneud yn hollol eglur bod yr Ysgrifennydd Iechyd a Gwasanaethau Cymdeithasol a’r Ysgrifennydd Cyllid wedi gwneud penderfyniadau cadarn i beidio ag achub ardaloedd â diffygion. Yn anochel, fodd bynnag, er mwyn adlewyrchu’r pwysau ar draws yr NHS yn ei gyfanrwydd, elwodd ardaloedd â diffygion ar y codiadau. Fodd bynnag, nid oes unrhyw amheuaeth gennyf y bydd Dyfed Powys a Bro Taf ar sail y cyfrifiadau y gallwn eu gwneud ar hyn o bryd yn wnebu diffyg cyfunol y flwyddyn nesaf a bydd yn rhaid i’r ddau ohonynt ymgymryd â mesurau er mewn cyfngu ar gostau a mynd i’r afael â phroblemau sylfaenol. Bydd hynny’n wir yn y flwyddyn ddilynol.

[45] Geraint Davies: You have partly answered my question. The University Hospital of Wales serves the whole of Wales and I feel that the poor areas of

[45] Geraint Davies: Yr ydych wedi ateb fy nghwestiwn. Mae Ysbyty Athrofaol Cymru yn gwasanaethu Cymru gyfan a theimlaf fod yr
Bro Taf are paying a disproportionate price to maintain that facility. There should be a far better, equitable way of funding the University Hospital of Wales or perhaps it should be taken out of Bro Taf altogether and have a separate identity.

Mr Gregory: I think that the point that you are making is a fair one. The teaching hospital clearly has a special place. It has special problems and special costs. I would not seek to argue against that in the slightest. I doubt very much if the answer is to treat it so differently that you take it out of the system. I think that that would only cause further difficulties and would also exacerbate the relationship between it and the Assembly because you would not then have a proper planning context within which to consider it because you would have taken it out of what is its natural planning context. The point you make about the special pressures is one that we accept. It was because of that that we have revisited the allocation process in the way I described to Mr Cairns just now in order to better reflect the real cost of the University Hospital of Wales. The Health and Social Services Committee has taken a decision to

Mr Gregory: Credaf fod y pwnt a wnewch yn un teg. Mae gan yr ysbyty addysgu safle arbennig. Mae ganddo broblemau arbennig a chostau arbennig. Ni hoffwn ddadlau yn erbyn hynny o gwbl. Yr wyf yn amau’n fawr iawn mai’r ateb fyddai ei drin mor wahanol nes ei dynnu allan o’r system. Byddai hynny ond yn achosi anawsterau pellach, yn fy marn i, gan beri i’r berthynas rhygddo a’r Cynulliad waethygu hefyd oherwydd na fyddai cyd-destun cynllunio priodol gennych lle y gellir ei ystyried gan y bydddech wedi ei dynnu o’i chyd-destun cynllunio naturiol. Yr ydym yn derbyn y pwnt a nodwch ynglyn â phwysau arbennig. Oherwydd hynny yr ydym wedi dychwelyd at y broses ddyrannu yn y ffordd yr wyf newydd ei disgrifio i

Mr Cairns er mwyn adlewyrchu cost wirioneddol Ysbyty Athrofaol Cymru yn well. Mae’r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol wedi penderfynu arolygu’r broses dyrrannu
review as you know very well the resource allocation process. Part of that will have to be to look at the role of the teaching trust and to see to what extent the resource allocation process can be better retuned to its special circumstances.

[46] Peter Black: I want to touch on the remaining three trusts, starting with Gwent. Why is it that the Gwent Health Authority appears largely immune to the financial problems experienced by the other four health authorities in Wales?

Mr Gregory: It has not always been immune. In preparation for this, I was trying to remind myself of how it has fared in the past and there have been occasions when Gwent has had financial difficulties. However, I would say that the fact that Gwent has only had three trusts means that the relations between the commissioning authority, the health authority and its trusts are less complicated than they might be in other areas where there are more trusts. Generally speaking, relations have been reasonably good between the trusts and the health authority. I think that the trusts and

adnoddau fel y gwyddoch. Bydd yn rhaid ystyrwedi rôl yr ymddiriedolaeth addysgu fel rhan o’r arolwg a chanfod i ba raddau y gellir addasu’r broses ddyranu adnoddau yn ôl ei amgylichiau arbennig.

[46] Peter Black: Hoffwn grybwyl y tair ymddiriedolaeth sydd yn weddill, gan drafod Gwent yn gyntaf. Pam yr ymddengys fod Awdurdod Iechyd Gwent, i raddau helaeth, yn rhydd o’r problemau ariannol y mae’r pedwar awdurlog iechyd yng Nghymru yn eu hwynebu?

Mr Gregory: Ni fu’n rhydd o broblemau bob amser. Wrth baratoi ar gyfer hyn, yr oeddwn yn ceisio atgoffa fy hun o sut yr oedd wedi llywddo yn y gorffenol a bu adegau pan oedd anawsterau ariannol gan Gwent. Fodd bynnag, dywedwn fod y ffaith mai tair ymddiriedolaeth yn unig sydd gan Gwent yn golygu bod y berthnas rhwng yr awdurlog comisiynu, yr awdurlog iechyd a’i ymddiriedolaethau yn llai cymhleth nag y gallai fod o bosibl mewn ardaloedd eraill lle mae mwy o ymddiriedolaethau. Yn gyffredinol, bu’r berthnas rhwng yr
the health authority have been well led. There is not much of a central funding issue between the Assembly and Gwent. We do not get into the same difficulties over central funding as we do with University Hospital of Wales and Bro Taf and, as a consequence, Gwent has fared well. Good financial management has played its part in that but, over that period, there have been occasions when we have become concerned about the financial state of what was Glan Hafren. However, it has managed to resolve that in partnership with its health authority. That is what we need to see elsewhere, where there are greater problems.

Mr Gregory: As I said, Glan Hafren has been in deficit and it has got out of that...
deficit by establishing the kind of
to a mutual agreement on
the way through the problem and it
has managed that effectively. I am not
sure whether I can elaborate more,
other than to say that all the
circumstances that I described earlier
need to be teased out in respect of
Gwent. You will remember that I used
Gwent as the example of the health
authority area that had the best
benefits from the formula. Over the
last three years, it has had one
percentage point greater growth than
the worst health authority. That is
obviously a factor in its ability to cope
with cost pressure.

[48] Peter Black: Do you think that
another factor is that it does not pay its
bills on time?

Mr Gregory: That should not be the
case. I think that that is a perfectly fair
point, and I will put my hand up to
that, if I can use that expression.
However, that is not a sufficient excuse
because we make short-term loans
available to trusts to deal with that
problem. You can rest assured that we
have made it quite clear to the trust
that we are expecting performance to

hynny drwy sefydlu’r math o
berthynas â’i hawdurdod iechyd sydd
yn arwain at gytundeb rhwng y ddau
ar sut i ddatrys y broblem ac mae wedi
llywyddo i wneud hynny mewn modd
effeithiol. Nid wyf yn siwr a allaf
ymhelaethu rhagor, heblaw am
ddweud bod angen archwilio pob un
o’r amgylchiadau a dysgrifiais yn
gynharach fesul un mewn perthynas â
Gwent. Cofiwch imi ddefnyddio Gwent
fel enghraiff o’r ardal awdurdod
iechyd a oedd wedi ei arwain a y fformwla
fwyaf. Yn ystod y tair blynedd
ddiwethaf, cafodd dwf o 1 y cant yn
uwch na’r awdurdod iechyd gwaethaf.
Mae hwnnw’n ffactor o ran ei gallu i
ymdopi â phwysau cost.

[48] Peter Black: Ai ffactor arall, yn
eich barn chi, yw nad ydyw’n talu ei
biliau’n brydlon?

Mr Gregory: Ni ddylai hynny
ddigwydd. Credaf fod hwnnw’n bywnt
cwbl deg, a byddaf yn cyfaddef hynny.
Fodd bynnag, nid yw’n esgus digonol
gan ein bod yn cyflenwi beth y daethau
ymor byr i’r ymddiriedolaethau er
mwyn galluogi iddynt ddelio â’r
broblem honno. A gaf eich sicr hau ein
bod wedi ei gwneud yn gwbl eglur i’r
ymddiriedolaeth ein bod yn digwyl i’w
improve and my understanding although I do not have the figures in my head is that the overall Gwent position has improved previously in 1999-2000.

[49] Peter Black: I will now move on to an area that is dearer to my heart, as I am based in Swansea Iechyd Morgannwg Health Authority. Morriston Hospital NHS Trust is referred to in paragraph D.4 of the report and in the Comptroller and Auditor General’s report on the previous year’s accounts of 1997-98, he noted that a recovery plan was in place. Although I see that this trust is now forecasting a further deficit during the current recovery period, why has the planned recovery of this trust not occurred?

Mr Gregory: Recovery, generally speaking, takes a period of time to unwind, as I am sure that you understand. The difficulties of Morriston have been public and entrenched. My understanding of the current position, bearing in mind that Swansea is now the host to Morriston, is that the underlying deficit in that trust, in other words, what it inherited
from Morriston, has been substantially reduced in the last financial year. I cannot for the life of me remember what it is but it is around a million. You can see from that that the deficit problem at Morriston has not fully recovered but is substantially on the way to being recovered and I would be very disappointed if, in the current financial year, Swansea trust were not in financial balance, and as a consequence, had eradicated the Morriston deficit.

[50] Peter Black: Do you think that the merger of Morriston Hospital NHS Trust with Swansea has had an impact on the recovery process?

Mr Gregory: I think that the bringing together of those two trusts and the leadership that has been provided by its current management team has had a significant impact. Part of the problem with financial deficits in individual trusts is that they tend to be inwardly focused. The management response is very much preoccupied with the circumstances, the history and all that has gone before and also with the limitations on management’s own ability to cope. I know both hospitals and both management teams as they

gan Dreforys, wedi gostwng yn sylwedol yn ystod y flwyddyn ariannol ddiwethaf. Ni allaf yn fy myw gofio faint ydyw ond mae tua milion. Gallwch weld felly fod y diffyg yn Nhreforys heb ei adfer yn llawn ond mae ar y ffordd o gael ei adfer a bvddwn yn siomedig iawn pe na bai ymddiriedolaeth Abertawe, yn ystod y flwyddyn ariannol gyfredol, wedi adennill cydbwysedd ariannol, ac o ganlyniad, wedi dileu diffyg Treforys.

[50] Peter Black: A ydych o’r farn fod uno Ymddiriedolaeth NHS Ysbyty Treforys ag Abertawe wedi cael effaith ar y broses adfer?  

Mr Gregory: Credaf fod cyfuno’r ddwy ymddiriedolaeth hyn a’r arweinyddiaeth a gafwyd gan ei thîm rheoli cyfredol wedi cael effaith sylwedol. Un agwedd ar y broblem o ddiffygion ariannol mewn ymddiriedolaethau unigol yw bod ymddiriedolaethau yn tueddu i fod yn fewnblyg. Bydd ymateb y rheolwyr i raddau helaeth yn canolbwyntio ar yr amgylchiadau, yr hanes a’r cwbl a fu’n digwydd cyn hynny a hefyd ar allu’r rheolwyr eu hunain i ymdopi. Yr wyf yn adnabod y ddau ysbyty a’r ddau
were very well and they are very different. They have different roles clinically, different traditions and the atmosphere is different, as is the style of leadership. All those things mean that when you open the situation out and have a bigger organisation, you have a good chance of resolving the problem, as long as you have an effective management team, which is what I believe that we have at Swansea. That is why this has happened. There are synergies between the two hospitals that have helped, but at the end of the day, I think it is down to astute leadership.

Mr Gregory: I think that there has been quite a long history of difficulty

[51] Peter Black: As I understand it, Morriston has additional difficulties because it is effectively a regional centre and people go to Morriston from other health authority areas, in particular, Dyfed Powys. Do you know if there is any impact on the deficit as a result of that? Is Morriston effectively carrying some of the deficit for Dyfed Powys and other area health authorities?

Mr Gregory: Credaf y bu cryn hanes o anawsterau rhwng Treforys, fel yr
between Morriston, as it was, and Dyfed Powys Health Authority about what was an appropriate level of funding and those difficulties have become quite sore in recent years as I am sure that you know. However, Morriston’s problems were largely associated with the hospital’s internal financial dynamic its cost base and its inability to take costs out adequately as a consequence of service changes, which certainly goes back to 1996. There is also an element of difficulty over contracting between the trust and the health authority and I would not want to gainsay that. I do not believe that that is a major contributor; it is a contributor, but it is not the principal one or, in my judgment, even a major factor in the difficulties.

[52] Peter Black: Therefore, you think that it is a very minor proportion of the deficit?

Mr Gregory: I am perfectly happy to provide the Committee with information on the relativities but that would involve adjudicating between the Swansea and the Dyfed Powys views of the situation. I am quite happy to do that, but if you look at the deficit that arose the £2.63 million in 1996-97

Mr Gregory: Yr wyf yn gwbl fodlon rhoi gwybodaeth ar y ffactorau i’w cymharu i’r Pwyllgor ond byddai hynny’n golygu dyfarnu rhwng safbwynt Abertawe a safbwynt Dyfed Powys ar y seflyf. Yr wyf yn fwy na pharod i wneud hynny, ond os ystyriwch y diffyg a gafwyd sef y £2.63
Dyfed Powys was a very small proportion of that.

Peter Black: Moving on to North Wales Health Authority area, how is north Wales the only authority to report a surplus in 1998-99?

Mr Gregory: Over the period 1996-97 to 1998-99, I said that Gwent had the best increase. That is not true, in fact, because North Wales Health Authority had an average 4.2 per cent increase. I do not think that that is a sufficient reply because Bro Taf Health Authority had a 4.3 per cent increase and yet ended up in a deficit position. My instinct says that North Wales Health Authority has benefited from a level of allocation relatively higher than is generally the case in Wales. It is higher than the Welsh average and that inevitably has an effect. I think that it is also true to say that the healthcare system in north Wales, except in the extreme north-east, is relatively more straightforward than in south-east Wales. North Wales now has three acute community and mental health trusts, which therefore have a relatively straightforward relationship with the health authority. Each of the

miliwn yn 1996-97 cyfran fach iawn o’r swm hwnnw oedd Dyfed Powys.

[53] Peter Black: Gan symud ymlaen at ardal Awdurdod Iechyd Gogledd Cymru, pam mai Gogledd Cymru yw’r unig awdurdod i gofnodi gwarged yn 1998-99?

Mr Gregory: Dywedais mai Gwent a gafodd y cynnydd mwyaf yn ystod y cyfnod rhwng 1996-97 a 1998-99. Nid yw hynny’n wir, mewn gwirionedd, oherwydd cafodd Awdurdod Iechyd Gogledd Cymru gynnydd cyfartalog o 4.2 y cant. Ni chredaf fod hwnnw’n ateb digonol, gan fod Awdurdod Iechyd Bro Taf wedi cael cynnydd o 4.3 y cant ond eto cafodd ddiffyg yn y pen draw. Fy nheimlad i yw bod Awdurdod Iechyd Gogledd Cymru wedi elwa ar lefel ddyrannu gymharol uwch na’r cyffredin yng Nghymru. Mae’n uwch na lefel gyfartalog Cymru a chafodd hynny effaith wrth reswm. Mae’n wir dweud hefyd, yn fy marn i, bod y system gofal iechyd yng ngogledd Cymru, ac eithrio’r gogledd-ddwyrrain pellaf yn symlach o’i gymharu â’r hyn a geir yn ne-ddwyrrain Cymru. Bellach mae tair ymddiriedolaeth gymuned gofal aciwt a iechyd meddwl yng ngogledd Cymru, sydd felly à
trusts has a very clear demarcation, whether it be for local or regional services. It is only when one starts to get towards the highly competitive health system involving Chester, the Wirral and Wrexham that you start to see the kind of difficult dynamics that are so typical of what happens in south Wales. So I think that it is for a combination of those sorts of reasons.

Mr Gregory: I would rather not answer questions about fairness. I think that is best left to politicians. Coming back to your point, I think that it is a mixed

Dafydd Wigley: I cannot allow that to go by without raising one question. It is clearly one that you might want to address. Is it not possible that in north Wales the structure has been particularly well-run, so that the authority has been able to deliver within the resources and that it would be quite unreasonable and unfair to penalise an authority where that has happened, such as North Wales Health Authority, because of difficulties experienced elsewhere?

Mr Gregory: Byddai’n well gennyf beidio ag ateb y cwestiynau ynglyn â thegwch. Credaf y byddai’n well gadael hynny i’r gwleidyddion. Gan
I could not accept that the situation in north Wales is uniformly excellent. I think that some of the trusts in north Wales have been particularly well run. I would agree with that. However, north-west Wales has had a history of financial difficulty that has been overcome. At the merger of the two health authorities this is from memory, I would need to check this if you challenged me on it the outgoing Gwynedd Health Authority left the new North Wales Health Authority with a financial difficulty. I would not say that that was a substantial problem, but North Wales Health Authority had to spend some time dealing with that difficulty. There is also the issue that in north-east Wales the NHS trust for Wrexham Maelor has had a history of financial difficulty. However, generally speaking I would say that financial management in north Wales has been of a high standard.

[Catwyd egwyl goffi rhwng 10.57 a.m. ac 11.12 a.m.]
A coffee break was held between 10.57 a.m. and 11.12 a.m.

[55] Janet Davies: We now move on to the section that is concerned with the rising costs of clinical negligence. Part 5 of the report addresses those problems and, unfortunately, notes that they are rising sharply. Mr Gregory, do you expect the costs of clinical negligence cases to continue to rise at this alarming rate?

Mr Gregory: Perhaps it would be helpful if I gave you a spread of figures to show what has happened over the last few years so that we can put your question into a proper context. I shall give you the amounts for the expenditure by what is called the Welsh risk pool, which is the main instrument for handling the financial impact of clinical negligence in Wales. I shall start with 1996-97, go through 1997, 1998 and 1999 and give an estimate for the current financial year. That will probably be helpful. In 1996-97, the expenditure on clinical negligence was £4.2 million; in 1997-98 it was £6.6 million; in 1998-99 it was £7.9 million. Projected expenditure in 1999-2000 is £12 million and, although...
this is a highly speculative estimate, for which I would not want to be held too closely to account, it is somewhere around £15.5 million for 2000-01. You can see that there are some very significant increases in that flow of figures.

I think that behind this lie two phenomena. The first is the increasing propensity of individuals to resort to law for the settlement of damages in respect of clinical incidents. The second is a developing view on the part of the courts, particularly the Court of Appeal, on the levels of compensation that should be provided. Those two things together, I think, are generating the increase that I have set out for you.

I should say that I think there is a short-term influence as well. That is that the implementation of the Woolf report’s recommendations on improving the process of law has had an impact on the promptness with which settlements are made. That may have had an impact in bringing forward settlements into earlier years than might otherwise have happened. That is a kind of abbreviated description of what has been going on.

Credaf fod dau ffenomenon y tu ôl i hwn. Yn gyntaf mae’r duedd gynyddol ymhliith unigolion i fynd i’r gyfraith er mwyn setlo iawndal mewn achosion esegeluistra clinigol. Yn ail, agwedd y llysioedd, yn enwedig y Llys Apêl, sydd yn datblygu o ran lefelau’r iawndal y dylid eu rhoi. Y ddau beth hynny gyda’i gilydd, yn fy marn i, sydd yn cynhyrchu’r cynnydd yr wyf wedi ei nodi ichi.

Dylwn ddweud bod dylanwad tymor byr yn ogystal, yn fy marn i. Hynny yw, mae gweithredo argymhellion adroddiad Woolf er gwella gweithredo’r gyfraith wedi cael effaith ar ba mor brydlon y caiff setliadau eu gwneud. Efallai bod hynny wedi cael effaith drwy ddyw setliadau ymlaen i flynyddoedd cynharach nag y byddai wedi digwydd fel arall. Disgrifiad cynho yw hwnnw o’r hyn sydd wedi bod yn digwydd.
Janet Davies: The whole issue of compensation is one upon which we would not wish to comment. While the costs are clearly rising in that area, I do not think that any members of this Committee would want to see people getting anything other than their just deserts when something goes wrong. However, what are you doing to improve the standard of risk management within the NHS?

Mr Gregory: There are a number of issues that I think need to be teased out in this respect. Perhaps I can run through some of them. The first is that we should not look at clinical negligence without looking at the whole concept of clinical effectiveness and clinical governance nationally. In other words, to put it briefly, you have to see clinical negligence in the context of the agenda for improving quality of care in the NHS.

Unless you have a strategic framework for improving quality, then tackling particular aspects of the clinical negligence agenda seem unlikely to be ultimately successful. As a consequence of that, we have undertaken by which I mean the Assembly has undertaken initiatives like promoting the concept of a strategic framework for improving quality of care in the NHS.
of clinical governance in trusts and making that a direct responsibility of chief executives; the provision of expert guidance on effective treatments and care produced by the National Institute for Clinical Excellence; the scrutiny of provision management and quality of care which will, as of 1 April, be undertaken by the Commission for Health Improvement and work with district audit to examine compliance with risk management standards that are set for trusts and health authorities. A number of organisations have over the years undertaken their own accreditation systems through, for example, the King’s Fund, Investors in People and the European Foundation for Quality Management.

