COFNDION CYMERADWY O GYFARFOD Y PWYLLGOR CYLLID A PERFFORMIAD/ APPROVED MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE MEETING

DATE OF MEETING: **9:30 AM, Tuesday 16 December 2025**
VENUE: **Microsoft Teams Meeting**

PRESENT:
Michael Imperato (Hywel Dda UHB - Independent Board Member) (Chair)
Anna Lewis (Hywel Dda UHB – Independent Member) (Vice Chair)
Rhodri Evans (Hywel Dda UHB – Independent Member)
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair)
Winston Weir (Hywel Dda UHB - Independent Board Member)

IN ATTENDANCE:
Thomas Alexander (Hywel Dda UHB - Principal Programme Manager) (part)
Shaun Ayres (Hywel Dda UHB - Director of Delivery)
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)
Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience) (part)
Mark Henwood (Hywel Dda UHB - Executive Medical Director) (part)
Siân Jenkins (Hywel Dda UHB - Deputy Director of Finance)
Leon Popham (Hywel Dda UHB - Senior Finance Business Partner)
Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences) (part)
Peter Skitt (Hywel Dda UHB - Clinical Care Group Service Director - Community & Integrated Medicine) (part)
Andrew Spratt (Hywel Dda UHB – Deputy Director of Finance)
Huw Thomas (Hywel Dda UHB - Director of Finance)
Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)
John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat)

MINUTES REF.	ITEM	ACTION

FPC(25)106 **WELCOME AND APOLOGIES**

Mr Michael Imperato welcomed all to the Finance and Performance Committee (FPC) meeting.

Apologies had been received from:

- Mr Lee Davies, Executive Director of Strategy and Planning
- Mr James Severs, Executive Director of Allied Health Professions and Health Science

FPC(25)107 **DECLARATION OF INTERESTS**

There were no declarations of interest.

FPC(25)108 MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025

The minutes of the FPC meeting held on 21 October 2025 were reviewed and agreed as an accurate record of proceedings.

Mrs Sharon Daniel left the meeting

Decision: The minutes of the Finance and Performance Committee meeting held on the 21 October 2025 were **APPROVED** as a correct record of proceedings.

FPC(25)109 TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025

The Table of Actions from the FPC meeting held on 21 October 2025 was reviewed and noted that all actions were complete.

Decision: The Finance and Performance Committee **REVIEWED** and **NOTED** the Table of Actions from the Finance and Performance Committee meeting held on 21 October 2025.

FPC(25)110 FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

Mr Huw Thomas presented the proposed revised terms of reference for the Committee following changes within the operational structure of the Health Board and to revise the Independent Member requirement for quoracy from 2 Independent Members to 3. The revised Terms of Reference were subject to approval by Board on 29 January 2026.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **APPROVED** the Finance and Performance Committee's Terms of Reference (version 4) for onward ratification by the Board on 29 January 2026.

FPC(25)111 ASSURANCE AND RISK REPORT

Mr Thomas presented the Assurance and Risk Report to the Committee for review and advised that there were 3 corporate risks assigned to FPC.

In response to a question from Cllr Rhodri Evans on whether the expected date to achieve the target risk score of Risk 1350 ('Risk of not meeting the 80% Single Cancer Pathway (SCP) waiting times target for March 2026 due to diagnostics capacity and delays at tertiary') was realistic, Mr Andrew Carruthers advised that current performance was 66.4% of suspected cancer patients starting a definitive treatment within 62 days of the point of suspicion of cancer with current work being undertaken to address to diagnostic backlog with the gynaecology cancer, post-menopausal bleeding, urology and lower gastro-intestinal colorectal pathways having been remodelled with the aim to shorten the time to diagnosis to under 30 days.

Mr Carruthers advised that as a result of the pathway remodelling, the gynaecology cancer pathway, average time for diagnosis had been reduced from 150 days to 29 days.

Mr Carruthers advised that the increase in capacity to address the backlog was anticipated to have a short-term impact on performance with performance anticipated to recover from February 2026 to above 70% with the ability to meet the 80% target by 31 March 2026 dependent on how the actions to remodel the pathways and increase capacity proceed.

Mr Carruthers believed that Welsh Government (WG) were considering reducing the SCP target to either 70% or 75% with clarification being sought from WG.

In response to a question from Ms Anna Lewis on the process for reporting long-term risks, Mrs Joanne Wilson advised that long-term risks were captured through the Board Assurance Framework (BAF) with the long-term finance risk being captured on the principal risk register. In response to a question from Ms Lewis on whether there needed to be more regular scrutiny of