There is also the role of the Royal College in terms of training standards and the controls assurance arrangements which are reflected in the Comptroller and Auditor General’s report. That is a panoply, if I can use the expression, of arrangements at the national level to put into context the effort to improve the quality of care. All of those will have an impact on the climate within which clinicians are mentrau megis hybu cysyniad rheoli clinigol yn yr ymddiriedolaethau a sicrhau mai cyfrifoledub uniongyrchol y prif weithredwyr ydyw; rhoi arweiniad arbenigol ar driniaethau a gofal effeithiol a gynhyrchir gan y Sefydiad Cenedlaethol dros Ragoriaeth Glinigol; archwilio’r gwaith o reoli darpariaeth ac ansawdd gofal y bydd y Comisiwn Gwella Iechyd yn ymgymryd ag ef o 1 Ebrill ymlaen a gweithio gyda’r archwiliad dosbarth i archwilio cydymffurfiaid â’r safonau rheoli risg a bennwyd ar gyfer ymddiriedolaethau ac awdurdodau iechyd. Bu nifer o sefydliaid dros y blynyddoedd yn ymgymryd â’u systemau achredu eu hunain drwy, er enghraifft, Cronfa’r Brenin, Buddsoddwyr mewn Pobl a’r Sefyliad Ewropeaidd dros Reoli Ansawdd.

Ceir hefyd rôl y Coleg Brenhinol o ran safonau hyfforddi a’r trefniadau ar gyfer sicrwydd rheolaethau sydd yn cael eu nodi yn adroddiad y Rheolwr ac Archwilydd Cyffredinol. Mae honno’n gyfres amryfath o drefniadau, os caf ddweud hynny, ar lefel genedlaethol i roi’r ymdrech i wella ansawdd gofal yn ei chyd-destun. Bydd pob un o’r rheiny’n cael effaith ar y sefyllfa gyffredinol pan fydd clinigwyr
treating patients. In respect of the particular, the Comptroller and Auditor General comments in his report on the Welsh risk pool. Clinical negligence has been a feature of the Comptroller and Auditor General’s reports over a number of years. The previous report indicated that the Welsh risk pool was taking measures to improve risk management standards in Wales, and that is proceeding.

Work is also in hand to implement discounted excess charges for trusts with good clinical negligence records. As recently as last month the Welsh risk pool, which is now managed by the Conwy and Denbighshire NHS Trust in north Wales, has appointed two clinical assessors to undertake audit compliance against the risk management standards which have been set.

I should say that my executive team and I met the chief executive of the risk pool very recently in order to hear at first hand what steps the pool is taking to undertake more rigorous risk management of this issue in the NHS.

Mae gweithredu taliadau disgowntedig dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer.

Mae gweithredu taliadau disgowntedig dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer dros ben a godir ar gyfer.
gave a very firm steer that we wanted the Welsh risk pool to be more proactive in ensuring good process, following up on audit of good practice and also in dissemination of incidents and effective responses to them. That is a challenge that it is readily taking up.

[57] Geraint Davies: I think that it was Confucius who said that a wise man learns from his mistakes, but a wiser man learns from the mistakes of others. With regard to this situation, what action do you take following a claim to reduce the risk of the event reoccurring, in issuing guidance to NHS trusts and strengthening the clinical audit?

Mr Gregory: I think that I should say at the start that this is not an area in which I think that we have been sufficiently proactive. I would not want to say to the Committee that this is something that we have sorted out and buttoned down and that you should be absolutely assured that everyone knows what is going on and that there is a good level of communication. I

Rhoddais gyfarwyddyd cadarn iawn ein bod am i gronfa risg Cymru fod yn fwy rhagweithiol wrth sicrhau gweithreddu da, gan ymateb i’r archwiliad o arfer da a hefyd wrth ledaenu gwybodaeth am ddigwyddiadau ac ymatebion effeithiol iddynt. Mae hynny’n her y mae pobl yn barod iawn i fynd i’r afael â hi.

[57] Geraint Davies: Credaf mai Confucius a ddywedodd fod dyn doeth yn dysgu oddi wrth ei gamgymeriadau, ond bod dyn doethach yn dysgu oddi wrth gamgymeriadau pobl eraill. Parthed y sefyllfa hon, pa gamau y byddwch yn eu cymryd yn sgîl cais leihau’r risg y bydd hyn yn digwydd eto, o ran rholo arweiniad i ymddiriedolaethau NHS ac atgyfnerthu’r archwiliad clinigol?

Mr Gregory: Credaf y dylwn ddweud ar y cychwyn cyntaf fod hwn yn faes lle nad ydym wedi bod yn ddigon rhagweithiol, yn fy marn i. Ni hoffwn ddweud wrth y Pwyllgor bod hwn yn faes yr ydym wedi ei ddatrys a’i sicrhau ac y dylech fod yn gwbl ffyddig bod pawb yn gwybod yr hyn sydd yn digwydd a bod lefel dda o gyfathrebu. A dweud y gwir, credaf fod
think, frankly, that this is an area that has needed improvement. One of the reasons why we met the risk pool recently was to explore how it might do that.

The risk pool itself, which represents all health authorities and trusts throughout Wales, has set up a risk managers’ network. This enables all risk managers in trusts and health authorities to share good practice. It is a bringing together of all the people who take responsibility in these organisations. It has the objective not just of sharing good practice, but also of trying to identify improvements in the way in which organisations respond to untoward clinical incidents.

This financial year, the risk pool will discuss the setting up of a computer based system to make sure that the NHS at large can learn the lessons it needs to learn from these mistakes. It will also draw together good practice guidance on a number of important issues. We are instituting a requirement that any untoward incident of an exceptional nature should be reported to the Welsh risk pool so that it can consider whether it

hwn yn faes yr oedd angen ei wella. Un o’r rhesymau pam y cyfarfuom â’r gronfa risg yn ddiweddar oedd ymchwilio i sut y gellid gwneud hynny.

Mae’r gronfa risg ei hun, sydd yn cynrychioli’r holl awdurdodau ac ymddiredolaethau iechyd ledled Cymru, wedi sefydlu rhwydwaith risg i reolwyr. Mae hyn yn galluogi pob rheolwr risg yn yr ymddiriedolaethau a’r awdurdodau iechyd rannu arferion da. Mae’n fater o ddod â’r holl bol sydd â chyfrifoldeb yn y sefydliau hyn ynghyd. Y nod yw rhannu arfer da, ond hefyd geisio nodi sut y gellir gwella’r modd y mae sefydliau’n ymateb i ddigwyddiadau clinigol annisgwyl.

Yn ystod y flwyddyn ariannol gyfreithiol, bydd y gronfa risg yn trafod sefydlu system gyfrifiadurol i sicrhau bod yr NHS yn ei gyfanrwydd i sicrhau bod yr NHS yn ei gyfanrwydd yn gallu dysgu’r gwersi y mae angen eu dysgu oddi wrth y camgymeryiadau hyn. Bydd hefyd yn casglu ynghyd arweiniaid arfer da ar nifer o faterion pwysig. Yr ydym yn ei gwneud yn ofynnol i adroddiad ar unrhyw ddigwyddiad annisgwyl gael ei gyflwyno i gronfa risg Cymru fel y gall ystyried a oes angen
needs to disseminate information about the risk, the incident and the action that needs to be taken in respect of it.

I should say that an automatic aspect of all of this is that if there is ever an incident which involves a piece of equipment, then the Medical Devices Agency is informed and it takes the necessary measures. It is not just the risk pool that one is relying on in this situation. There are other agencies involved.

All of that, I think, provides a development platform that is the way I would describe it in which we are going to explore ways of substantially improving the way in which the NHS learns lessons. In addition to that, the activities of NICE and the Commission for Health Improvement will supplement that at a national level by putting into the system kitemarked advice I think that is the expression drawn from their experience and from the expert resources on which they have to draw.

[58] Geraint Davies: I am surprised that only 10 out of the 21 member bodies have filled in a self-assessment form with regard to the risk management

Dylwn nodi mai agwedd awtomatig ar hyn i gyd yw bod yr Asiantaeth Dyfeisiadau Meddygol yn cael gwybod pan fydd unrhyw ddigwyddiad yn ymwneud â chyfarpar ac mae’n cymryd y camau angenrheidiol. Nid y Gronfa Risg yn unig sydd â chyfrifoldeb yn y sefyllfa hon. Mae asiantaethau eraill yn gysylltiedig â hyn.

Mae hyn i gyd yn darparu llwyfan datblygu, yn fy marn i felly y byddwn yn ei disgrifo lle y byddwn yn ei disgwyl a chyfrifoldeb o ran y modd y mae’r NHS yn dysgu gwersi. Yn ogystal â hynny, bydd gweithgareddau’r Sefydliad Cenedlaethol dros Ragoriaeth Glinigol a’r Comisiwn Gwella lechyd yn ategu hyn yn genedlaethol drwy gyflwyno cyngor nod ansawdd credaf mai dyna’r term i’r system gan dynnu ar eu profiad a’r adnoddau arbenigol sydd ganddynt wrth gefn.

[58] Geraint Davies: Yr wyf yn synnu mai dim ond 10 o blith y 21 corff aelod sydd wedi llenwi ffurflen hunan-asesu o ran y safon rheoli risg, a fyddai’n 
standard, which would assess the excess that they pay on any claim. Are we going to ensure that more people fill in these forms in order to see what the situation is in the various trusts?

Mr Gregory: Yes, we shall. I was surprised to learn this too. We will follow it up.

[59] Geraint Davies: Will they be penalised if they do not fill these in and will the excess payments be greater as a result?

Mr Gregory: There is a very strong case for trying to relate the premium costs to experience of clinical negligence in the particular organisation, as long as we can have a robust and fair system which also has the effects that we are looking for. I agree with you that this needs much further work. That is in hand.

[60] Geraint Davies: How does the performance of the Welsh risk pool compare with the NHS litigation authority in England, which uses private solicitors? Is it true that the lawyers in the Welsh risk pool are less

Mr Gregory: Byddwn. Yr oeddwn innau’n synnu pan gefais wybod am hyn. Byddwn yn gweithredu ar hynny.
experienced than those in the private
sector and, as a consequence, the
health service is at a disadvantage? I
have been told that we tend to settle
our claims more slowly than is done in
England. Is that the case?

Mr Gregory: I do not think that I am
well placed to make comparisons
between England and Wales. I am
inclined to deflect that question in the
direction of the Auditor General for
Wales and his colleagues. I am
confident that the level of legal
expertise that we have in Wales
specialising in this work and in close
contact with the trusts and health
authorities is of a high order. As to the
promptness with which they undertake
their work, what I had to say about the
Woolf report is relevant. The
requirements that are now placed on
solicitors on both sides, are more
rigorous than they were. I am
confident that the Welsh risk pool and
the Welsh legal health services are
improving on the quality of their
service and compare favourably. I
deer to Sir John.

Sir John Bourn: I cannot give a
definitive comparison of how these

Mr Gregory: Ni chredaf fy mod mewn
seffylfa dda i dynnu cymariaethau
rhwng Cymru a Lloegr. Teimlaf y
dylwn gyfeiri’r cwestiwn hwnnw at
Archwilydd Cyffredinol Cymru a’i
gydweithwyr. Yr wyf yn hyderys bod
lefel yr arbenigedd cyfreithiol sydd
gennym yng Nghymru yn y maes hwn
ac sydd mewn cysylltiad agos à’r
ymddiriedolaethau a’r awdurddodau
iechyd o safon uchel. Ynglyn â’u
prydoldebo o ran ymgymryd â’r
gwraith, mae’r hyn a ddywedais am
adroddiad Woolf yn berthnasol. Mae’r
gofohnion sydd bellach wedi eu rhoi ar
gyfreithwyr ar y ddwy ochr yn llawer
llwmach nag yr oeddent. Yr wwf yn
ffyddioig bod cronfa risg Cymru a
gwasanaethau cyfreithiol iechyd
Cymru’n gwella ansawdd eu
gwasanaeth a’u bod yn cymharu’n
ffafriol. Yr wwf yn ildio i farn Syr
John.

Syr John Bourn: Ni allaf dynnu
cymhariaeth ddifiniol o’r modd y
matters are managed in different parts of the United Kingdom. If it would help
the Committee, I will examine this to see if I can provide information on it.
Recognising that the business of signing up the Scots to doing rather
less than the northern Irish and the northern Irish doing less well than the
English will be a rather complex matter. I will look at this and see whether I can help the Committee with it.

[61] Janet Davies: Thank you. I recognise that you are not a witness to
your own report.

[62] Geraint Davies: I return to the risk pool arrangement. Do you think that,
in the future, trusts will take out commercial insurance against clinical
negligence as opposed to relying on the Welsh risk pool?

Mr Gregory: I would not advocate that. That would undermine the whole
notion of having a consistent approach based on high levels of expertise across
Wales. That would be a return to a disconnected and disjointed approach
about which I would have serious misgivings.
Dafydd Wigley: I would be grateful if we could reconcile the figures that we have heard in relation to clinical negligence. We have heard figures from Mr Gregory which show an increase in expenditure from £4 million a year four years ago to £12 million now. We are led to believe that the size of the risk pool is between £145 million and £214 million in Wales. That is over £200 million of risk. I would like to know whether Mr Gregory accepts that the pool is of that size, considering that there is a possibility of claiming against the pool. If that is true, does that not mean that money will have to be set aside to meet this risk, money that would otherwise be available for improving health services and therefore reducing the risk for people receiving those services?

Mr Gregory: To deal with Mr Wigley's last point, if money is being spent as a consequence of compensation claims laid against the NHS, I think that it is inevitable that that money can only come from within the NHS and is therefore not available to be spent on patient care. That is unarguable. To sound a note of caution, however, whenever the Comptroller and Auditor
General produces his report, the newspapers always pick the largest figure that they can find and quote it as the most important figure. The sort of figures that you were quoting are the maximum level of risk that, at the moment, we believe is conceivably possible. Welsh health legal services will do their best within the legal system to ensure that that amount is reduced to the maximum extent possible. The actual likely exposure over the next few years is at the sort of levels that the Comptroller and Auditor General sets out in paragraph 5.4 so that the large figure includes wet-finger-in-the-air type calculations of the maximum degree of exposure. Some of that will never come to payment because the case will be lost, it will fall in other ways or if it is settled, it might be settled at levels lower than currently thought conceivable.

Dafydd Wigley: May I press you further on this? You said that the expenditure had trebled over the four years. Is it correct to say that the size of the largest possible pool has trebled from about £70 million to £214 million?
Mr Gregory: I do not have the precise figures in front of me but I would guess that that was right. By the way, in talking about the Welsh risk pool, I am talking about the organisation in the trust that runs the payment process for claims of over £30,000 on behalf of the NHS. The sort of sums that you describe are the total aggregation of what health authorities and trusts think might conceivably be at risk over the next 10 or 15 years. That is made up of two elements: the provisions, which are those for cases where we know that there is a high likelihood of a successful claim and some estimate, and the rest are those which are just a possibility.

Dafydd Wigley: Felly byddai'n iawn dweud bod maint y gronfa yn cynyddu fwy neu lai ar yr un raddfa â'r taliadau, mai ffigur 1998-99 oedd £214 miliwn a bod eich ffigurau'n dyblu rhwng 1998-99 a 2000-01 o £7.9 miliwn i £15.5. A allwn ddehongli o hynny bod maint y gronfa hon yn debygol o ddyblu o £200 miliwn i £400 miliwn? Yr wyf yn eich eichwyso ar hyn. A yw'r ffigur o £200 miliwn yn 1999 a'r ffigur posibl o £400 miliwn erbyn 2000-01 yn realistig, neu a yw'n

Mr Gregory: Nid yw'r ffigurau manwl gywir gennym o'm blaen ond byddwn yn dyfulu bod hynny'n gywir. Gyda llaw, wrth gyfeirio at gronfa risg Cymru, yr wyf yn sôn am y sefydliad yn yr ymddiriedolaeth sydd yn gweinyddu'r broses talu ceisiadau dros £30,000 ar ran yr NHS. Mae'r math o symiau yr ydych yn eu disgrifio yn gyfanswm ar gyfer yr hyn y mae'r awdurduodau a'r ymddiriedolaethau iechyd yn tybio y bydd o dan risg dros y 10 neu 15 mlynedd nesaf. Ceir dwy elfen: y darpariaethau, sef darparu ar gyfer achosion lle yr ydym yn gwybod y bydd cais yn debygol iawn o lwyddo a bras amcioni, a'r achosion hynny sydd yn weddill a chanddynt bosibilrwydd yn unig o lwyddo.

Dafydd Wigley: Then it would be true to say that the size of the pool increases more or less at the same rate as the payments, the 1998-99 figure was £214 million and that your figures are doubling between 1998-99 and 2000-01 from £7.9 million to £15.5. Can we interpret from that that the size of this pool is likely to double from £200 million to £400 million? I press you on this. Is the figure of £200 million in 1999 and the possible figure of £400 million by 2000-01 realistic, or is it
Mr Gregory: Thank you. That is a helpful explanation of the line of questioning. Making calculations of the kind that you describe about what the level will be in future is fraught with difficulty. I cannot remember whether you were here, Mr Wigley, when I was discussing this earlier. One of the reasons why this has increased so much is not because of an increase in claims, although that has also been happening, but a change in the attitude of the courts to making compensation payments. We have very recently had another Court of Appeal judgment that will have an effect, I believe, though nowhere near as severe as the one in 1998.

One has to make a judgment about the level of claims coming forward and the attitude of the courts. My instinct, and I may be proved wrong over the next couple of years, is that we have seen a very big hike in the levels of compensation being paid that we are unlikely to see over the next couple of years. It would therefore be misleading to extrapolate on an arithmetic basis.
from one to another. However, candidly, that is at risk of another high value case coming to court, being fought through to the Court of Appeal, and the Court of Appeal making a judgment on that case which has implications for that class of cases across the NHS. It is very difficult to judge but I think that simply extrapolating is far too simplistic.

[66] Dafydd Wigley: Mae un cwestiwn arall gennyf ar hyn. I ba raddau yr ydych yn cadw ar sail rifyddol. Fodd bynnag, a dweud y gwir, mae o dan berygl y bydd achos gwerth aral yn mynd i’r llys, yn cael ei ymladd hwyd at y Llys Apêl, gan arwain at y Llys Apêl yn rhoi dyfarniad ar yr achos hwnnw a fydd â goblygiadau ar gyfer y math hwnnw o achos ar draws yr NHS. Mae’n anodd iawn barnu ond credaf fod cynnig amcangyfrifon yn unig yn llawer rhy syml.

[66] Dafydd Wigley: I have one more question on this. To what extent do you keep money back in the Assembly’s health fund this year, for the possibility that a figure of between £15-£200 million, or even £400 million, becomes payable? If it becomes payable, we must find the money. If that money needs to be available to be spent in this way, it will not be spent on other things. How much of a sum are we keeping back, or do we have another process that provides additional money from outside the health budget to ensure that money is available?

Mr Gregory: I gave you an estimate of what we think will be paid out of the Welsh risk pool in 2000-01, which is
£15.5 million. That is our current best estimate. It is not our estimate, actually. It belongs to the Welsh risk pool and the Welsh Health Legal Services. That is the best estimate that they can make, in consultation with the NHS, of the level of compensation claims that will be paid this financial year. They have, broadly speaking, but subject to unexpected court judgments, been quite accurate in that. They are making a judgment on the cases that they know are likely to be settled over the next 10 years on occasions these cases can take a considerable length of time and on which of those cases is likely to come to judgment in 2000-01 and at what level. As a consequence, the premiums that the NHS pay into the Welsh risk pool are levied on the basis of that mutual appreciation of what the total cost is likely to be. One of the things that I cannot emphasise too much is that out of the big figure I forget which it was now of £200 million that you quoted, a very significant proportion of that will never be paid, for a variety of reasons, such as the case falls away, compensation levels will be much lower or the case is lost.

£15.5 miliwn. Hwnnw yw ein amcangyfrif gorau ar hyn o bryd. Nid ein amcangyfrif ni ydyw, a dweud y gwir. Amcangyfrif cronfa risg Cymru a Gwasanaethau Cyfreithiol Iechyd Cymru ydyw. Hwnnw yw’r amcangyfrif gorau y gallant ei wneud, mewn ymgynghoriad â’r NHS, o ran lefel y ceisiadau am iawndal a gaiff eu talu yn ystod yr flwyddyn ariannol gyfredol. Yn gyffredinol, maent wedi bod yn eithaf cywir yn hynny o beth er eu bod yn ddarostyngedig i ddvfarnidau llwyddiant annigwyl. Maent yn barnu achosion y maent yn gwybod â chant eu setlo yn ystod yr 10 mlynedd nesaf weithiau gall yr achosion hyn gynryd cryn amser a’r achosion hynny sydd yn debygol o gael eu dyfarnu yn 2000-01 ac ar ba lefel. O ganlyniad, codir y taliadau premiwn y mae’r NHS yn eu talu i gronfa risg Cymru ar sail y gyd-ddealltwriaeth honno ynghylch faint y maes cyfanswm cost yn debygol o fod. Un o’r agweddu na allaf eu gorbwysleisio yw na chaff cyfran sylwedol iawn o’r ffigur mawr ni choifiaf pa un ai a oedd yn awr o £200 miliwn a ddwyynnwyd gennych eu talu byth, am nifer o resymau, er enghraifft oherwydd nad yw’r achos yn parhau, bydd lefelau iawndal yn llawer is neu caiff yr achos ei golli.
Dafydd Wigley: What was the answer to the question about the figure in our accounts? Is it £15 million?

Mr Gregory: All claims are paid by the health trusts and the Welsh risk pool reimburses them in respect of claims above £30,000. It is open to the Assembly, if it wanted to relieve pressure on the NHS, to pay money directly into the Welsh risk pool, which would have the effect of keeping premiums down. At the moment, we expect the NHS to make a proper calculation of what the cost will be and itself to fund them without direct assistance from the Assembly. Mr Gregory: Caiff pob cais ei dalu gan yr ymddiriedolaethau iechyd ac mae cronfa risg Cymru yn digolledu eu ceisiadau dros £30,000. Caiff y Cynulliad, pe bai am dynnu pwysau oddi ar yr NHS, dalu’r arian yn uniongyrchol i gronfa risg Cymru a fyddai’n golygu y câi y taliadau premiwm eu rheoli. Ar hyn o bryd, disgwylwyd i’r NHS gyfrifo’n gywir faint fydd y gost a’u hariannu ei hun heb gymorth uniongyrchol gan y Cynulliad.

Dafydd Wigley: It is equivalent to 500 nurses.

Mr Gregory: Yes, it is something of that order.

Janet Davies: Did you want to raise something, Peter, or has it been covered?

Mr Gregory: Ydyw, mae’n rhywbeth tebyg i hynny.

Janet Davies: A oeddech am godi rhywbeth, Peter, neu a gafodd ei drafod ei eisoes?

Peter Black: I will not talk about individual cases but, since becoming an Assembly Member, one of the main areas of concern that has been raised with me in relation to the NHS is...
clinical negligence claims. I have been struck almost in every incidence by how difficult it is for people to access the appeals procedure, especially for those who cannot afford to go to a solicitor. Have you talked to the health authorities and trusts, the latter in particular, about their attitude towards claims? Do you not feel that an early admission of blame would actually reduce costs? How can the defensive culture that surrounds these claims be overcome?

Mr Gregory: There a number of complex issues tied up in that. I see far too frequently, because I receive them on behalf of the Assembly, individual outcomes to independent panel reviews of complaints made against NHS clinicians. A constant theme and aspect of these complaints, almost without exception, is the quality of communication between clinician and patient, whether that be with a GP, consultant, nurse or even a general manager. It is the quality of the relationship. I think that you are right to say that there is significant issue in the extent to which a response which is less defensive and feels less threatened at the earlier stage can have a

Mr Gregory: Mae nifer o faterion cymhleth ynghlwm wrth hynny. Yn rhy aml o lawer yr wyf yn gweld, gan fy mod yn eu derbyn ar ran y Cynulliad, ganlyniadau unigol ar ôl arolygon paneli annibynnol o gwynion yn erbyn clinigwyr o’r NHS. Un o’r themâu a’r agweddau mwyaf cyson ar y cwynion hyn yn ddieithriad bron, yw ansawdd y cyfathrebu rhwng y clinigwr a’r claf, waeth a yw’n fedyg teulu, yn fedyg ymgynghorol, yn nyrs neu’n rheolwr cyffedol hdy yn oed. Ansawdd y berthynas sydd dan sylw. Credaf eich bod yn gywir wrth ddweud ei fod yn fater o bwys i ba raddau y gall ymateb sydd yn llai amddiffynol ac sydd yn teimlo ei fod o dan lai o
significant effect on the attitude of people making complaints. Those people, because they feel that things are being held back and that they do not understand why it is that something has happened, however unavoidable that might have been, feel impelled to pursue the question in the way that they do. It is not actually out of a desire to get a lot of money but to get a plain and simple answer. I have seen a number of cases recently in which the complainant has repeatedly said ‘I am not interested in compensation’, and has not subsequently pursued the compensation, but has said ‘All I want to know is why did my mother die’, or ‘Why do I now have this disability?’ I strongly believe that there is an issue there.

On the other hand, there is nothing new in that. The NHS and ourselves have been considering for some time measures to improve the training of doctors, nurses and healthcare professionals of all kinds in communication skills, and also to make the complaints review processes more independent and less threatening to those involved. It is a difficult row to

Ar y llaw arall, nid rhywbeth newydd ydyw. Ers tro ma’r NHS a ninau wedi bod yn ystyried mesurau i wella hyfforddiant meddygon, nyrsys a gweithwyr proffesiwol gofal iechyd o ran pob math o sgiliau cyfathrebu, a hefyd sicrâu bod y prosesau arolgygu cwynion yn fwy annibynnol ac yn llai bygythiol i’r rhai dan sylw. Talcen caled ydyw, a dweud y gwir. Yr ydych
hoe, candidly. You still see, far too frequently, complaints, which had they been dealt with differently at the outset, would never have reached even the independent review, let alone led to a settlement in a court of law. There will always be people who believe, however, that because of the suffering they have endured, they need compensation. That is an individual decision and is often very appropriate. Nonetheless, I believe that the point that you are making is an important one that we still have not cracked and need to work at constantly.

[71] Peter Black: How are you actually working to do that? Are there any instant solutions or long-term solutions?

Mr Gregory: In part I think that it comes down to the training and education processes that I have described. It is also in part down to the whole process of the quality agenda that I described earlier. Many of the measures that are being put in place to promote more effective and higher quality care ought to have the effect of creating a climate in which better care is delivered in the first instance, but also one in which the healthcare providers are encouraged to perform better.
professionals delivering that care are better able to communicate with patients. Incidentally, I am not suggesting for a moment that the difficulties are all on one side. Clinicians are very frequently faced with exceptionally difficult situations where communication with people who have been traumatised in one way or another is very difficult. I am not ascribing blame, I am merely observing a phenomenon.

[72] Janet Davies: We have explored the whole issue of the rising costs of clinical negligence fairly thoroughly. We will move on to whether there is any progress in tackling national health service fraud. I see that there is no Welsh equivalent of the English fraud investigator. Do you not consider this to be a key priority?

Mr Gregory: Yes, I do. I will not go into the background of this in any great detail, but simply say that, for reasons that I explained earlier in this evidence session, we have not felt able to make the kind of progress with the appointment of a director and the forming of a directorate as they have in
gallu cyfathrebu â’u cleifion yn well. Gyda llaw, nid wyf yn awgrymu am eiliad fod yr anawsterau ar yr un ochr yn unig. Yn aml mae clinigwyr mewn sefyllfaoedd hynod ddyrys lle mae’n anodd iawn cyfathrebu à phobl sydd wedi cael eu trawmateiddio mewn rhyw fforedd neu’i gilydd. Nid wyf yn gosod bai, dim ond arsylwi ar ffenomenon yr wv.

[72] Janet Davies: Yr ydym wedi ymchwilio i bwnc costau cynyddol esgeulustra clinigol yn gymharol drwyadl. Symudwn ymlaen at holi a oes unrhyw gynnydd wrth fynd i’r afael â thwyll yn y gwasanaeth iechyd gwladol. Gwelaf nad oes ymcchwiliwr twyll vng Nghymru sydd yn cvfateb i’r un yn Lloegr. Onid yw hyn yn flaenoriaeth allwedol, yn eich barn chi?
England. We are currently in active discussion with Mr Gee, who is the director, to explore whether it is possible for him and his staff to have a remit in Wales on behalf of the Assembly so that we gain the cost-effective benefits of using a larger organisation but also, and, in my judgment, more importantly, so that we are well plugged into its experience of the kind of frauds that occur and best practice in tackling them. I wrote to him some time ago and he and I had discussions about how that might be set up. When it is, I am confident that we will see the kinds of improvements in this area that are beginning to be detected in England.

Mr Gregory: I will not make grand claims for this. As I have said, it has been exceptionally difficult for us to get this under way. It is under way now. We have extended the remit of the working group to include trusts relatively recently and as a consequence, we will be developing a

[73] Lorraine Barrett: Could you expand on the progress that the all-Wales anti-fraud working group is making with development of the fraud strategy?

Mr Gregory: Ni allaf honni ryw lawer am hyn. Fel y dywedais, bu’n hynod anodd inni roi hyn ar waith. Bellach mae wedi ei roi ar waith. Yn gymharol ddiweddar ymestynnwyd cylich gwaith y gweithgor gennym i gynnwys yr ymddiriedolaethau ac o ganlyniad, byddwn yn datblygu ymagweddiad lawer
much more comprehensive and strategic approach. However, I would not want to seek to convince you that we have got this absolutely right because we are still in a formative stage.

Lorraine Barrett: I note the hesitancy in your answers in this area. Do you have your own estimate of the level of fraud in Wales? Looking at an exercise in England that was carried out by its fraud investigator, there appears to have been £95 million of fraud in the area of prescriptions alone. It sends a shiver down my back to think of the amount of money that we could be losing within the NHS in Wales. It should be a priority. I accept your hesitancy but, given the amount of money that we could be talking about, I think that we all feel that it should be a priority. Do you have an idea of the levels that we are talking about?

Mr Gregory: I shall attempt an estimate. To be clear, I am not comfortable at all with this situation. I think that we need to do a considerable amount more and I am very hopeful that working with the directorate in England, if it can meet our request,
will make a considerable difference. I am not at all happy with it. If you take a direct pro rata of the directorate’s calculation for England and say that the experience in England was typical of the experience in Wales, you would be talking about £8 million. The Audit Commission has done a study of this and its estimate of prescription evasion in Wales is around £10 million. Candidly, that is what it says it is an estimate. I do not know how much we can rely on it. However, I shall give you some hard information. In 1998-99, the AGW’s report year, our fraud register revealed fraud of something like £102,000. In the next year, we expect that to increase to £950,000. While I get no satisfaction from the increase, it suggests that there is a greater interest in this issue and that more attention is being paid to it. However, I am sure that the current levels of fraud being detected and resulting in criminal investigations are only a small fraction of what is actually going on.

[75] Lorraine Barrett: I do not condone this practice but I would like to ask you...
what you think about it. Has the anti-fraud working group addressed the issue of data matching between the NHS and possibly the Department of Social Security? What might be the legal or practical difficulties involved in this?

Mr Gregory: Clean bowled, I think, is my response to that. I do not know and I will not pretend that I do. Could I submit a note, Chair, to answer that?

Mr Gregory: Yr ydych wedi fy nal yw fy ateb i hynny, fe gredaf. Nid wyf yn gwybod ac ni fyddaf yn cymryd arnaf fy mod yn gyvwod. A gaf gyflwyno nodyn i ateb hynny, Gadeirydd?

Janet Davies: Yes. That would be helpful.

Janet Davies: Cewch. Byddai hynny o gymorth.

Lorraine Barrett: There is obviously a lot more to be done here, Chair.

Lorraine Barrett: Mae’n amlwg bod llawer mwy i’w wneud yma, Gadeirydd.

Janet Davies: We are running short of time. We will take a brief look at the issues of asset management and the cost of primary care drugs. First, Mr Gregory, could I ask you about the public private partnerships? There have only been 15 deals so far within the NHS here, most of them for small projects. Could you outline how you see the use of PPPs developing in the future?

Janet Davies: Mae amser yn mynd yn brin. Cymerwn gipolgwr ar y materion yn ymwneud â rheoli asedau a chost cyffuriau gofal sylfaenol. Yn gyntaf, Mr Gregory, a gaf eich holi ynglyn â’r partneriaethau preifat a chyhoeddus? Dim ond 15 cytundeb a gafwyd yma yn yr NHS hŷd yn hyn, ac mae’r rhan fwyaf ohonynt ar gyfer prosiectau bach. A wnewch amlinellu sut y bydd y defnydd o bartneriaethau preifat a chyhoeddus yn datblygu yn y
Mr Gregory: Yes, gladly. First, I would not want us to pursue this as an end in itself. I do not believe that is appropriate. It has to be seen within a wider context of the strategy for developing the NHS. PPP would be a legitimate aspect of that strategy, but not necessarily one that suits every circumstance. I believe that there is a place for this in that strategy, just as there is a place for central funding of capital from the Assembly and, candidly, a place for private charitable initiatives on occasion. They have also played a significant part in the way in which the NHS has developed over the years and I would not want to see that fall away either. I believe that it needs to be seen in a strategic context. We need to know what our strategic objectives for the NHS are and we need then to put in place all the measures, including the funding of capital, which are appropriate to the particular circumstances. There will be occasions and the Comptroller and Auditor General’s report in figure 13 lists some of the successes when it is appropriate to go down that route. There will be other occasions when it is quite inappropriate because you are not
going to generate private sector interest or there may be other reasons why you think that central funding is more suitable.

Janet Davies: Can I clarify that you are saying that there will be times when capital expenditure is not met in this way?

Mr Gregory: Our experience is that some projects are attractive to the private sector. You have a list of some of those here. We have plenty of experience that some are not, which is sometimes to do, for instance, with the way in which a development is integrated physically into the NHS. If you want to develop something inside a hospital, often the private sector will see too many legal and physical impediments to doing that and therefore you have to fall back as long as it is a priority for you on the public sector. However, I would want us to ask on each occasion whether the public or the private approach to these initiatives is the right one and then take it forward on the basis of a good assessment of the likely outcome and also what our strategic objectives are.
and how much of a priority it is.

[80] Geraint Davies: Before we go on to primary care drugs, I declare an interest as a pharmacist.

strategol a faint o flaenoriaeth ydyw?

[80] Geraint Davies: Cyn inni symud ymlaen at gyffuriau gofal sylfaenol, yr wyf yn datgan budd fel fferyllydd.

[81] Brian Gibbons: We have had some reports on individual private finance initiative cases. However, how long do you think that we would need to make a strategic evaluation of the value for money that PFI represents three years, five years, or do we have to wait 10 years?

[81] Brian Gibbons: Yr ydym wedi cael rhei adroddiadau ar achosion unigol o fentrau cyllid preifat. Fodd bynnag, faint o amser fyddai ei angen arnom er mwyn gwneud gwerthusiad strategol o’r gwerth am arian yn mae menter cyllid preifat yn ei roi tair blynedd, pum mlwynedd, neu a oes angen inni aros am 10 mlwynedd?

Mr Gregory: We have to undertake all PFI projects on the basis of our assessment of their value for money. They cannot proceed unless they show, on paper, that they will produce value for money. That value for money is then expressed in a contractual relationship, which is very tight on both sides and is the subject of considerable negotiation. Some of these projects have long lead times. I think that Baglan has a life of 30 years. So at what point in that time can you realistically make an assessment? I think that what maybe lies behind your point is the extent to which evaluation of a capital programme needs to be

Mr Gregory: Mae’n rhaid inni ymgymryd â phob prosiect menter cyllid preifat yn seiliedig ar ein hasesiad o’u gwerth am arian. Ni allant fynd rhagddvnt oni fyddant yn dangos, ar bapur, y byddant yn cynhyrchu gwerth am arian. Yna caiff y gwerth am arian ei fynegi mewn perthynas gytundebol, sydd yn gaeth iawn ar y ddwy ochr ac sydd yn destun i gryn negodi. Mae gan rai o’r prosiectau hyn gyfnodau arwain hir. Credaf fod gan Faglan oes o 30 mlwynedd. Felly pryd o fewn y cyfnod hwnnw y gallwch wneud asesiad mewn gwirionedd? Credaf mai’r hyn sydd y tu ôl i’ch pwnt efallai yw i ba raddau y mae angen
built in, whether it is public or private.
I would not myself want to make a
distinction between the two. I am
havering because I cannot give you a
figure. All I can say is that I believe
that the current PPP arrangements
emphasise, because they have to, the
value for money aspect. That can be
evaluated over time and I would expect
trusts and health authorities with such
projects to keep a keen eye on the
extent to which they continue to get
value for money from the revenue
expenditure that they are incurring on
these projects.

[82] Brian Gibbons: So what would be a
reasonable timescale within which to
make that value for money
assessment?

Mr Gregory: As I have said, I am not
sure that I can give you an answer. I
could pluck a figure out of the air, but
it would not be very helpful. I do not
know, frankly.

[83] Brian Gibbons: The reason why I
asked that is because we are

[82] Brian Gibbons: Felly beth fyddai’n
amserlen resymol ar gyfer gwneud yr
asesiad gwerth am arian hwnnw?

Mr Gregory: Fel y dwwedais, nid wyf yn
siwr a allaf roi ateb ichi. Gallwn dynnu
rhyw ffigur o’r awyr, ond ni fyddai’n
ddefnyddiol iawn. Nid wyf yn gywod,
a dweud y gwir.

[83] Brian Gibbons: Y rheswm pam yr
oeddwn yn gofyn hynny yw am ein bod
continually telling clinicians to proceed on the basis of the best evidence base, but in this particular area you are almost saying that it is impossible to have an evidence base on which to make a decision.

Mr Gregory: Sorry, I misunderstood your question. There will be performance criteria for each public-private partnership project. A trust and health authority and, for some of these projects, the Assembly itself, will incur expenditure against those performance criteria. I would expect those to be under not exactly continual, but very regular, review. As long as we are clear about the service specification, about the performance criteria related to it and about the performance as it unfolds over time, I am absolutely sure that the trusts and health authorities will keep a very close eye on this because if they do not, they cannot assure themselves that they will get the value for money for which they are looking.

Mr Gregory: Mae’n ddrwg gennyf, camddeallais eich cwestiwn. Bydd meini prawf perfformiad ar gyfer pob prosiect partneriaeth preifat a chyhoeddus. Bydd costau gan ymddiriedolaeth ac awdurdod iechyd ac, ar gyfer rhai o’r prosiectau hyn, y Cynulliad ei hun o ganlyniad i’r meini prawf perfformiad hynny. Ni fyddwn yn disgwyl i’r rhai hynny gael eu harolygu’n barhaus, yn union, ond eu harolygu’n rheolaidd iawn. Cyhyd â’n bod yn sicr ynglyn â manyleb y gwasanaeth, ynglyn â’r meini prawf sydd ynghlwm ag ef ac ynglyn â’r perfformiad wrth iddo ddatblygu gyda threigl amser, yr wyf yn gwbl argyhoeddig y bydd yr ymddiriedolaethau a’r awdurdodau iechyd yn cadw llygad barcud ar hyn am na allant eu sicrhau eu hunain eu bod yn cael y gwerth am arian y maent yn chwilio amdano oni fyddant yn gwneud hyn.
There is also an issue about the evaluation of the policy as a whole, which is a rather different question, which is what I thought that you were asking. In respect of that, there is an issue for us as an Assembly as to whether, at some stage, it would be appropriate to look at the experience, not just on the health side, and judge whether it is producing the results expected of it. That would be a perfectly natural part of looking at any policy outcome. I would guess that, in that respect, you would be looking for three or five years' experience or something of that order, and then you would want to make judgments about value for money and utility on the basis of that.

[84] Janet Davies: Having looked at the cost of primary care drugs, the report notes that this is rising steeply. What measures are available to control these costs?

Mr Gregory: You will know, Chair, because the Comptroller and Auditor General’s report makes reference to it, that the per capita cost of drugs in Wales is higher and levels of prescribing higher than in England. Unit costs are actually lower than in...
England, but that is only because the number of prescriptions is very significantly higher. Self-evidently, we have a difficulty, and one that represents, if we are talking about ineffective prescribing and I am not entirely sure that we are a very serious overhead for the NHS. Mr Wigley mentioned how much clinical negligence might be costing us in nurse employment. In my judgment, that is nothing compared to the cost of the extent to which, by comparison with England, for instance, we are overprescribing, if I can put it that way.

As far as tackling this issue is concerned, we have been trying to do that for several years. We have had a degree of success in reducing the rates at which prescribing costs increase. The Audit Commission, as a consequence of a study in England, has also set out a whole raft of measures for improving prescribing. We are following that prescription and we would expect to achieve a significant cost saving. In addition, we have set up a prescribing task and finish group which is, I think, mentioned in the report which will report in the summer and will look at a whole range of issues.
in this respect. I confidently expect that that will produce a strategy for dealing with this issue over the next three to four years.

[85] Dafydd Wigley: Pe baem, fel Cynulliad Cendlaethol Cymru, eisiau tynhau ar y gost cyffuriau hon drwy symud at ddefnyddio mwy o gyffuriau generig, a ydym yn hapus bod gennym y pwerau i wneud hynny? Hynny yw, wrth i chi edrych i mewn i'r posibiliadau o arbed arian, a ydych hefyd yn edrych ar geisio sicrhau pwerau i ni wneud hynny?

Mr Gregory: I think that it is arguable that we have taken the prescribing of generic drugs in terms of the proportion of total prescribing I would defer to Brian Gibbons and Geraint Davies on this about as far as we are going to. Performance in Wales is very comparable to England and is flattening out. In the process, we are getting into difficulties about the availability of generic drugs. As you know, that has caused us a significant problem over the last year. I am not saying that we should not pursue this;
we need to pursue every avenue. However, I think that we need to look at issues around joint formula redevelopments, prescribing incentive schemes and the incidence of repeat prescribing. All of these are avenues that need to be pursued. While generic drugs have played an important part in containing the rising costs, I am not absolutely sure that they will provide a basis for doing so to any significant extent in the future. I may be wrong about that, but that would be my judgment.

Janet Davies: We have now come to the end of the session. I thank the witnesses for their very full and helpful answers.

Janet Davies: Yr ydym bellach wedi dod i ddiwedd y sesiwn. Diolch i'r tystion am eu hatebion llawn a defnyddiol iawn.

Daeth y sesiwn cymryd tystiolaeth i ben am 12.00 p.m.

The evidence-taking session ended at 12.00 p.m.
Annex B

Information from the Assembly’s Director of NHS, Wales on the issue of data matching between the NHS and the Department of Social Security

Audit Committee – 6 April 2000

Action point arising from the Director, NHS Wales’ evidence session

Mr Gregory offered to write to the Audit Committee in response to Lorraine Barrett, AM’s question about whether the All-Wales Anti-Fraud Working Group had addressed the issue of data-matching between the NHS and, for example, the Department of Social Security’s databases. She also wondered about the practical difficulties which might be involved.

The Anti Fraud Working Group has not addressed this issue to date. It is, however, a major aspect of the work that the Assembly expects the new counter fraud operational service (CFOS) to undertake. A new link is to be established between Wales and England to counter fraud in the NHS, with Wales becoming a partner in the counter fraud service already in place in England. The joint working with CFOS will provide a comprehensive service extending to both the primary and secondary sectors. Arrangements will be made to ensure proper reporting arrangements to the NHS in Wales and to the National Assembly.

This counter fraud service has existed in England since April 1999, and has already agreed the necessary protocols in place with the Department of Social Security (DSS). It is also in discussion with the Inland Revenue about similar arrangements over Working Families Tax Credit eligibility.

Such checks could only be undertaken cost effectively by electronic means. It is intended that checks with DSS over eligibility for free prescriptions will be implemented, following the introduction of new electronic scanning of prescriptions, at Bro Taf Health Authority, who have responsibility for calculations of payments to pharmacists and checking all prescriptions in Wales.

The Assembly will be seeking to commence the necessary legislation to give effect to the penalty charge, in part in conjunction with the Department of Health, in readiness for this. For falsely claiming a free prescription the Health Act 1999 sets the penalty charge as the outstanding charge on the prescription form plus a penalty charge of five times the prescription charges due, with a maximum of £100. The penalty can be increased by 50 per cent if it is not paid within 28 days and there is the risk of additional costs if court action has to be taken to recover the charge.

Other penalty charges, calculated in a similar way, exist in respect of falsely claiming exemption from dental charges or falsely claiming benefit in respect of optical services. Once the legislation has been commenced for Wales it would be open to the National Assembly to set a different level of penalty charge from the other home countries, although there would be advantages in maintaining consistency across the NHS and the UK. This matter can be
considered once the secondary legislation giving effect to the penalty charges has been brought forward.

There is some concern that electronic checks of DSS or Inland Revenue may contravene the Data Protection Act unless the prescription or other form in which exemptions are claimed specifically makes clear that these checks may take place. This matter is being considered by the Department of Health and may require a redesign of the reverse of the relevant forms. A suggested solution is for all such forms to carry an authorisation from patients for such checks to be undertaken.
CLINICAL NEGLIGENCE WITHIN THE NATIONAL HEALTH SERVICE

At the Audit Committee meeting on 6 April 2000 to consider the C&AG’s Report on the 1998-99 NHS (Wales) Summarised Accounts, Geraint Davies (Q60) questioned the performance of the legal services employed by the NHS in Wales (the ‘Welsh Health Legal Services’), and how these compared with the private sector lawyers employed by the NHS Litigation Authority in England.

As the Committee will be aware from my forward work programme, I plan to undertake a value for money investigation of clinical negligence in Wales. My intention is to examine the work of the Welsh Health Legal Services as part of this study and I will look to see if useful comparisons can be drawn to assess its performance.

I also undertook, in discussion with you outside that meeting, to provide the Committee with further information on the comparative anticipated future costs of clinical negligence across Wales, England, Scotland and Northern Ireland. These are given in the following table, and are based on a broad estimate of future settlements broken down between ‘Provisions’ for clinical negligence, being probable
payments, and ‘Contingent Liabilities’, which are only possible payments.

As you will see, the amounts for Scotland and Northern Ireland are so out of line with those for Wales and for England that there must be some special explanation – for example, there may be some difference in the accounting treatment of these transactions.

I will pursue this with the authorities in Scotland and Northern Ireland, and let you know the results.

<table>
<thead>
<tr>
<th>Financial Year 1998-99</th>
<th>Provisions £000</th>
<th>Contingent liabilities £000</th>
<th>Total clinical negligence £000</th>
<th>Total NHS expenditure on NHS £000</th>
<th>Clinical negligence as a % of total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wales</td>
<td>98,392</td>
<td>115,992</td>
<td>214,384</td>
<td>2,283,000</td>
<td>9.4%</td>
</tr>
<tr>
<td>England</td>
<td>2,342,048</td>
<td>1,502,596*</td>
<td>3,844,644*</td>
<td>36,612,000</td>
<td>10.5%</td>
</tr>
<tr>
<td>Scotland</td>
<td>24,760</td>
<td>34,924</td>
<td>59,684</td>
<td>4,977,493</td>
<td>1.2%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Nil</td>
<td>69,817</td>
<td>69,817</td>
<td>1,725,134</td>
<td>4.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,465,200</td>
<td>1,723,329</td>
<td>4,188,529</td>
<td>45,597,627</td>
<td>9.19%</td>
</tr>
</tbody>
</table>

*Note: the * figures include net contingent liabilities in respect of NHS trusts in England.*

I hope that this information is of assistance to the Committee.

JOHN BOURN
THE AUDIT COMMITTEE

The National Assembly’s Audit Committee ensures that proper and thorough scrutiny is given to the Assembly’s expenditure. In broad terms, its role is to examine the reports on the accounts of the Assembly and other public bodies prepared by the Auditor General for Wales; and to consider reports by the Auditor General for Wales on examinations into the economy, efficiency and effectiveness with which the Assembly has used its resources in discharging its functions. The responsibilities of the Audit Committee are set out in detail in Standing Order 12.

2.2 The membership of the Committee as appointed on 05 April 2000 is:

Chair: Janet Davies (Plaid Cymru)
Lorraine Barrett (Labour)
Brian Gibbons (Labour)
Jane Davidson (Labour)
Alison Halford (Labour)
Dafydd Wigley (Plaid Cymru)
Geraint Davies (Plaid Cymru)
Alan Cairns (Conservative)
Peter Black (Liberal Democrat)

NB: Christine Chapman and Alun Pugh were members of the Committee from 23 June 1999 to 5 April 2000.

Further information about the Committee can be obtained from:

Andrew George
Clerk to the Audit Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA
Tel: (029) 20 898155
Email: Audit.comm@wales.gsi.gov.uk
Cynulliad Cenedlaethol Cymru: Y Pwyllgor Archwilio

Adroddiad 00-04 – Cyflwynwyd i’r Cynulliad Cenedlaethol ar 13 Gorffennaf yn unol ag adran 102(1) o Ddeddf Llywodraeth Cymru 1998

Adroddiadau ar Gyfrifon Cryno NHS (Cymru), 1998-99

Cynnwys

1. Cyflwyniad
2. Iechyd ariannol yr NHS yng Nghymru drwyddo draw
3. Iechyd ariannol ardaloedd pum awdurdod iechyd Cymru
4. Esgeulustod clinigol
5. Twyll
6. Cost cyffuriau gofal sylfaenol
7. Crynodeb o’r Argymhellion
8. Casgliadau Cyffredinol

Atodiadau

Atodiad A: Trafodion perthnasol y Pwyllgor – Cofnodion Tystiolaeth (Dydd Iau 6th Ebrill 2000)

Atodiad B: Gwybodaeth gan Gyfarwyddwr NHS - Cymru y Cynulliad ar bwnc cyfatebu data rhwng yr NHS a’r Adran Nawdd Cymdeithasol

Atodiad C: Llythyrau i’r Pwyllgor oddi wrth Syr John Bourn, Archwiliwr Cyffredinol Cymru ar esgeulustod clinigol

Atodiad D: Y Pwyllgor Archwilio
Cyflwyniad


2. Cyllidir yr NHS yng Nghymru yn bennaf drwy daliadau i bum awdurdod iechyd Cymru, a gwnaethant hwythau yn eu tro daliadau i ymddiriedolaethau NHS o dan gytwynynau am wasanaethau eraill (£1,485 miliwn). Ar gyfer gwasanaethau gofal iechyd sylfaenol, gwnaeth yr awdurdodau iechyd daliadau i Feddygon Teulu sydd â’u cyllideb eu hunain ac ar ran Meddygon Teulu sydd heb eu cyllideb eu hunain (£747 miliwn) a hefyd daliadau i Ddeintyddion (£61 miliwn) ac Optegwyr (£18 miliwn).

3. Cwbllheir Cyfrifon Cryno yr NHS yng Nghymru drwy gyfansymio cyfrifon y cyrff NHS sy’n rhan o’r gwasanaeth, a dyma’r peirianwaith a ddefnyddir i adrodd ar ganlyniadau’r NHS yng Nghymru drwyddynt draw. Rhydd Adroddiadiad y Rheolwr a’r Archwiliwr Cyffredinol ar gyfrifon 1998-99 y wybodaeth ddiweddar a’r iechyd ariannol yr NHS yng Nghymru a’r prif faterion sy’n effeithio ar y sefyllfa honno 38


6. Cymerwyd tystiolaeth oddi wrth Mr Peter Gregory, Cyfarwyddwr Cyfarwyddiadaeth NHS y Cynulliad a Swyddog Cyfrifo Cyfrifon Cryno NHS (Cymru). Yn bresennol gydag ef yr oedd Mrs Sarah Beaver, pennaeth Is-adran Cyllid NHS y Cynulliad. Ceir trawsgrifiad o’r dystiolaeth hon yn Atodiad A. Derbynwyd tystiolaeth yrgrifenedig hefyd gan Mr Gregory (Atodiad B), a chan Syr John Bourn, Archwiliwr Cyffredinol Cymru (Atodiad C). Hoffem ddiolch i Mr Gregory am y ffordd gadarnhaol a adeiladol yr ymatebodd i gwestiynau’r Pwylgor.

38 Cyfrifon Cryno NHS (Cymru) 1998-99 (HC 301 o 1999-2000), a gyflwynwyd ar 13 Mawrth 2000
7. Yn yr adroddiad hwn, rydym yn edrych ar y Gwasanaeth Iechyd yng Nghymru o dan bump prif bennawd:

- Iechyd ariannol yr NHS yng Nghymru drwyddo draw;
- Iechyd ariannol ardaloedd pum awdurdod iechyd Cymru;
- Esgeulustod clinigol;
- Twyll; a
- Chost cyffuriau gofal sylfaenol.

Iechyd ariannol yr NHS yng Nghymru drwyddo draw

8. Yn 1998-99, cofnododd yr NHS yng Nghymru ddiffyg ariannol o £21.8 miliwn i gyd 39. Cynyddodd hyn y diffyg cronedig llawn o £32.1 miliwn i £53.9 miliwn ar 31 Mawrth 1999. Am 1999-2000, roedd dau o’r pum awdurdod iechyd a 10 o’r 16 ymddiriedolaeth NHS a oedd yn gweithredu yn y flwydden honno yn darogan diffygion ariannol pellach 40. Gyda’i gilydd, roedd y diffygion net a gâi eu darogan am 1999-2000 yn £20 miliwn, a fyddai’n cynyddu diffyg cronedig yr NHS yng Nghymru i tua £73.9 miliwn ar 31 Mawrth 2000 41. Dywedodd Mr Gregory wrthym nad oedd y sefyllfa hon o ddiffyg ariannol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffredinol a phroblemau ariannol yr NHS yn gyffred

9. Fodd bynnag, mae ffactorau eraill hefyd wedi dylanwadu ar y sefyllfa hon. Yn gynnar yn 1999, comisiynodd Ysgrifennydd Gwladol Cymru ar y pryd adroddiad cloriannu ar iechyd ariannol yr NHS yng Nghymru. Deuai’r Adroddiad Cloriannu, a ryddhawyd ym Mehefin 1999, i’r casgliad nad oedd yna un eglurhad i’r problemau ariannol sy’n bodoli o fewn yr NHS yng Nghymru 43. Dywedodd Mr Gregory wrthym nad oedd y sefyllfa hon o ddiffyg ariannol a phroblemau ariannol yr NHS yn unigryw i Gymru, ond eu bod yn gyffredin i systemau gofal iechyd mewn mannau eraill yn y byd datblygedig 42.

10. Yn ychwanegol at berfformiad lleol yr awdurdodau iechyd a’r ymddiriedolaethau NHS, awgrymodd y Swyddog Cyfrifo wrthym fod y ffactorau išod yn cyfrannu ar lefel genedlaethol at y problemau ariannol yr NHS yng Nghymru:

- Cafodd yr amgylchedd ariannol ei dynhau yn ystod y 1990au canol i hwyr, a chafwyd gofyniad hefyd ar i’r NHS gyflawni targedau arbedion effeithlonrydd a fyddai’n rhyddhau arian ond a oedd, yn ymarferol, yn anodd i’w gwireddu 44;

39 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 4.6
40 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 4.19 a 4.20
41 C18
42 C2
43 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 4.31 i 4.33
44 C3
Arweiniodd pwysau o safbwynt adnoddau ac effeithlonrwydd o fewn Adran Iechyd y Swyddfa Gymreig at leihau’r adran honno, gan gynnwys crebachu ei rôl monitro, a gwneud perfformiad ei rôl rheoli strategol yn llai effeithiol. Aeth y berthynas rhwng y Swyddfa Gymreig a’r cyrff NHS yn anoddach o’r herwydd 45. Argymhellai’r Adroddiad Cloriannu y dylid cryfhau Cyfarwyddiaeth NHS y Cynulliad fel y gellid ymldrwm mewn ffordd integredig â monitro perfformiad ariannol, gwerth am arian a gwireddu amcanion yr NHS yng Nghymru. Dywedodd Mr Gregory wrthym fod arowlwg diweddar wedi arwain at gynnydd yn yr adnoddau staff, a bod y broblem hon wedi’i lliniaru bellach 46;

Bu marchnad fewnol yr NHS, a seiliwyd ar gystadleuaeth a gwahanu swyddogaethau’r prynwr/darparwr, o fudd o ran crisialu cyfrifoldeb gweithredol ar y lefel leol. Fodd bynnag, roedd hefyd wedi creu anawsterau yn y berthynas waith rhwng awdur-dodau icheyd ac ymddiriedolaethau NHS, a dywedodd Mr Gregory wrthym ei fod o’r farn bod dileu cystaldeuaeth o’r NHS yn cyfrannu at welliant sylweddol yn hyn o beth 47;

Cyfwynwyd y rhaglen i ad-drefnu’r ymddiriedolaethau NHS er mwyn sicrhau darpariaeth gofal fwy effeithlon i gleision. Disgwyliai Mr Gregory i hyn arwain at arbedion sylweddol, ond dywedodd wrthym y byddai’n golygu cost o oddeutu £4 miliwn i’r NHS yng Nghymru i ddechrau, gan gyfrannu yn y tymor byr at y diffyg ariannol. Mae Cyfarwyddiaeth yr NHS yn disgwyl i’r ad-drefnu olygu arbedion o £4 miliwn yn 2000-01, gan godi ar ôl tair blynedd i arbediad blyneddol rheolaid o £6 miliwn 48.

11. Un peirianwaith allweddol ar gyfer monitro perfformiad ariannol ymddiriedolaethau’r NHS yng Nghymru yw’r tri amcan ariannol a bennwyd ar gyfer pob ymddiriedolaeth NHS gan Gyfarwyddiaeth NHS y Cynulliad (Adran Iechyd y Swyddfa Gymreig gynt). Yr amcanion yw:

- Adennill eu costau dros y cyfnod tair-blynedd 1997-98 i 1999-2000;
- Cyflawn ‘Cyfradd Cydnabod Costau Cyfalaf’ (hynny yw, i dalu cost amcanol cyllido ei asedau cyfalaf ar ôl caniatáu ar gyfer dibrisiant) o chwech y cant yn union yn flynyddol; ac
- Aros o fewn y Terfyn Cyllido Allanol penodedig 49.

45 C7 ac 8
46 C8
47 C4
48 C15
49 Rhagair i Gyfrifon Cryno’r NHS ar gyfer Cymru, 1998-99, paragraffau 20-23
12. Am 1998-99, adroddodd y Rheolwr a’r Archwiliwr Cyffredinol bod 25 o’r 26 ymddiriedolaeth NHS wedi methu cyflawni un neu fwy o’u tri amcan ariannol allweddol, gan gynnwys pedwar oedd wedi methu ar y tri amcan. Methodd pedair ymddiriedolaeth ar ddeg y targed adennill costau interim a methodd 21 gyflawni’r Gyfradd Cydnabod Costau Cyfalaf o 6 y cant yn union. Aeth pedair ymddiriedolaeth y tu hwnt i’w Terfyn Cyllido Allanol, er i Mr Gregory ddweud wrth ym.50. Egluroedd Mr Gregory wrth y methiannau hyn i gyd yn deillio o’r anawsterau a wynebir gan ymddiriedolaethau NHS wrth weithredu oddi mewn i’w hamgylchedd ariannol. 51.

13. Dyletswydd ariannol arall ar bob corff NHS yw’r gofyniad i setlo’u holl filiau o fewn 30 diwrnod iddynt dderbyn anfoneb ddilys, yn unol â Chod Ymarfer Talu Cyflenwyr Cyd-ffederasiwn Diwydiant Prydain. Mae perfformiad yr awdurdodau iechyd gyda’i gilydd yn erbyn y targed hwn yn dal, gyda dim ond 85 y cant o anfonebau’n cael eu talu o fewn y cyfnod 30-diwrnod, er bod y rhan yn cynrychioli tua 97 y cant o’r anfonebau yn ôl gwerth. O’r ymddiriedolaethau NHS, gwellodd 16 eu perfformiad yn ystod 1998-99, ond mewn naw ymddiriedolaeth gwaethygodd y lefelau talu’n brydlon – ac ni thalodd un ymddiriedolaeth (Ymddiriedolaeth NHS Glan Hafren) ond 26 y cant o’i biliau o fewn 30 diwrnod 52.

14. Hysbysodd y Swyddog Cyfrifo ni fod y Cynulliad wedi monitoro’r perfformiad mewn awdurdodau iechyd ac ymddiriedolaethau NHS o ran talu cyflenwyr ar sail fisol, gan chwilio am welliannau yn y sefyllfa honno. Dywedodd wrthym nad oedd yn fodlon à’r lefelau perfformiad cyfredol, a’i fod yn bwriadu cynnwys yn y llythyr blynyddol am y dyraniau cyllido a anfonir at bob corff NHS ofyniad ar iddynt wneud gwelliannu 53.

15. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ynglŷn ag iechyd ariannol yr NHS yng Nghymru drwyddo draw fel a ganlyn:

(i) Nodwn fod y problemau ariannol sy’n wynebu’r NHS yng Nghymru yn gyffredin i systemau gofal iechyd mewn mannau eraill yn y byd datblygedig; a hefyd mai nid problemau diweddar mo’r rhan, gyda diffygion ariannol yn cael eu hadrodd ers y 1980au. Mewn sefyllfa o gyllid cyfyngedig, bydd darparu gofal iechyd bob amser yn golgu cydhwyso’r angen yn erbyn y gost yn ofalus;

(vii) Rydym yn bryderus ynglŷn ag anallu’r Swyddfa Gymreig gynt i fonitro’r NHS yng Nghymru yn ddigonol fel yr oedd y problemau hynnyn’r datblygu, a hefyd ynglŷn â’r dirywiaid a fu yn y berthynas rhwng y

50 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 4.15 ac C23
51 C23
52 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 4.23 i 4.30
53 C28
Swyddfa Gymreig a gwahanol rannau o'r NHS. Rydym yn falch o glywed am welliannau diweddar yn y maes hwn, a bod y problem hon yn cael ei datrys bellach. Anogwn Gyfarwyddiaeth yr NHS i weithio’n agosach gyda chyrff iechyd ar draws Cymru, gan roi rheolaeth strategol ac arweiniad gwirioneddol i’r gwasanaeth;

(viii) Ystyriwn fod perfformiadau gwael yr ymddiriedolaethau NHS yng Nghymru yn erbyn eu tri amcan ariannol yn annerbyniol, er y cydnabyddwch mai canlyniadau uniongyrchol eu hamglychdded ariannol oedd hyn. Edrychwn tuag at Gyfarwyddiaeth yr NHS i weithredu i sicrhau bod ymddiriedolaethau NHS yn gallu cyflawni’r arbedion y profiwydwyd y byddent ar gael yn sgil ad-drefnu’r ymddiriedolaethau NHS yng Nghymru, a nodwn ein bwrud i fwrw golwg manwl ar lwyddiant yr haglon hon maes o law; ac

(ix) Anogwn fod proses lyrhych i’w sefydlu i amcangyfrif y costau a’r arbedion y gellid eu cyfawni drwy ad-drefnu strwythturol yr yr NHS; ac

(x) Rydym yn bryderus iawn ynglŷn â’r perfformiadau a gwaelodd yr ymddiriedolaethau NHS yng Nghymru yn erbyn y targed talu’n brydon. Anogwn Gyfarwyddiaeth yr NHS i weithredu’r briedol i sicrhau bod pob corff NHS yn cydymffurfio â Chod Ymarfer Cydweddaf i Chwarae a Channu’r Tref, a nodwn ein bwrud i fwrw golwg manwl ar lwyddiant yr haglon hyn.

Iechyd ariannol ardaloedd pum awdurdod iechyd Cymru

16. Yn Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol ceid dadansoddiad o’r diffyg ariannol a ddaeth i ran cyrff NHS yng Nghymru yn 1998-99 rhwng ardal y pum awdurdod iechyd, a dangosai amrywiad eang mewn perfformiadau ariannol 54. Cyflwynodd y Swyddog Cyfrifol sawl ffactor ger ein bron, ar lefel ardal yr awdurdodau iechyd a’r arbedion ymysg cyrff NHS unigol, y credai ef sydd wedi cyfrannu at yr amrywiad hwn.

17. Ar lefel ardal yr awdurdodau iechyd, awgrymai fod y ffactorau a ddylanwadaid yn cynnwys y ffactorau amrywiadau ariannol, cyfranir gan yr ardalau meddygon teulu sy’n dal cronfa, ac i ba raddau sy’n oedd pob ardal yn ddibynnol ar wasanaethau a gaffaelid gan allanol. O fewn yr ymddiriedolaethau NHS, roedd ffactorau megis lefel y gwestygleu a thros yr enw a gynigai a’r cyllid sy’n olynol i gynnal swyddogaethau mwy arbenigol rhai ymddiriedolaethau NHS yn cyfrannu’n sylweddol hyd at eu perfformiadau ariannol. Awgrymodd Mr Gregory hefyd wrthym y gallai ystod o ffactorau personol ar gyfer hefyd yr arbedion ar drefnu iechyd arbennig pobl yw gweld eu hynnwymiad i reolaeth ariannol i gyd yn cyfrannu at yr amrywiad hwn mewn

54 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 4.6 a Ffigwr 2
performiad ariannol yr adroddwyd amdanyn ym ardaloedd y pum awdurddod iechyd.


Ardal awdurddod iechyd Dyfed Powys

19. Adroddodd ardal awdurddod iechyd Dyfed Powys fod ganddi ddiffyg net o tua £11.5 milion yn 1998-99, a gynrychiolai dros hanner ddiffyg Cymru-gyfan. Roedd y Swyddfa Gymreig gynt wedi darparu cyfanswm o £12.5 milion mewn arian brocera (cyllid tymor byr mewn ymateb i anawsterau llif-arian) i Awdurddod Iechyd Dyfed Powys. Wrth ddisgrifio rôl Cyfarwyddiaeth yr NHS yn cefnogi adferiad ariannol Awdurddod Iechyd Dyfed Powys, eglurodd Mr Gregory fod ei benderfyniad i drosglwyddo’r cyllid ychwanegol hwn a oedd yn daladwy i’r ymddiriedolaethau NHS lleol drwy’r Awdurddod Iechyd yn gofygu bod yr ymddiriedolaethau NHS yn ddibynnol yn nhermau cyllid ar un tâl-feistr. O ganlyniad, roedd yr ymddiriedolaethau NHS hynny yn parhau i adrodd am sefyllfa ariannol fwy ffafriol, tra bo’r Awdurddod Iechyd yn adrodd am ddiffyg cronediog a oedd yn cynyddu.

20. Wrth grynhoi’r broses adfer ar gyfer ardal Dyfed Powys, dywedodd y Swyddog Cyfrifo y cytunwyd ar Gynllun Adfer rhwng yr Awdurddod Iechyd, Cyfarwyddiaeth yr NHS a phob un o’r Ymddiriedolaethau NHS hyn: Gofal Iechyd Powys, Ceredigion a Chanolbarth Cymru a Sir Benfro a Derwen. Mewn perthynas à’r bedwaredd ymddiriedolaeth, Ymddiriedolaeth NHS Sir Gaerfyrddin, mynegodd Mr Gregory ei amheuon ynglŷn à’r sefyllfa ariannol yr oedd yn ei darogan, a dywedodd wrthym nad oedd yn hyderus fod strategaeth adfer briodol wedi’i dyfeisio eto.

Ardal awdurddod Iechyd Bro Taf

21. Yn ei Adroddiad, dywedodd y Rheolwr a’r Archwiliwr Cyffredinol mai’r darogan oedd y byddai sefyllfa ariannol Awdurddod Iechyd Bro Taf yn dirywio’n ddrwg, gyda ddiffyg o £6.1 milion wedi’i ddarogan am 1999-2000 a ddiffyg sylwedol pellach yn cael ei ddigwydd yr 2000-01. Roedd Mr Gregory mewn sefyllfa i ro i rhagolygon diwygiedig i ni am 2000-01 a oedd wedi gwella’n sylweddel, gan ostwng y ddiffyg a broffwydwyd yn wreiddiol o

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55 C30
56 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad B, paragraffau B.1 a B.3
57 C36
58 C37
59 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad A, paragraff A.2
£17.4 miliwn i ddim ond diffyg ymylol am y flwyddyn honno. Roedd hyn yn deillo’n rhannol o gymorth ychwanegol oddi wrth Gyfarwyddiath yr NHS i liniaru pwysau cost penodol. Ymysg y rhain yr oedd swyddogaeth ddysgu Ysbyty Athrofaol Cymru o fewn Ymddiriedolaeth NHS Caerdydd a’r Fro, a’r costau cyfalaf ychwanegol a ddeilliai o Ysbyty Brenhinol newydd Morgannwg 60.

**Ardal awdurdod iechyd Gwent**

22. Adrooddodd ardal awdurdod iechyd Gwent ddiffyg drwyddo draw o £0.4 miliwn am 1998-99, sef y ddiffyg isaf o blith ardal oedd y pum awdurdod iechyd yng Nghymru 61. Dim ond tair ymddiriedolaeth NHS sydd yna yn ardal Gwent, ac awgrymodd Mr Gregory wrthym fod y ddiffyg cynhlethdod cymarol hwn wedi helpu’r berthnas rhwng yr awdurdod comisiynu a’r ymddiriedolaethau 62. Dywedodd wrthym i’r ardal wynebu anawsterau ariannol yn y gorffennol, ond y rhoddwyd sylw i’r rhain a’u datrys drwy reolaeth ariannol effeithiol yr ymgysmerwyd â hi mewn partneriaeth rhwng yr amryw gynrychiol oedd y diffyg cymhlethdod hwn. Dywedodd wrthym i’r ardal wynebu anawsterau ariannol a brofwyd gan ardal yr awdurdod iechyd hwn yn deillo’n bennaf o ddiffygion ariannol mawr cyn-ymddiriedolaeth NHS Ysbyty Treforys, a ddeuai i gyfanswm o tua £7.2 miliwn ar 31 Mawrth 1999 64. Dywedodd Mr Gregory wrthym fod y diffygion hyn wedi eu gostwng yn sylwedol yno ystod bwyddyn ariannol 1999-2000. Credai i arweinyddiaeth graff y tîm rheoli sy’n gweithredu bellach yn sgil uno’r ymddiriedolaeth gydag Ymddiriedolaeth NHS Abertawe, yng nghyflymddiad a ddeilliodd o hynny, wedi chwarae rhan o bwys yn y llwyddiant hwnnw 65.

**Ardal awdurdod iechyd Mynydd Morgannwg**

23. Mae’r anawsterau ariannol a brofwyd gan ardal yr awdurdod iechyd hwn yn deillo’n bennaf o ddiffygion ariannol mawr cyn-ymddiriedolaeth NHS Ysbyty Treforys, a ddeuai i gyfanswm o tua £7.2 miliwn ar 31 Mawrth 1999 64. Dywedodd Mr Gregory wrthym fod y diffygion hyn wedi eu gostwng yn sylwedol yno ystod bwyddyn ariannol 1999-2000. Credai i arweinyddiaeth graff y tîm rheoli sy’n gweithredu bellach yn sgil uno’r ymddiriedolaeth gydag Ymddiriedolaeth NHS Abertawe, yng nghyflymddiad a ddeilliodd o hynny, wedi chwarae rhan o bwys yn y llwyddiant hwnnw 65.

**Ardal awdurdod iechyd Gogledd Cymru**

24. Nododd y Rheolwr a’r Archwiliwr Cyffredinol yn ei adroddiad i ardal gogledd Cymru drwyddi draw gofnodi diffyg o £1.8 miliwn yn 1998-99, er mai Awdurdod Iechyd Gogledd Cymru ei hun oedd yr unig awdurdod i

60 C41 a 43
61 Adrooddodd y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad C, paragraff C.1
62 C46
63 C46 a 47
64 Adrooddodd y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad D, paragraffau D.3 a D.4
65 C49 a 50
gofnodi gwarged 66. Rhododd y Swyddog Cyfrifo nifer o resymau inni am sefyllfa ariannol gymharol gryf Awdurod Iechyd Gogledd Cymru. Er enghraifft, roedd yr ardal yn elwa o’r fformiwla dyrannu adnoddau gyfredol, gyda’r cyllid i’r ardal yn uwch na’r cyfartaledd drwy Gymru. Tynnodd Mr Gregory sylw hefyd at ddiffyg cymhlethdod cymharol yr amgylchedd gofal iechyd yng Ngogledd Cymru, a adlewyrchir yn y system gofal iechyd symlach sy’n ofynnol o’i chymharu, er enghraifft, â sefyllfa de Cymru. Roedd y berthynas rhwng yr awdurod gofal iechyd a’i amryw ymddiriedolaethau yn gymharol syml ac roedd maes cyfrifoldeb pob ymddiriedolaeth wedi’i ddynodi’n glir, rhywbeth nad yw’n wir am dde Cymru 67. I gloi, dywedodd Mr Gregory fod rheolaeth ariannol o fewn cyrrff NHS yr ardal yn safon uchel 68.

25. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar iechyd ariannol ardaloedd pum awdurod gofal iechyd Cymru fel a ganlyn:

(v) Nodwn ystod cymhleth y ffactorau sy’n effeithio’n uniongyrchol ar berfformiad ardal pob un o’r pum awdurod gofal iechyd, a’r cydberthynas rhwng y ffactorau;

(vi) Cytunwn â Mr Gregory nad yw ynysu’r Ymddiriedolaethau NHS o fewn Dyfed Powys rhag dyledion yr awdurod gofal ynddull effeithiol o reolaeth ariannol. Os digwydd yn y dyfodol y bydd ar yr ymddiriedolaethau NHS angen cymorth ariannol ac esblym cyfieirio cyllid o’r fath, er mwyn sicrhau ei fod yn cael ei defnyddio i’w effeithiol i’w ddibenion bwriedig, gyda golwg ar yr angen y fodd yn drwywy ac agored;

(vii) Tra’r ydym yn nodi’r cynllun adfer bwriedig y cytunwyd arno gydag Awdurod Iechyd Dyfed Powys a thair o’r pedair ymddiriedolaeth NHS yn yr ardal honno, rydym yn rhanu pryderon Mr Gregory ynglŷn â pherfformiad ariannol Ymddiriedolaeth NHS Sir Gaerfyrddin, yn nhermau ei sefyllfa ariannol gyfredol a hefyd y methiant i gwblhau cynllun adfer y cytunwyd amno ar gyfer yr ymddiriedolaeth honno. Anogwn Gyfarwyddiaeth yr NHS i weithio’nn agos gyda’r ymddiriedolaeth ac Awdurod Iechyd Dyfed Powys i gywirio unrhyw ddiwygion yn eu cynllun Adfer ar frys; ac

(viii) Rydym o’r farn nad yw’r peirianwaith presennol ar gyfer dyrrannu adnoddau mwyach yn fuddiol ac nad yw’n rhoi sylw digonol i’r pwysau amrywiol a gwahanol o ran costau sy’n effeithio ar gyrrff NHS ar draws Cymru. Anogwn Gyfarwyddiaeth yr NHS felly, mewn ymgyrchiau agos a’r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol, i weithredu’n gyfylm ar ganlyniadau’r arolwg o’r

66 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad E, paragraff E.1
67 C53
68 C54
fformiwla gyllido sydd ar y gweill ar hyn o bryd a sefydlu system sy’n cydnabod ffactorau o’r fath ac yn rhoi setliadau ariannol blynyddol teg a chyfiawn.

Esgeulustod clinigol

26. Mae Esgeulustod Clinigol yn golygu tor-dyletswydd gan ymarferwyr gofal iechyd wrth iddynt gyflawn eu dyletswyddau yn yr NHS 69. Adroddodd y Rheolwr a’r Archwiliwr Cyffredinol i gost uchafswm hawliadau am esgeulustod clinigol drwyddi draw, yn ôl yr amcanwyfrif, godi’n sylweddol yn ystod 1998-99, o £145 miliwn i £214 miliwn ar 31 Mawrth 1999 (mae’r amcanwyfrif hwn yn cynnwys taliadau tebygol a phosibl) 70. Awgrymodd y Swyddog Cyfrifo wrthym fod y cynnydd hwn i’w briodoli i ddau ffactor: tuedd gynyddol unigolion i hawlio iawn cyfreithiol; a lefelau cynyddol yr iawndal sy’n daladwy mewn achosion o’r fath 71.

27. Cyn dwyn achos cyfreithiol mewn achosion lle’r honnir esgeulustod clinigol, gall cleifion geisio iawn drwy Drefn Gwyno’r NHS ac, os ydynt yn dal yn anfodlon, gallant ddwyn eu cyf y gerbron Ombwdsman y Gwasanaeth Iechyd dros Gymru. Yng nghyd-destun hyn yn cael eu hystyried gan banel adolygu annibynnol, dywedodd Mr Gregory mai un gwendid cyffredin a nodir yw ansawdd wael y cyfathrebu rhwng y clinigwr a’r claf. Awgrymodd mai un maen prawf pwysig sy’n effeithio ar benderfyniad unigolion i wneud yr ymadlal yw’r modd yr ymdriniwyd â’r gwyn, a pha mor agored y buwyd wrth ddadlennu ffefthiau achos y claf iddynt 72.

28. Mae cyswllt agos rhwng mater esgeulustod clinigol a chysyniadau effeithiolrwydd clinigol a llywodraethu clinigol, yng nghyd-destun gwella ansawdd gofal o feunwr yr NHS. Amlinellodd Mr Gregory nifer o beirianweithiau sy’n cefnogi’r amcan hwn, gan gynnwys y Sefydliaid Cenedlaethol dros Ragoriaeth Glinigol, sydd â’r darganfod o adolygu effeithiolrwydd triniaethau newydd a rhai presennol o safbwynt clinigol ac o ran cost, a’r Comisiwn Gwella Iechyd sy’n gyfrifol am yr arlowg ar ansawdd gofal 73. Nododd hefyd fod Cronfa Risg Cymru yn gyfrifol am y ‘Rhwydwaith Rheolwyr Risg’, sydd à chynrychiolwyr o bob corff NHS yng Nghymru ymysg ei aelodaeth, ac sy’n trafo gwelliannau posibil i’r modd y rheolir digwyddiadau ac yn lleadaenu engheirióitha o’r ymarfer gorau 74.

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69 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.2
70 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.4-5.5
71 C55
72 C70 a 71
73 C56
74 C57
29. Mae Cronfa Risg Cymru hefyd wedi arwain y fforodd yn hyrwyddo gwaith rheoli risg effeithiol ar draws yr NHS yng Nghymru, gan gynnwys cyfres o Safonau Rheoli Risg sy’n berthnasol i awdurdodau iechyd ac ymddiriedolaethau NHS fel ei gilydd. Yn 1998-99, fodd bynnag, canfu’r Rheolwr a’r Archwiliwr Cyffredinol mai dim ond deg o’r 21 aelod gorff oedd wedi cyfwyno hunan-asesiad o’u perfformiad yn erbyn y safonau hyn.

30. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar fater esgeulustod clinigol fel a ganlyn:

(iv) Ymddengys i ni fod dau brif faes i ganolbwyntio arnynt wrth reoli nifer cynyddol yr achosion o esgeulustod clinigol yn yr NHS yng Nghymru, a’r gost gynyddol sef: ymdrin yn ddiymdroi ac yn gost- effeithiol â’r hawliadau sy’n disgwyl i gael eu prosesu ar hyn o bryd, ac effeithiol rwydd y dulliau gweithredu ar reoli risg er mwyn atal hawliadau newydd rhag codi yn y lle cyntaf. Rydym o’r farn nad yw Cyfarwyddiaeth yr NHS wedi gwneud cynnydd digonol yn y naill na’r llall o’r meysydd hyn, a phwysleisiwn y potensial i wella drwy ymateb i ganfyddiadau perthnasol y Sefydliad Cenedlaethol dros Ragoriaeth Glinigol a’r Comisiwn Gwella Iechyd y rhyfodol. Argymhellwn yn gryf fod Cyfarwyddiaeth yr NHS yn gweithredu i ganfod a lledaenu enghefirefftiau o’r ymarfer gorau mewn rheolaeth ariannol ar draws NHS Cymru;

(v) Rydym yn bryderus iawn i nodi mai dim ond hanner y cyrff NHS yng Nghymru a gyflwynodd hunan-asesiadau, gan adrodd a ydym yn cydyrnffurfio â’r Safonau Rheoli Risg, er ein bod yn cydnabod y gallai’r ad-drefnu ar yr ymddiriedolaethau ar y pryda’r dwy fodi o’r ymddiriedolaethau perthnasol y Sefydliad Cenedlaethol y gweld yn gweithredu i ganfod a lledaenu enghefirefftiau o’r ymarfer gorau mewn rheolaeth ariannol ar draws NHS Cymru;

(vi) Rydym hefyd o’r farn y gellid ac y dylid gwella’r drefn gwyno ar gyfer cleifion a’u perthnasau os ceir canlyniad clinigol anfoddaol. Credwn mai cyfathrebu mwy agored a chynharach rhwng clinigwyr a cleifion yw’r allwedd i ddatrys llawer o hawliadau am esgeulustod ac atal yr angen am weithredu cyfreithiol. Dylai mwy o ddyloywder wrth ddadlennu manylion meddygol i achwynydd ddod yn drefn safonol ac anogwn Gyfarwyddiaeth yr NHS i roi sylw i’r mater hwn yn rhannol drwy newidiadau yn addysg a hyfforddiant staff meddygol.

Twyll

31. Mae lefel y twyll o fewn yr NHS yn fater o bwys allweddol, gan arwain at golli adnoddau sylweddol y gellid fel arall eu gwario ar ofalu am gleifion. Er bod yna Weithgor Ymladd Twyll, gyda chylch gwaith i ddatblygu strategaeth twyll a lledaenu enghefirefftiau o’r ymarfer gorau o ran mynd i’r afael â thyll

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75 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.10
ar draws Cymru, cydnabyddai'r Swyddog Cyfrifo nad oedd fawr ddim cynnydd wedi'i wneud o ran rhai sylw i dwyll yng Nghymru. Yn 1998-99, dim ond gwerth £102,000 o dwyll a ganfuwyd yng Nghymru; o seilio ffigyrâu Cymru ar y twyll a ganfuwyd yn Lloegr yn y flwyddyn honno yng nghyflymddiadau presgripsiwn yn unig, byddai amcangyfrif cymesur o dwyll tebygol o’r math hwn yng Nghymru yn rhoi ffigrwyr o ryw £8-10 miliwn. Dywedodd Mr Gregory wrthym fod lefel y twyll a ganfuwyd yn amlwg heb ei llwyr fynegi, ac adlewyrchai’r ffaith nad oedd llawer o waith wedi’i wneud yn y maes hwn hyd yma.

32. Dywedodd Mr Gregory wrthym am y trafodaethau a oedd ar y gweill gyda Chyfarwyddiaeth y Gwasanaethau Ymladd Twyll, y corff o fewn Gweithrediadaeth yr NHS sy’n gyfrifol am fynd i’r afael â thwyll a llygredigaeth o fewn yr NHS yng Lloegr, a oedd yn ymchwilio i’r posiblirwydd y gellid ymestyn ei gilydd gwaith i gynnwys Cymru. Yn dilyn y gwrando a ddiwyd y dyluniau a’r bydd, mae’r Prif Ysgrifennydd wedi cyhoeddi bod y trafodaethau hynny wedi’u ddefnyddio ac y bydd yr NHS yng Nghymru yn cael ei gynnwys yng ngwaith Cyfarwyddiaeth y Gwasanaethau Ymladd Twyll.

33. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar fater twyll fel a ganlyn:

(iv) Rydym yn bryderus ynglŷn â’r diffyg cynnydd hyd yma o ran mynd i’r afael â thwyll yng Nghymru. Rydym felly yn croesawu’r cyhoedd y bu o fewn yr NHS. Rydym fel y dychmyg o’r tro, rydym o’r afael â’r gwaith y bydd y gwaith o fonirio twyll a llygredigaeth o fewn yr NHS yng Nghymru y mae’n rhaid i ysgolion ei gilydd gwaith estynedig Cyfarwyddiaeth y Gwasanaethau Ymladd Twyll;

(v) Rhyfeddir ni fod lefelau’r twyll a ganfuwyd mor isel (£102,000 yn 1998-99; £950,000 (amcangyfrif) yn 1999-2000), a chytunwn â Chyfarwyddiaeth yr NHS yng Nghymru. Rydym o’r farn fod angen gwelliannau sylweddol ym mynd i’r gwaith a ganfod ac atal twyll. Anogwn Cyfarwyddiaeth yr NHS i fynd i’r afael â’r broblem hon fel mater o frys, ac yn enwedig i ystyried y defnydd posibl o gymhellion “gwario i’r arbed” a fyddai’n caniatáu i unrhyw arbedion a grëir gael eu rhyddhau’n uniongyrchol ar gyfer gofal eu rhyddhau’n uniongyrchol ar gyfer gofal eu

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76 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.21
77 C72 a 73
78 C74
79 C72
80 Hysbysiad i’r Wasg (cyfeirnod W00345-hlt) a ryddhawyd gan y Cynulliad 10 Ebrill 2000
Sylwn hefyd mai at ofal sylfaenol yn unig y cyfeiriwyd y camau a gymeryd hyd yma i fynd i’r afael â thwyll, ac mai dim ond yn ddiweddar y mae Gweithgor Ymladd Twyll Cymru-gyfan wedi ystyried mater twyll yn y sector gofal eilaidd. Anogwn Gyfarwyddiaeth yr NHS hefyd i roi sylw i’r perygl o dwyll yn y sector gofal eilaidd, gan roi sylw dyledus i’r risg gymharol o dwyll sydd ymhlyg yn y sector.

Cost cyffuriau gofal sylfaenol

34. Adroodd y Rheolwr a’r Archwiliwr Cyffredinol fod cost cyffuriau a roddir ar bresgripsiwn gan feddygon teulu yng Nghymru, a oedd oddeutu £318 milwiwn yn 1998-99, wedi codi'n flynyddol ar gyrfaoch uwch na chwyddiant. Hefyd, mae’r cyfraddau roh i gyffuriau ar bresgripsiwn yn sylweddol uwch yng Nghymru na Lloegr, hyd yn oed mewn ardaloedd o amddifadiad 81.

35. Dywedodd Mr Gregory wrthym fod y Cynulliad wedi bod yn ceisio rheoli’r costau hyn, gan gynnwys gwneud hynny drwy benodi ‘Grwp Gorchwyl a Gorffen’ a sefydlwyd yn ddiweddar i ystyried faint o le sydd yna i wella effeithlonrwydd ac effeithiolrwydd rhy i presgripsiynau yng Nghymru. Mae’r Grwp hwn i fod i roi adroddiad ar ei gyfuniad ym Mehefin 2000, a disgylfyr lido gynfrychru strategaeth i ddelio â’r mater hwn dros y tair i’r pedair blynedd nesa 82.

36. Mae ein prif ganfydiadau, casgliadau ac argymhellion ar fater cost cyffuriau gofal sylfaenol fel a ganlyn:

(iii) Nodwn y codiadau mawr diweddar yng nghost cyffuriau gofal sylfaenol, a chynhwyddwn y camau a gymeryd gan Gyfarwyddiaeth yr NHS i liniaru hyn, gan gynnwys penodi’r Grwp Gorchwyl a Gorffen. Argymhellwn yn gryf fod canfyddiadau’r Grwp yn cael eu hadolygu fel mater o flaenoriaeth a, lle bo hynny’n briodol, eu rhoi ar waith gan Gyfarwyddiaeth yr NHS ar y cyfle cyntaf posibl; a

(iv) Mae opsiynau eraill ar gael hefyd i fynd i’r afael â’r afael â chostau cynyddol cyffuriau gofal sylfaenol, ac anogwn Gyfarwyddiaeth yr NHS i ddatblygu strategaeth gydlynus, a fydd yn cynnwys ystyried materion megis gwneud mwy o ddefnydd o gyffuriau generig, aildatblygiadau cyd-fformiwlau, cynlluniau cymhellion o ran presgripsiynau a pha mor gyffredin yw rhoi ail-bresgripsiynau.

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81 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 8.2 i 8.4

82 C84 ac 85
Crynodeb o’r Argymhellion

37. Yng ngoleuni ein canfyddiadau a’r casgliadau, gwnawn yr argymhellion isod:

**Ar iechyd ariannol yr NHS yng Nghymru drwyddo draw**

(xiii) Anogwn Gyfarwyddiaeth yr NHS i weithio’n agosach ar draws Cymru, gan roi rheolaeth strategol ac arweiniad gwirioneddol i’r gwasanaeth;

(xiv) Edrychwn tuag at Gyfarwyddiaeth yr NHS i weithredu i sicrhau bod ymddiriedolaethau NHS yn gallu cyflawni’r arbedion y proffwydwyd y byddent ar gael yn sgîl ad-drefnu’r ymddiriedolaethau NHS yng Nghymru, a nodwn ein bwrw i fwrw golwg manwl ar lwyddiant y rhaglen hon maes o law;

(xv) Anogwn Gyfarwyddiaeth yr NHS i weithredu’n briodol i sicrhau bod pob corff NHS yn cydymffurfio â Chod Ymarfer Cyd-ffederasiwn Diwydiant Prydain ar Dalu Cyflenwyr, gan weithredu yn unol â pholisi’r Llywodraeth yn y dysylwch hwn;

**Ar iechyd ariannol ardaloedd pum awdurdod iechyd Cymru**

(xvi) Os digwydd yn y dyfodol y bydd ar ymddiriedolaethau NHS angen cymorth ariannol ychwanegol oddi wrth y Cynulliad, argymhellwn fod Gyfarwyddiaeth yr NHS yn ystyried sianelu’r gefnogaeth honno yn uniongyrchol i’r ymddiriedolaethau dan sylw;

(xvii) Yng nghyswllt Ymddiriedolaeth NHS Sir Gaerfyrddin, a’i hanawsterau ariannol ar hyn o bryd, anogwn Gyfarwyddiaeth yr NHS i weithio’n agos gyda’r ymddiriedolaethau ac Awdurod Iechyd Dyfed Powys i gywiro unrhyw ddiffygion yn eu Cynllun Adfer yn unedig o safbwynt lefel y realaeth yn y Cynllun a sicrhau bod gwasanaethau i gleifion yn cael eu gwarchod;

(xviii) Nid yw’r peirianwaith presennol ar gyfer dyrannu adnoddau mwyach yn fuddiol ac nid yw’n rholi sylw dibyn i’r pwysau amrywiol a gwahanol o ran costau sy’n effeithio ar gyrff NHS ar draws Cymru. Anogwn Gyfarwyddiaeth yr NHS fel y mayr, mewn ymgynghoriad agos â’r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol, i weithredu’n gyfym a ganlyniadau arolyg y ffmoniwlwa yllyddo sydd ar y gweill ar hyn o bryd a sefydlu system sy’n cydnabod ffactorau o’r fath ac yn rhoi setliadau ariannol blynyddol teg a chyfiawn;
**Ar esgeulustod clinigol**

(xix) O safbwynt rheoli esgeulustod clinigol gan yr NHS yng Nghymru, argymhellwn yn gyfrif fod Cyfarwyddiaeth yr NHS yn gweithredu i ganfod a lledaenu engheithiau o’r ymarfer gorau mewn rheolaeth ariannol ar draws NHS Cymru;

(xx) Dylai mwy o dryloywder wrth ddadlennu manylion meddygol i achwynydd ddod yn drefn safonol. Anogwn Gyfarwyddiaeth yr NHS i roi sylw i’r mater hwn yn rhannol drwy newidiadau yn addysg a hyfforddiant staff meddygol ac i gymryd rôl arweiniol yn y gwaith o ddatblygu diwylliant o fod yn agored a chyfathrebu’n dda;

**Ar dwyll**

(xxi) Nid yw cost lawn twyll yn yr NHS yng Nghymru yn hysbys, ac mae angen gwelliannau sylwedddol o ran canfod ac atal twyll. Anogwn Gyfarwyddiaeth yr NHS i fynd i’r afael â thyll. Anogwn Gyfarwyddiaeth yr NHS i roi sylw hefyd o dwyll yn y sector gofal eilaidd, gan roi sylw dyledus i’r risg cywir o dwyll sydd yr unigrychol eu adeiladu am gleision;

(xxii) Hyd yma, canolbwyntiwyd yn bennaf ar y sector gofal sylfaenol wrth fynd i’r afael â thyll. Anogwn Gyfarwyddiaeth yr NHS i roi sylw hefyd i’r pergl o dwyll yn y sector gofal eilaidd, gan roi sylw dyledus i’r risg gymharol o dwyll sydd ymhlyg yn y sector;

**Ar gost cyffuriau gofal sylfaenol**

(xxiii) Cydnabyddwn fod yr NHS yn cymryd camau i reoli cost gynyddol cyffuriau gofal sylfaenol. Mae’r Grwp Gorochwyl a Gorffen yn ymchwilio i’r maes hwn, ac argymhellwn yn gyfrif fod canfyddiadau’r Grwp yn cael eu hadolygu fel mater o flaenoriaeth a, lle bo hynn’n briodol, eu rhoi ar waith gan Gyfarwyddiaeth yr NHS ar y cyfle cyntaf posibl;

(xii) Mae opsiynau eraill ar gael ar gael hefyd i fynd i’r afael â chostau cynyddol cyffuriau gofal sylfaenol, ac anogwn Gyfarwyddiaeth yr NHS i ddatblygu strategaeth gydlynus, a fydd yn cynnwys ystyried materion megis gwneud mwy o ddefnydd o gyffuriau generig, ailddatblygiau cyd-fformiwlau, cynlluniau cymhellion o ran presgripsiynau a pha mor gyffredin yr ymwybodol ei bresgrisiynau.

**Crynodeb**

38. Y Gwasanaeth Iechyd Gwladol yn ein sefydliad mwyaf gwerthfawr. Mae ei enw da wedi dodi defod dros y blynyddoedd diwethaf, ac mae hyn i’w briodoli i raddau sylwedddol i’w berfformiadi ariannol gwael. Ni ellir caniatáu i hyn barhau.
39. Rhaid i’r Gwasanaeth Iechyd Gwladol ailadeiladu ei enw da drwy gyflwyno safonau gofal iechyd uchel i bobl Cymru o fewn yr adnoddau a roddir iddo gan y Cynulliad Cenedlaethol. Anogwn Gyfarwyddiaeth NHS y Cynulliad felly a rheolwyr y gwasanaeth iechyd, clinigwyr a staff i wneud popeth a allant i hyrwyddo rheolaeth ariannol dda, gan gynnwys cymryd camau mwy rhagweithiol i leihau lefel yr achosion o esgeulusod glinigol a’u cost, gostwng lefel twyll, a sicrhau gwerth am arian. Yn arbennig, disgwyliwn weld diweddd buan ar y cylch parhaus o ddiffygion ariannol yr adroddwyd amdanynt gan awdurddodau iechyd ac ymddiriedolaethau NHS dros y blynyddoedd diwethaf.
Atodiad A

[Trawsgrifiad i’w gynnwys]
Gwybodaeth oddi wrth Gyfarwyddwr NHS - Cymru y Cynulliad ar fater
cyfatebu data rhwng yr NHS a’r Adran Nawdd Cymdeithasol

Pwyllgor Archwilio- 6 Ebrill 2000

Pwyntiau Gweithredu sy'n deillio o sesiwn dystiolaeth Cyfarwyddwr NHS Cymru

Cynigiodd Mr Gregory ysgrifennu at y Pwyllgor Archwilio yn ymateb i cwestiwn Lorraine Barrett AC ynghylch a oedd Gweithgor Atal Twyll Cymru-gyfan wedi mynd i'r afael â'r mater o gydweddu data rhwng yr NHS a chronfeydd data'r Adran Nawdd Cymdeithasol, er enghraifft. Yr oedd hefyd am wybod yr anawsterau ymarferol a allai godi.

Sylwer y byddai'r nodyn yn cael ei gynnwys fel atodiad i adroddiad y Pwyllgor. Nid yw'r Gweithgor Atal Twyll wedi mynd i'r afael â'r mater hyd yma. Fodd bynnag, mae'n agweddu bwysig o'r gwaith y mae'r Cynulliad yn disgwyl i'r gwasanaeth gweithredol atal twyll (GGAT) newydd ei gyflawni. Mae cywirdeb newydd i'w sefydlu rhwng Cymru a Lloegr i atal twyll yng Nhs, gyda Chymru yn dod yn bartner yn y gwasanaeth atal twyll sydd eisoes yn bodoli yn Lloegr. Bydd cydweithio â'r GGAT yn darparu gwasanaeth cynhwysfawr sy'n ymestyn i'r sectorau sylfaenol ac eilaidd fel ei gilydd. Caiff trefniadau eu gwneud i sicrhau trefniadau adrodd priodol i'r NHS yng Nghymru a'r Cynulliad Cenedlaethol.

Mae'r gwasanaeth atal twyll hwn wedi bodoli yn Lloegr ers mis Ebrill 1999, ac mae eisoes wedi cytuno ar y protocolau angenheidiol gyda'r Adran Nawdd Cymdeithasol (ANC). Mae trafodaethau yn mynd rhagddyd gydag Adran Cyllid y Wlad hefyd hefyd yng Nghymru a'r Cynulliad Cenedlaethol.

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Mae cosbau eraill yn bodoli, a gyfrifir mewn ffordd debyg, mewn perthynas â hawlio drwy dwyll esemptiad rhag costau deintyddol neu hawlio drwy dwyll am fudd-dâl mewn perthynas â gwasanaethau optegol. Unwaith y daw'r ddeddfwriaeth i rym yng Nghymru, bydd rhwydd hynt i'r Cynulliad Cenedlaethol bennu lefel wahanol o gosb na'r gwledydd cartref eraill, er y byddai'n dda o beth arfer cysondeb ar draws yr NHS a'r DU. Gellir ystyried y mater hwn unwaith y cyflwynir is-ddeddfwriaeth ynghylch cosbau.

Ceir peth pryder y gall gwiriadau electronig yr Adran Nawdd Cymdeithasol neu Adran Cyllid y Wlad fod yn groes i'r Ddeddf Diogelu Data oni bai fod y presgripsiwn neu'r ffurflen arall ar gyfer hawlio esemptiad yn nodi'n benodol y gall y gwiriadau hyn gael eu gwneud. Caiff y mater hwn ei ystyried gan yr Adran Iechyd ac efallai y bydd angen ail-gynllunio'r wybodaeth ar gefn y ffurfleni perthnasol. Ateb posibl yw bod lle ar bob ffurflen i gleifion roi caniatâd i wiriadau gael eu gwneud.
Cynulliad Cenedlaethol Cymru: Y Pwyllgor Archwilio

Adroddiad 00-04 – Cyflwynwyd i’r Cynulliad Cenedlaethol ar 13 Gorffennaf yn unol ag adran 102(1) o Ddeddf Llywodraeth Cymru 1998

Adroddiad ar Gyfrifon Cryno NHS (Cymru), 1998-99

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Atodiadau

Atodiad A: Trafodion perthnasol y Pwyllgor – Cofnodiwn Tystiolaeth (Dydd Iau 6ed Ebrill 2000)

Atodiad B: Gwybodaeth gan Gyfarwyddwr NHS - Cymru y Cynulliad ar bwnc cyfatebu data rhwng yr NHS a’r Adran Nawdd Cymdeithasol

Atodiad C: Llythyr i’r Pwyllgor oddi wrth Syr John Bourn, Archwiliwr Cyffredinol Cymru ar esgeulustod clinigol

Atodiad D: Y Pwyllgor Archwilio
Cyflwyniad


17. Cylldir yr NHS yng Nghymru yn bennaf drwy daliadau i bum awdurdod iechyd Cymru, a gwnaethant hwythau yn eu tro daliadau i ymdiriedolaethau NHS o dan gytwndebau am wasanaethau ysbyty a gwasanaethau eraill (£1,485 miliwn). Ar gyfer gwasanaethau gofal iechyd sylfaenol, gwnaeth yr awdurdodau iechyd daliadau i Feddygon Teulu sydd â’u cyllideb eu hunain ac ar ran Meddygon Teulu sydd heb eu cyllideb eu hunain (£747 miliwn) a hefyd daliadau i Ddeintyddion (£61 miliwn) ac Optegwyr (£18 miliwn).

18. Cwbllheir Cyfrifon Cryno yr NHS yng Nghymru drwy gyfansymio cyfrifon y cyrff NHS sy’n rhan o’r gwasanaeth, a dyma’r peirianwaith a ddefnyddir i adrodd ar gyfrifon y cyfrifon 1998-99 yr wybodaeth ddiweddar am iechyd ariannol yr NHS yng Nghymru a’r prif faterion sy’n effeithio ar y sefyllfa honno 83.


21. Cymerwyd tystiolaeth oddi wrth Mr Peter Gregory, Cyfarwyddwr Cyfarwyddiaeth NHS y Cynulliad a Swyddog Cyfrifon Cryno NHS (Cymru). Yn bresennol gydag ef yr oedd Mrs Sarah Beaver, pennaeth Is-adran Cyllid NHS y Cynulliad. Ceir tawsgrifiaid o’r dyluniau hon yn Atodiad A. Derbiniwyd tystiolaeth ysgrifenedig hefyd gan Mr Gregory (Atodiad B), a chan Syr John Bourn, Archwiliwr Cyffredinol Cymru (Atodiad C). Hoffem ddiolch i Mr Gregory am y ffordd gadarnhaol ac adeiladol yr ymatebodd i gwestiynau’r

83 Cyfrifon Cryno NHS (Cymru) 1998-99 (HC 301 o 1999-2000), a gyflwynwyd ar 13 Mawrth 2000
22. Yn yr adroddiad hwn, rydym yn edrych ar y Gwasanaeth Iechyd yng Nghymru o dan bump prif bennawd:

- Iechyd ariannol yr NHS yng Nghymru drwyddo draw;
- Iechyd ariannol ardaloedd pum awdurdod iechyd Cymru;
- Esgeulustod clinigol;
- Twyll; a
- Chost cyffuriau gofal sylfaenol.

**Iechyd ariannol yr NHS yng Nghymru drwyddo draw**


Dyweddodd Mr Gregory wrthym nad oedd y sefyllfa hon o ddiffyg ariannol a phroblemau ariannol yr NHS yn gyffredinol yn unigryw i Gymru, ond eu bod yn gyffredin i systemau gofal iechyd mewn mannau eraill yn y byd datblygedig.

24. Fodd bynnag, mae ffactorau eraill hefyd wedi dylanwadu ar y sefyllfa hon. Yn gynnar yn 1999, comisiynodd Ysgrifennydd Gwladol Cymru ar y pryd adroddiad cloriannu ar iechyd ariannol yr NHS yng Nghymru. Deuai’r Adroddiad Cloriannu, a ryddhawyd ym Mehefin 1999, i’r casgliad nad oedd yna un eglurhad i’r problemau ariannol sy’n bodoli o fewn yr NHS yng Nghymru.

25. Yn ychwanegol at berfformiad lleol yr awdurdodau iechyd a’r ymddiriedolaethau NHS, awgrymodd y Swyddog Cyfrifo wrthym fod y ffactorau isod yn cyfrannu ar lefel genedlaethol at y problemau ariannol yng Nghymru:

- Cafodd yr amgylchedd ariannol ei dynhau yn ystod y 1990au canol i hwyra, a chafwyd cofyniad hefyd ar i’r NHS gyflawni targedau arbedion effeithlonrwydd a fyddai’n rhychdhu arian ond a oedd, yn ymarferol, yn anodd.

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84 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 4.6
85 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 4.19 a 4.20
86 C18
87 C2
88 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 4.31 i 4.33
Arweiniodd pwysau o safbwynt adnoddau ac effeithlonrwydd o fewn Adran Iechyd y Swyddfa Gymreig at leihau'r adran honno, gan gynnwys crebachu ei rôl monitro, a gwneud perfformiad ei rôl rheoli strategol yn llai effeithiol. Aeth y berthynas rhwng y Swyddfa Gymreig a’r cyrff NHS yn anoddach o’r herwydd. Argymhellai’r Adroddiad Cloriannu y dylid cryfhau Cyfarwyddiaeth NHS y Cynulliad fel y gellid ymddrin ffodd intregedig à monitro perfformiad ariannol, gwerth am arian a gwirieddu amcanion yr NHS yng Nghymru. Dywedodd Mr Gregory wrthym fod arolwg diweddar wedi arwain at gynnydd yn yr adnoddau staff, a bod y problem hon wedi’i lliniaru bellach.

Bu marchnad fewnol yr NHS, a seilwyd ar gystadleuaeth a gwahanu swyddogaethau’r prynwr/darparwr, o fudd o ran crisialu cyfrifoldeb gweithredol ar y lefel leol. Fodd bynnag, roedd hefyd wedi creu anawsterau yn y berthynas waith rhwng awdur-dodau iechyd ac ymddiriedolaethau NHS, a dywedodd Mr Gregory wrthym ei fod o’r farn bod dileu cystadleuaeth o’r NHS yn cyfrannu at welliant sylweddol yn hyn o beth.

Cyflwynwyd y rhaglen i ad-drefnu’r ymddiriedolaethau NHS er mwyn sicrhau darpariaeth ofal fwy effeithlon i glefion. Disgwyliai Mr Gregory i hyn arwain at arbenedd sylweddol, ond dywedodd wrthym y byddai’n golygu cost o oddeutu £4 miliwn i’r NHS yng Nghymru i ddechrau, gan gyfrannu yn y tymor byr at y diffyg ariannol. Mae Cyfarwyddiaeth yr NHS yn disgwyl i’r ad-drefnu olygu arbenedd o £4 miliwn yn 2000-01, gan godi ar ôl tair blynedd i arbediad blyneddol rheolaidd o £6 miliwn.

26. Un peirianwaith allweddol ar gyfer monitro perfformiad ariannol ymddiriedolaethau NHS yng Nghymru yw’r tri amcan ariannol a bennwyd ar gyfer pob ymddiriedolaeth NHS gan Cyfarwyddiaeth NHS y Cynulliad (Adran Iechyd y Swyddfa Gymreig gynt). Yr amcanion yw:

- Adennill eu costau dros y cyfnod tair-blynedd 1997-98 i 1999-2000;
- Cyflawni ‘Cyfradd Cydnabod Costau Cyfalaf’ (hynny yw, i dalu cost amcanol cyllido ei asedau cyfalaf ar ôl caniatáu ar gyfer dibrisiant) o chwech y cant yn union yn flynyddol; ac
27. Am 1998-99, adroddodd y Rheolwr a'r Archwiliwr Cyffredinol bod 25 o'r 26 ymddiriedolaeth NHS wedi methu cyflawni un neu fwy o’u tri amcan ariannol allwedol, gan gynnwys pedwar oedd wedi methu ar y tri amcan. Methodd pedair ymddiriedolaeth ar ddeg y targed adennill costau interim a methodd 21 gyflawni’r Gyfradd Cydabod Costau Cyfalaf o 6 y cant yn union. Aeth pedair ymddiriedolaeth y tu hwnt i’w Terfyn Cyllido Allanol, er i Mr Gregory ddweud wrthym mai dim ond methu o’r braidd wnaeth tair o’r rhain. 95. Eglurodd Mr Gregory wrthym fod y methiannau hyn i gyd yn deillio o’r anawsterau a wynebir gan ymddiriedolaethau NHS wrth weithredu oddi mewn i’w hamgylchedd ariannol. 96.

28. Dyletswydd ariannol arall ar bob corff NHS yw’r gofyniad i setlo’u holl filiau o fewn 30 diwrnod iddynt dderbyn anfoneb ddïlys, yn unol à Chod Ymarfer Talu Cyflenwyr Cyd-ffederasiwn Diwydiant Prydain. Mae perfformiad yr awdurdodau iechyd gyda’i gilydd yn erbyn y targed hwn yn dal yn wael, gyda dim ond 85 y cant o anfonebau’n cael eu talu o fewn y cyfnod 30-diwrnod, er bod y rhan yn cynrychioli tua 97 y cant o’r anfonebau yn ôl gwerth. O’r ymddiriedolaethau NHS, gwellodd 16 eu perfformiad yn ystod 1998-99, ond mewn naw ymddiriedolaeth gwaethygodd y lefelau talu’n brydlon – ac ni thalodd un ymddiriedolaeth (Ymddiriedolaeth NHS Glan Hafren) ond 26 y cant o’i biliau o fewn 30 diwrnod 97.

29. Hysbysodd y Swyddog Cyfrifo ni fod y Cynulliad wedi monitro’r perfformiad mewn awdurdodau iechyd ac ymddiriedolaethau NHS o ran talu cyflenwyr ar sail fisol, gan chwilio am welliannau yn y sefyllfa honno. Dywedodd wrthym nad oedd yn fodlon à’r lefelau perfformiad cyfredol, a’i fod yn bwriadu cynnwys yn y llythyr blynyddol am y dyranid cyllido a anfonir ar bob corff NHS ofyniad ar iddynt wneud gwelliannau 98.

30. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ynglŷn ag iechyd ariannol yr NHS yng Nghymru drwyddo draw fel a ganlyn:

(ii) Nodwn fod y problemau ariannol sy’n wynebu’r NHS yng Nghymru yn gyffredin i systemau gofal iechyd mewn mannau eraill yn y byd dabtlygeidig; a hefyd mai nid problemau diweddar mo’r rhain, gyda diffygion ariannol yn cael eu hadrodd ers y 1980au. Mewn sefyllfa o gyllid cyfïngedig, bydd darparu gofal iechyd bob amser yn golygu

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94 Rhagair i Gyfrifon Cryno’r NHS ar gyfer Cymru, 1998-99, paragraffau 20-23
95 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 4.15 ac C23
96 C23
97 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 4.23 i 4.30
98 C28
Rydym yn bryderus ynglyˆ n ag anallu’r Swyddfa Gymreig gynt i fonitro’r NHS yng Nghymru yn ddigonol fel yr oedd y problemau hynny’n datblygu, a hefyd ynglŷn â’r dirywiaid a fu yn y berthynas rhwng y Swyddfa Gymreig a gwahanol rannau o’r NHS. Rydym yn falch o glywed am welliannau diweddar yn y maes hwn, a bod y problem hon yn cael ei datrys bellach. Anogwn Gyfarwyddiaeth yr NHS i weithio’nagosach gyda chyrff iechyd ar draws Cymru, gan roi rheolaeth strategol ac arweiniad gwirioneddol i’r gwasanaeth;

Ystyriwn fod perfformiad gwael yr ymddiriedolaeth NHS yng Nghymru yn erbyn eu tri amcan ariannol yn annerbyniol, er y cydnabyddwn mai canlyniad uniongyrchol eu hammglychedd ariannol oedd hyn. Edrychwn tuag at Gyfarwyddiaeth yr NHS i weithredu i sicerhau bod ymddiriedolaethau NHS yn gallu cyflawni’r ardaloedd i proffwydwyd y byddent ar gael yn sgîl ad-drefnu’r ymddiriedolaethai NHS yng Nghymru, a nodwn ein bwriad i fwrw golwg manwl ar lwyddiant y rhaglen hon maes o law; ac

Anogwn fod proses lymach i’w sefydlu i amcangyfrif y costau a’r arbedion a gyflawnwyd gan awdurdodau iechyd ac ymddiriedolaethau NHS yng Nghymru yn yr NHS; ac

Rydym yn bryderus iawn ynglŷn â’r perfformiad a gyflawnwyd gan awdurdodau iechyd ac ymddiriedolaethau NHS yng Nghymru yn erbyn y targed talu’n ymdeithiol. Anogwn Gyfarwyddiaeth yr NHS i weithredu’n briodol i sicerhau bod pob corff NHS yn cydymffurfio â Chod Ymarfer Cyd-ffederasiwn Diwydiant Prydain ar Dalu Cyflenwyr, gan weithredu yn unol â pholisi’r Llywodraeth yn y cyswllt hwn.

Iechyd ariannol ardaloedd pum awdurdod iechyd Cymru

40. Yn Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol ceid dadansoddiai o’r diffyg ariannol a ddaeth i ran cyff y NHS yng Nghymru yn 1998-99 rhwng ardal y pum awdurdod iechyd, a dangosai amrywiad eang mewn perfformiada ariannol 99. Cyflwynodd y Swyddog Cyfrifol sawl ffactor ger ein bron, ar lefel ardal yr awdurdodau iechyd a hefyd ymysg cyff y NHS unigol, y credai ef sydd wedi cyfrannu at yr amrywiad hwn.

41. Ar lefel ardal yr awdurdodau iechyd, awgrymai fod y ffactorau a ddylanwadaid ar perfformiada yn cynnwys y fformiwla dyrannu adnoddau, cyfran y practisiau meddygol teulu sy’n dal cronfa, a'i ba raddau yr oedd pob ardal yn ddibynnol ar wasanaethau a gaffael ym anallol. O fawr y ymddiriedolaethau NHS, roedd ffactorau megis lefel y gystadleuaueth am y gwasanaethau penodol a gyniged a’r cyllid sy’n oynnol i gynnal swyddogaethau mwy arbenigol rhai ymddiriedolaethau NHS yn cyfrannu’n sylweddol i eu perfformiad ariannol. Awgrymodd Mr Gregory hefyd

99 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 4.6 a Ffignwr 2
wrthym y gallai ystod o ffactorau personel effeithio hefyd ar berfformiad ardal pob awdurdod iechyd. Mae natur y berthynas waith rhwng yr awdurdod iechyd a’i ymddiriedolaethau NHS lleol, profiadau gwahanol uwch swyddogion ac aelodau’r Bwrdd, ac amrywiadau yn lefel eu hymrwymiad i reolaeth ariannol i gyd yn gyffrous at y gwaithaniaethau mewn perfformiad ariannol yr adroddwyd amdanynt yn ardaloedd y pum awdurdod iechyd 100.

42. Holodd y Pwyllgor Mr Gregory ymhellach yn fanwl am berfformiad ariannol ardal pob un o’r pum awdurdod iechyd: Dyfed Powys, Bro Taf, Gwent, Iechyd Morgannwg a Gogledd Cymru.

**Ardal awdurdod iechyd Dyfed Powys**

43. Adroddodd ardal awdurdod iechyd Dyfed Powys fod ganddi ddiffyg net o tua £11.5 milion yn 1998-99, a gynrychiolai dros hanner diffyg Cymru-gyfan. Roedd y Swyddfa Gymreig gynt wedi darparu cyfanswm o £12.5 milion mewn arian brocera (cyllid tymor byr mewn ymateb i anawsterau llif-arian) i Awdurdod Iechyd Dyfed Powys 101. Wrth ddisgrifio rôl Cyfarwyddiaeth yr NHS yn cefnogi adferiad ariannol Awduradod Iechyd Dyfed Powys, eglurodd Mr Gregory fod ei benderfyniad i drosglwyddo’r cyllid ychwanegol hwn a oedd yn daladwy i’r ymddiriedolaethau NHS lleol drwy’r Awdurdod Iechyd yn golygu bod yr ymddiriedolaethau NHS yn ddibynnol ym mhob cyllid ar un tal-fesiwr. O ganlyniad, roedd yr ymddiriedolaethau NHS hynny yn parhau i adrodd am sefyllfa ariannol fwy ffafriol, tra bo’r Awdurdod Iechyd yn adrodd am ddiffyg cronedig a oedd yn cynyddu 102.

44. Wrth grynhoi’r broses adfer ar gyfer ardal Dyfed Powys, dywedodd y Swyddog Cyfrifo y cytunwyd ar Cynllun Adfer rhwng yr Awdurdod Iechyd, Cyfarwyddiaeth yr NHS a phob un o’r Ymddiriedolaethau NHS hyn: Gofal Iechyd Powys, Ceredigion a Chanolbarth Cymru a Sir Benfro a Derwen. Mewn perthynas â’r bedwaredd ymddiriedolaeth, Ymddiriedolaeth NHS Sir Gaerfyrddin, mynegodd Mr Gregory ei amheuon ynglŷn â’r sefyllfa ariannol yr oedd yn ei darogan, a dywedodd wrthym nad oedd yn hyderus fod strategaeth adfer brodol wedi’i dyfeisio eto 103.

**Ardal awdurdod Iechyd Bro Taf**

45. Yn ei Adroddiad, dywedodd y Rheolwr a’r Archwiliwr Cyffredinol mai’r darogan oedd y byddai sefyllfa ariannol Awdurdod Iechyd Bro Taf yn ddirywio’n ddwrwg, gyda diffyg o £6.1 milion wedi’i ddarogam am 1999-2000 104

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100 C30
101 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad B, paragraffaith B.1 a B.3
102 C36
103 C37
a diffyg sylweddol pellach yn cael ei dd disgwyl yn 2000-01 104. Roedd Mr Gregory mewn sefyllfa i roi rhagolygon diwygiedig i ni am 2000-01 a oedd wedi gwella’n sylweddol, gan ostwng y diffyg a broffwydwyd yn wreiddiol o £17.4 miliwn i ddim ond diffyg ymylol am y flwyddyn honno. Roedd hyn yn deillio’n rhannol o gymorth ariannol o gymorth ychwanegol addigiwr Gyfarwyddiadaeth yr NHS i liniaru pwysau cost penodol. Ymysg y rhaï yr oedd swyddogaeth ddiysgu Ysbyty Athrofaol Cymru o fewn Ymddiriedolaeth NHS Caerdydd a’r Fro, a’r costau cyfalaf ychwanegol a ddeilliai o Ysbyty Brenhinol newydd Morgannwg 105

**Ardal awdurdod iechyd Gwent**

46. Adroddodd ardal awdurdod iechyd Gwent ddiffyg drwyddo drwbl o £0.4 miliwn am 1998-99, sef y diffyg isaf o blith ardalocedd y pum awdurdod iechyd yng Nghymru 106. Dim ond tair ymddiriedolaeth NHS sydd yna yn ardal Gwent, ac awgrymodd Mr Gregory wrthym fod y diffyg cymhlethdod cymharol hwn wedi helpu’r berthynas rhwng yr awdurdod comisiynu a’r ymddiriedolaethau 107. Dywedodd wrthym i’r ardal wynebu anawsterau ariannol yn y gorffennol, ond y rhodwyd sylw i’r rhaï a’u datrys drwy reolaeth ariannol effeithiol yr ymgymerwyd â’i mewn partneriaeth rhwng yr amryw gryff NHS perthnasol. Nododd hefyd i ardal Gwent gael un y cant yn fwy o dwf yn ei chyllid na’i chyd-awdurdod a berfformiodd waethaf, a oedd hefyd wedi cyfrannu at allu’r ardal i ymdopi ap phwysau o ran costau 108.

**Ardal awdurdod iechyd Iechyd Morgannwg**


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104 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad A, paragraff A.2
105 C41 a 43
106 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad C, paragraff C.1
107 C46
108 C46 a 47
109 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad D, paragraffau D.3 a D.4
110 C49 a 50
Ardal awdurod iechyd Gogledd Cymru

48. Nododd y Rheolwr a’r Archwiliwr Cyffredinol yn ei adroddiad i ardal gogledd Cymru dwyddi draw gofnodi diffyg o £1.8 milion yn 1998-99, er mai Awdurod Iechyd Gogledd Cymru ei hun oedd yr unig awdurod i gofnodi gwarged 111. Rhoddodd y Swyddog Cyfrifo nifer o resymau inni am sefyllfa ariannol gymharol ymgyrwch Awdurod Iechyd Gogledd Cymru. Er enghraifft, roedd yr ardal yn elwa o’r fformiwla dyrannu adnoddau gyfredol, gyda’r cyllid i’r ardal yn uwch na’r cyfartaledd drwy Gymru. Tynnodd Mr Gregory sylw hefyd at ddiffyg cymhlethdod cymharol yr amgylchedd gofal iechyd yng Ngogledd Cymru, a adlewyrchir yn y system gofal iechyd symllach sy’n ofynnol o’i chymharu, er enghraifft, á sefyllfa de Cymru. Roedd y berthynas rhwng yr awdurod iechyd a’i amryw ymddiriedolaethau yn gymharol syml ac roedd maes cyfrifofo deb pob ymddiriedolaeth wedi’i ddyndod i glir, rhywtheth nad yw’r wir am dde Cymru 112. I gloi, dywedodd Mr Gregory fod rheolaeth ariannol o fewn cyrff NHS yr ardal o safon uchel 113.

49. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar iechyd ariannol ardaloedd pum awdurod iechyd Cymru fel a ganlyn:

(ix) Nodwn ystod cymhleth y ffactorau sy’n effeithio’n uniongyrchol ar berfformiad ardal pob un o’r pum awdurod iechyd, a’r cydberthynas rhwng y ffactorau;

(x) Cyfunwn â Mr Gregory nad yw ynyssu’r Ymddiriedolaethau NHS o fewn Dyfed Powys rhag dyledion yr awdurod iechyd yn ddiffyg effeithiol o reolaeth ariannol. Os digwydd yn y dyfodol y bydd ar yr ymddiriedolaethau NHS angen cymorth ariannol ychwanegol oddi wrth y Cynulliad, argymhelliwn fod Cyfarwyddiaeth yr NHS yn ystyried yn ofalus ar hyd pa lwybr y dylid cwymer wythnos o’r fath, er mwyn sicrhau ei fod yn cael ei ddefnyddio’i effeithiol i’w ddibenion bwriedig, gyda golwg ar yr angen i fod yr dryloyw ac agored;

(xi) Tra’r ydym yn nodi’r cynlun adfer bwriedig y cytunwyd arno gydag Awdurod Iechyd Dyfed Powys a thair o’r pedair ymddiriedolaeth NHS yn yr ardal honno, rydym yn rhannu pryderon Mr Gregory ynglŷn a pherfformiad ariannol Ymddiriedolaeth NHS Sir Gaerfyrddin, yn hnerau ei sefyllfa ariannol gyfredol a hefyd y methiant i gwblhau cynlun adfer y cytunwyd arno ar gyfer yr ymddiriedolaeth honno. Anogwn Gyfarwyddiaeth yr NHS i weithio’n agos gyda’r ymddiriedolaeth ac Awdurod Iechyd Dyfed Powys i gywiro unrhyw ddiffygion yn eu Cynllun Adfer ar frys; ac

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111 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, Atodiad E, paragraff E.1
112 C53
113 C54
(xii) Rydym o’r farn nad yw’r peirianwaith presennol ar gyfer dyrannu adnoddau mwya chyn fuddiol ac nad yw’n rhoi sylw digonol i’r pwysau amrywiol a gwahanol o ran costau sy’n effeithio ar gyrff NHS ar draws Cymru. Anogwn Gyfarwyddiaeth yr NHS felly, mewn ymgynghoriad agos â’r Pwyllgor Iechyd a Gwasanaethau Cymdeithasol, i weithredu’n gyflogi ar ganlyniadau’r arolwg o’r fformiwlwl y gall gwylio sydd ar y gweili ar hyn o bryd a sefydlu system sy’n cydnabod ffactorau o’r fath ac yn rhoi setliadau ariannol blynyddol teg a chyfiawn.

**Esgeułustod clinigol**

50. Mae Esgeułustod Clinigol yn golygu tor-dyletswydd gan ymarferwyr gofal iechyd wrth iddynt gyflawni eu dyletswyddau yn yr NHS. Adroddodd y Rheolwr a’r Archwiliwr Cyffredinol i gost uchafswm hawliadau am esgeułustod clinigol drwyddi draw, yn ôl yr amcangyfrif, godi’n sylweddol yn ystod 1998-99, o £145 miliwn i £214 miliwn ar 31 Mawrth 1999 (mae’r amcangyfrif hwn yn cynnwys taliadau tebygol a phosibl). Awgrymodd y Swyddog Cyfrifo wrthym fod y cynnydd hwn i’w briodoli i ddau ffactor: tuedd gynyddol unigolion i hawlio iawn cyfreithiol; a lefelau cynyddol yr iawndal sy’n daladwy mewn achosion o’r fath.

51. Cyn dwyn achos cyfreithiol mewn achosion lle’r honnir esgeułustod clinigol, gall cleifion geisio iawn drwy Drefn Gwyno’r NHS ac, os ydynt yn dal yn anfodlon, gallant ddwyn eu cwyn gerbron Ombwdsman y Gwasanaeth Iechyd dros Gymru. Yng nghamol olaf y Drefn Gwyno, pan fydd yr achosion hyn yn cael eu hystyried gan banel adolygu annibynnol, dywedodd Mr Gregory mai un gwendi wyth myned i nodir yw ansawdd wael y cyfathrebu rhwng y clinigwr a’r claf. Awgrymodd Mai un maen prawf pwysig sy’n effeithio ar benderyniad unigolion i wneud cais ffurfiol am iawndal yw’r modd yr ymdriniewyd â’r gwyn, a pha mor agored y buwyd wrth ddadlennu ffeithiau achos y claf iddynt.

52. Mae cyfswllt agos rhwng mater esgeułustod clinigol a chysyniadau efeithiolrwydd clinigol a llywodraethu clinigol, yng nghyd-destun gwella ansawdd gofal o fewn yr NHS. Amlinellodd Mr Gregory nifer o beirianweithiau sy’n cefnogi’r amcan hwn, gan gynnwys y Sefydliad Cenedlaethol dros Ragoriaeth Glinigol, sydd â’r dasg o adolygu efeithiolrwydd triniaethau newydd a rhai presennol o safbwynt clinigol ac o ran cost, a’r Comisiwn Gwella Iechyd sy’n gyfrifol am yr arolwg ar ansawdd gofal. Nododd hefyd fod Cronfa Risg Cymru yn gyfrifol am y

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114 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.2  
115 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.4-5.5  
116 C55  
117 C70 a 71  
118 C56
‘Rhwydwaith Rheolwr Risg’, sydd â chynrychiolwyr o bob corff NHS yng Nghymru ymysg ei aelodaeth, ac sy’n trafod gwelliannau posibl i’r modd y rheolir digwyddiadau ac yn lleadaenu enghreifftiau o’r ymarfer gorau 119.

53. Mae Cronfa Risg Cymru hefyd wedi arwain y ffordd yn hyrwyddo gwaith rheoli risg effeithiol ar draws yr NHS yng Nghymru, gan gynnwys cyfres o Safonau Rheoli Risg sy’n berthnasol i awdurdogau iechyd ac ymddiriedolaethau NHS fel ei gilydd. Yn 1998-99, fodd bynnag, canfu’r Rheolwr a’r Archwiliwr Cyffredinol mai dim ond deg o’r 21 aelod gorff oedd wedi cyflwyno hunan-asesiad o’u perfformiad yn erbyn y safonau hyn. 120.

54. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar fater esgeulustod clinigol fel a ganlyn:

(vii) Ymddengys i ni fod dau brif faes i ganolbwyntio arnynt wrth reoli nifer cynyddol yr achosion o esgeulustod clinigol yn yr NHS yng Nghymru, a’r gost gynyddol sef: ymdrin yn ddiymdroi ac yn gost-effeithiol â’r hawliadau sy’n disgwyl i gael eu prosesu ar hyn o bryd, ac effeithiolrwydd y dulliau gweithredu ar reoli risg er mwyn atal hawliadau newydd rhag codi yn y lle cyntaf. Rydym o’r farn nad yw Cyfarwyddiadaeth yr NHS wedi gwneud cynnydd digonol yn y naill na’r llall o’r meysydd hyn, a phwysleisiwn y potensial i wella drwy ymateb i ganfyddiadau perthnasol y Sefydliad Cenedlaethol dros Ragoriaeth Glinigol a’r Comisiwn Gwella Iechyd i’r dyfodol. Argymhellwn yn gryf fod Cyfarwyddiadaeth yr NHS yn gweithredu i ganfod a lleadaenu enghreifftiau o’r ymarfer gorau mewn rheolaeth ariannol ar draws NHS Cymru;

(viii) Rydym yn bryderus iawn i nodi mai dim ond hanner y cyrff NHS yng Nghymru a gyflwynodd hunan-asesiadau, gan adrodd a ydynt yn cydymffurfio â’r Safonau Rheoli Risg, er ein bod yn cydnabod y gallai’r ad-drefnu ar yr ymddiriedolaethau ar y pryddod wedi effeithio ar lefel yr ymateb; ac

(ix) Rydym hefyd o’r farn y gellid ac y dyliad gwella’r drefn gwyno ar gyfer cleifion a’u perthnasau os ceir canlyniad clinigol anfoddhaol. Credwn mai cyfathrebu mwy agored a chynharach rhwng clinigwyr a chleifion yw’r allwedd i ddatrys llawer o hawliadau am esgeulustod ac atal yr angen am weithredu cyfreithiol. Dylai mwy o dryloywder wrth ddadlennu manylion meddygol i achwynddydd ddod yn drefn safonol ac anogwn Gyfarwyddiadaeth yr NHS i roi sylw i’r mater hwn yn rhannol drwy newidiadau yn addysg a hyfforddiad staff meddygol.

119 C57
120 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.10
Twyll

55. Mae lefel y twyll o fewn yr NHS yn fater o bwys allweddol, gan arwain at gollod yna Weithgor Ymladd Twyll, gyda chyflech gwaith i ddatblygu strategaeth twyll a lledaenu engheithniau o'r ymarfer gorau o ran mynd i'r afael â thyll ar draws Cymru 127, cydnabyddai’r Swyddog Cyfrifo nad oedd fawr ddim cynnydd wedi'i wneud o ran roh i sylw i dyll yng Nghymru 122. Yn 1998-99, dim ond gwerth £102,000 o dyll a ganfuwyd yng Nghymru; o seilio ffigyrau Cymru ar y twyll a ganfuwyd yn Lloegr yr hwn yng Nghymru yn rhoi ffigwr o ryw £8-10 milwn. Dywedodd Mr Gregory wrthym fod lefel y twyll a ganfuwyd yn amlwg heb ei llwyr fynegi, ac adlewyrchai'r ffaith nad oedd llawer o waith wedi'i wneud yn y maes hwn hyd yma 123.

56. Dywedodd Mr Gregory wrthym am y trafodaeth am y corff o fewn Gweithrediaeth yr NHS sy’n gyfrifol am fynd i'r afael â thyll a llygredigaeth o fewn yr NHS yn Lloegr, a oedd yn ymchwilio i’r posibilrwydd y gellid ymestyn ei gylch gwaith i gynnwys Cymru 124. Yn dilyn y gwrandawiad Pwyllgor hwn, mae'r Prif Ysgrifennydd wedi cyhoeddi bod y twyll o daffod a hynny wedi’u cwbhau, ac y bydd yr NHS yng Nghymru yn cael ei gynnwys yng nghylliadaeth y Wwasanaethau Ymladd Twyll 125.

57. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar fater twyll fel a ganlyn:

(vii) Rydym yn bryderus iawn ynglŷn â’r diffyg cynnydd hyd yma o ran mynd i’r afael â thyll yn yr NHS yng Nghymru. Rydym felly yn croesawu’r cyhoeddiaeth diweddar gan y Prif Ysgrifennydd y bydd y gwaith o fonitro twyll a llygredigaeth o fewn yr NHS yng Nghymru yn dod yn rhan o gyflawni gwaith estynedig Cyfarwyddiaeth y Gwasanaethau Ymladd Twyll;

(viii) Rhyfeddir ni fod lefelau’r twyll a ganfyddir mor isel (£102,000 yn 1998-99; £950,000 (amcangyfrif) yn 1999-2000), a chytunwn â Chyfarwyddiaeth yr NHS nad yw hyn o reidrwydd ond yn cynrychioli elfen fach o’r gwir gyfanswm. Rydym o’r farm fod angen

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121 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraff 5.21
122 C72 a 73
123 C74
124 C72
125 Hysbysiad i’r Wasg (cyfeirnod W00345-hlt) a ryddhawyd gan y Cynulliad 10 Ebrill 2000
gwelliannau sylweddol yn y gwaith o ganfod ac atal twyll. Anogwn Gyfarwyddiaeth yr NHS i fynd i’r afael â’r broblem hon fel mater o frys, ac yn enwedig i ystyried y defnydd posibl o gymhellion “gwario i arbed” a fyddai’n caniatáu i unrhyw arbedion a grëir gael eu rhyddhau’n uniongyrchol ar gyfer gofalu am glefion; a

(ix) Sylwn hefyd mai at ofal sylfaenol yn unig y cyfeiriwyd y camau a gymerwyd hyd yma i fynd i’r afael â thwyll, ac mai dim ond yn ddiweddar y mae Gweithgor Ymladd Twyll Cymru-gyfan wedi ystyried mater twyll yn y sector gofal eilaidd. Anogwn Gyfarwyddiaeth yr NHS hefyd i roi sylw i'r perygl o dwyll yn y sector gofal eilaidd, gan roi sylw dyyledus i’r risg gymharol o dwyll sydd ymhlyg yn y sector.

Cost cyffuriau gofal sylfaenol


59. Dywedodd Mr Gregory wrthym fod y Cynulliad wedi bod yn ceisio rheoli’r costau hyn, gan gynnwys gwneud hynny drwy benodi ‘Grŵp Gorchwyl a Gorffen’ a sefydlwyd yn ddiweddar i ystyried faint o le sydd yna i wella effeithlonrwydd ac effeithiolrwydd rholo presgripsiynau yng Nghymru. Mae’r Grŵp hwn i fod i roi adroddiad ar ei ganfyddiadau ym Mehefin 2000, a digwyli'r iddo gynhrychu strategaeth i ddelio â’r mater hwn dros y tair i’r pedair blynedd nesaf 127.

60. Mae ein prif ganfyddiadau, casgliadau ac argymhellion ar fater cost cyffuriau gofal sylfaenol fel a ganlyn:

(v) Nodwn y codiadau mawr diweddar yng nghost cyffuriau gofal sylfaenol, a chydna byddwn y camau a gymerwyd gan Gyfarwyddiaeth yr NHS i liniau hyn, gan gynnwys penodi’r Grŵp Gorchwyl a Gorffen. Argymhellwn yn grŵp fod canfyddiadau’r Grŵp yn cael eu hadolygu fel mater o flaenoriaeth a, lle bo hynny’n briodol, eu rhoi ar waith gan Gyfarwyddiaeth yr NHS ar y cyfle cyntaf posibl; a

(vi) Mae opsiynau eraill ar gael hefyd i fynd i’r afael â’r chostau cynyddol cyffuriau gofal sylfaenol, ac anogwn Gyfarwyddiaeth yr NHS i ddatblygu strategaeth gydlynsus, a fydd yn cynnwys ystyried materion megis gwneud mwy o ddefnydd o gyffuriau generig, ailddatblygiadau

126 Adroddiad y Rheolwr a’r Archwiliwr Cyffredinol, paragraffau 8.2 i 8.4
127 C84 ac 85
cymhellion o ran presgripsiynau a pha mor gyfrifin yw rhoi ail-bresgripsiynau.

Crynodeb o’r Argymhellion

61. Yng ngoleuni ein canfyddiadau a’n casgliadau, gwnawn yr argymhellion isod:

Ar iechyd ariannol yr NHS yng Nghymru drwyddo draw

(xxiv) Anogwn Gyfarwyddiaeth yr NHS i weithio’n agosach gyda chyrff iechyd ar draws Cymru, gan roi rheolaeth strategol ac arweiniad gwirioneddol i’r gwasanaeth;

(xxv) Edrychwn tuag at Gyfarwyddiaeth yr NHS i weithredu i sicrhau bod ymddiriedolaethau NHS yn gallu cyflawni’r arbedion y proffwydwyd y byddent ar gael yn sgîl ad-drefnu’r ymddiriedolaethau NHS yng Nghymru, a nodwn ein bwriad i fwrw golwg manwl ar lwyddiant y rhaglen hon maes o law;

(xxvi) Anogwn Gyfarwyddiaeth yr NHS i weithredu’n briodol i sicrhau bod pob corff NHS yn cydymffurfio â Chod Ymarfer Cyd-ffederasiwn Diwydiant Prydain ar Dalu Cyflenwyr, gan weithredu yn unol â pholisi’r Llywodraeth yn y cyswllt hwn;

Ar iechyd ariannol ardaloedd pum awdurdod iechyd Cymru

(xxvii) Os digwydd yn y dyfodol y bydd ar ymddiriedolaethau NHS angen cymorth ariannol ychwanegol oddi wrth y Cynulliad, argymhellwn fod Cyfarwyddiaeth yr NHS yn ystyried sianelu’r gefnogaeth honno yn uniongyrchol i’r ymddiriedolaethau dan sylw;

(xxviii) Yng nghyswllt Ymddiriedolaeth NHS Sir Gaerfyrrddin, a’i hanawsterau ariannol ar hyn o bryd, anogwn Gyfarwyddiaeth yr NHS i weithio’n agos gyda’r ymddiriedolaeth ac Awdurddod Iechyd Dyfed Powys i gywiro unrhyw ddiffygion yn eu Cynllun Adfer yn enwedig o safbwynt lefel y realaeth yn y Cynllun a sicrhau bod gwasanaethau i gleifion yn cael eu gwarchod;

(xxix) Nid yw’r peirianwaith presennol ar gyfer dyrannu adnoddau mwyach yn fuddiol ac nid yw’n rhoi sylw digonol i’r pwysau amrywiol a gwahanol o ran costau sy’n effeithio ar gyfer NHS ar draws Cymru. Anogwn Gyfarwyddiaeth yr NHS felly, mewn ymgyngorriad agos â’r Pwyllgor Iechyd a Gwasaenaethau Cymdeithasol, i weithredu’n gyflwm ar ganlyniadau arolwg y fformiwla gyllido sydd ar y gweill ar hyn o bryd a sefydlu system sy’n cydnabod ffactorau o’r fath ac yn rhoi setlïadau ariannol blynyddol teg a chyfiawn;
Ar esgeulustod clinigol

O safbwyt rheoli esgeulutod clinigol gan yr NHS yng Nghymru, argymhellwn yn grwy fod Cyfarwyddiaeth yr NHS yn gweithredu i ganfod a llledaenu enghreiffiau o’r ymfaror gorau mewn rheolaeth ariannol ar draws NHS Cymru.

Dylai mwy o dryloywder wrth ddadlennu manylion meddygol i achwynydd ddod yn drefn safonol. Anogwn Gyfarwyddiaeth yr NHS i roi sylw i’r mater hwn yn rhannol drwy newidiadau yn addysg a hyfforddiant staff meddygol ac i gymryd rôl arweiniol yn y gwaith o ddatblygu diwylliant o fod yn agored a chyfathrebu’n dda;

Ar dwyll

Nid yw cost lawn twyll yn yr NHS yng Nghymru yn hysbys, ac mae angen gwelliannau sylweddol o ran canfod ac atal twyll. Anogwn Gyfarwyddiaeth yr NHS i fynd i’r afael â’r broblem hon fel mater o frys, ac yn enwedig i ystyried y defnydd posibl o gymhellion “gwario i arbed” a fyddai’n caniatâu i unrhyw arbedion a grëir gael eu rhyddhau’n uniongyrchol ar gyfer gofalu am gleifion;

Hyd yma, canolbwyntiwyd yn bennaf ar y sector gofal sylfaenol wrth fynd i’r afael â thyll. Anogwn Gyfarwyddiaeth yr NHS i roi sylw hefyd i’r perygl o dwyll yn y sector gofal eilaidd, gan roi sylw dyledus i’r risg gymharol o dwyll sydd ymhlyg yn y sector;

Ar gost cyffuriau gofal sylfaenol

Cydabyddwn fod yr NHS yn cymryd camau i reoli cost gynyddol cyffuriau gofal sylfaenol. Mae’r Grwp Gorochwyl a Gorffen yn ymchwilio i’r maes hwn, ac argymhellwn yn grwy fod canfyddiadau’r Grwp yn cael eu hadolygu fel mater o flaenoriaeth a, lle bo hynny’n briodol, eu rhoi ar waith gan Gyfarwyddiaeth yr NHS ar y cyfle cyntaf posibl;

Mae opsiynau eraill ar gael hefyd i fynd i’r afael â chostau cynyddol cyffuriau gofal sylfaenol, ac anogwn Gyfarwyddiaeth yr NHS i ddatblygu strategaeth gydlyns, a fydd yn cynnwys ystyried materion megis gwneud mwy o ddeffnydd o gyffuriau generaig, ailddatblygiadau cyd-fformiwlau, cynlluniau cymhellion o ran presgripsiynau a pha mor gyffredin yw rhoi ail-bresgripsiynau.

Crynodeb

Y Gwasanaeth Iechyd Gwladol yn ein sefydliad mwyaf gwerthfawr. Mae ei enw da wedi dioddef dros y blynyddoedd diwethaf, ac mae hyn i’w briodoli i raddau sylweddol i’w berfformiad ariannol gwael. Ni ellir caniatáu i hyn barhau.
63. Rhaid i'r Gwasanaeth Iechyd Gwladol ailadeiladu ei enw da drwy gyflwyno safonau gofal iechyd uchel i bobl Cymru o fewn yr adnoddau a roddir iddo gan y Cynulliad Cenedlaethol. Anogwn Gyfarwyddiaeth NHS y Cynulliad felly a rheolwyr y gwasanaeth iechyd, clinigwyr a staff i wneud popeth a allant i hyrwyddo rheolaeth ariannol dda, gan gynnwys cymryd camau mwy rhagweithiol i leihau lefel yr achosion o esgeulusod glinigol a’u cost, gostwng lefel twyll, a sicrhau gwerth am arian. Yn arbenig, disgwyliwn weld diweddu buan ar y cylch parhaus o ddiffygion ariannol yr adroddwyd amdanynt gan awdurdodau iechyd ac ymddiriedolaethau NHS dros y blynydiodd diwethaf.

Ceir cofnod dwyeithog o drafodion y pwylgorau Saesneg yr adroddiad (Atodiad A)
Gwybodaeth oddi wrth Gyfarwyddwr NHS - Cymru y Cynulliad ar fater
cyfatebu data rhwng yr NHS a’r Adran Nawdd Cymdeithasol

Pwyllgor Archwilio- 6 Ebrill 2000

Pwntiau Gweithredu sy'n deilio o sesiwn dystiolaeth Cyfarwyddwr NHS
Cymru

Cynigiodd Mr Gregory ysgrifennu at y Pwyllgor Archwilio yn ymateb i cwestiwn
Lorraine Barrett AC ynghylch a oedd Gweithgor Atal Twyll Cymru-gyfan wedi mynd
i’r afael â’r mater o gydweddu data rhwng yr NHS a chronfeydd data’r Adran Nawdd
Cymdeithasol, er enghraifft. Yr oedd hefyd am wybod yr anawsterau ymarferol a
allai godi.

Sylwer y byddai'r nodyn yn cael ei gynnwys fel atodiad i adroddiad y Pwyllgor.

Nid yw'r Gweithgor Atal Twyll wedi mynd i’r afael â’r mater hyd yma. Fodd bynnag,
mae’n agwedd bwysig o'r gwaith y mae'r Cynulliad yn disgwyl i'r gwasanaeth
weddigrwyd atal twyll (GGAT) newydd ei gyflawni. Mae cysylltiadau newydd i'w sefydlu
rhwng Cymru a Lloegr i atal twyll yn yr NHS, gyda Chymru yn dod yn bartner yn y
gwasanaeth atal twyll sydd eisoes yn bodoli yn Lloegr. Bydd cydweithio â’r GGAT
yn darparu gwasanaeth cynhwysfawr sy'n ymestyn i'r sectorau sylfaenol ac eilaidd fel
ei gilydd. Caiff trefniadau eu gwneud i sicrhau trefniadau adrodd priodol i'r NHS yng
Nghymru a'r Cynulliad Cenedlaethol.

Mae'r gwasanaeth atal twyll hwn wedi bodoli yn Lloegr ers mis Ebrill 1999, ac mae
cyswllt newydd i'w sefydlu rhwng Cymru a Lloegr i atal twyll yn yr NHS, gyda Chymru yn dod yn bartner yn y
gwasanaeth atal twyll sydd eisoes yn bodoli yn Lloegr. Bydd trefniadau tebyg am gynhwys
ar y sectorau sylfaenol ac eilaidd fel i gilydd. Caiff trefniadau eu gwneud i sicrhau trefniadau adrodd priodol i'r NHS yng
Nghymru a'r Cynulliad Cenedlaethol.

Mae'r gwasanaeth atal twyll hwn wedi bodoli yn Lloegr ers mis Ebrill 1999, ac mae
cyswllt newydd i'w sefydlu rhwng Cymru a Lloegr i atal twyll yn yr NHS, gyda Chymru yn dod yn bartner yn y
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ar y sectorau sylfaenol ac eilaidd fel i gilydd. Caiff trefniadau eu gwneud i sicrhau trefniadau adrodd priodol i'r NHS yng
Nghymru a'r Cynulliad Cenedlaethol.

Drwy gyfryngau electronig yn unig y gall gwiriadau o'r fath gael eu gwneud yn gost-
effeithiol. Bwriedir cyflwyno gwiriadau gyda’r Adran Nawdd Cymdeithasol (ANC). Mae trafodaethau yn mynd rhagdlynt gydag Adran Cylld y Wlad hefyd
ynghylch trefniadau tebyg am gymhwyster ar gyfer Credyd Treth Teuluoedd sy’n
Gweithio.

Bydd angen i'r Cynulliad roi'r ddeddfwriaeth angenrheidiol ar waith i roi effaith i’r
gosb, yn rhannol ar y cyd â’r Adran Lechyd. Os oes rhywun yn hawlio presgripsiwn
di-dâl drwy dwyll, mae Deddf Lechyd 1999 yn pennu cosb sy'n gyfwerth â’r tâl sy’n
ddyledus ar y presgripsiwn ynghyd â chosb sydd bum gwaith yn fwy na'r taliad
presgripsiwn sy'n ddyledus - gydag uchafswm o £100. Gellir cynyddu'r cosb 50% os
na thelir y gosb o fewn 28 diwrnod. Mae posibilrwydd y codir costau ychwanegol os oes rhaid mynd â'r achos gerbron llys i gael yr arian.

Mae cosbau eraill yn bodoli, a gyfrifir mewn ffodd debyg, mewn perthynas â hawlio drwy dwyll esemptiad rhag costau deintyddol neu hawlio drwy dwyll am fudd-dâl mewn perthynas â gwasanaethau optegol. Unwaith y daw'r ddeddfwriaeth i rym yng Nghymru, bydd rhwydd hynt i'r Cynulliad Cenedlaethol bennu lefel wahanol o gosb na'r gwledydd cartref eraill, er y byddai'n dda o beth arfer cysondeb ar draws yr NHS a'r DU. Gellir ystyr f tezeun y mater hwn unwaith y cyflwynir is-ddeddfwriaeth ynghylch cosbau.

Ceir peth pryder y gall gwiriadau electronig yr Adran Nawdd Cymdeithasol neu Adran Cyllid y Wlad fod yn groes i'r Ddeddf Diogelu Data oni bai fod y presgripsiwn neu'r ffurflen arall ar gyfer hawlio esemptiad yn nodi'n benodol y gall y gwiriadau hyn gael eu gwneud. Caiff y mater hwn ei ystyr i gan yr Adran Iechyd ac efallai y bydd angen ail-gynllunio'r wybodaeth ar gefn y ffurfleni perthnasol. Ateb posibl yw bod lle ar bob ffurflen i gleifion roi caniatâd i wiriadaw eu gwneud.
Llythyron at y Pwyllgor oddi wrth Syr John Bourn, Archwiliwr Cyffredinol Cymru, ar esgeulustod clinigol.

Nid yw'r llythyr yn Atodiad C ar gael yn Gymraeg. Gweler fersiwn Saesneg yr Adroddiad.
Y PWYLLGOR ARCHWILIO

Mae pwyllgor Archwilio'r Cynulliad Cenedlaethol yn sicrhau bod gwariant y Cynulliad yn cael ei archwilio'n gywir ac yn ddrywyr. Yn fras, rôl y Pwyllgor Archwilio fydd ymchwilio i'r adroddiadau ar gyfrif y Cynulliad a chyrff cyhoeddus eraill a baratowyd gan Archwilydd Cyffredinol Cymru ac ystyried adroddiadau gan Archwilydd Cyffredinol Cymru ar ymchwiliadau i ddarbodaeth, effeithlonrwydd ac effeithiolrwydd y Cynulliad wrth ddefnyddio'i adnoddau i gyflawni ei swyddogaethau. Nodir cyfrifoldebau’r Pwyllgor Archwilio yn fanwl yn Rheol Sefydlog 12.

Dyma aelodaeth y Pwyllgor a benodwyd ar 5 Ebrill 2000:

Cadeirydd: Janet Davies (Plaid Cymru)
Peter Black (Democrat Rhyddfrydol)
Alan Cairns (Ceidwadwr)
Geraint Davies (Plaid Cymru)
Brian Gibbons (Llafur)

Alison Halford (Llafur)

Dafydd Wigley (Plaid Cymru)
Christine Chapman (Llafur)
Alun Pugh (Llafur)

Bu Christine Chapman ac Alun Pugh yn aelodau o’r pwyllgor rhwng 23 Mehefin, 1999 a 5 Ebrill, 2000

Gellir cael gwybodaeth bellach am y Pwyllgor gan:

Andrew George
Clerc y Pwyllgor Archwilio
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
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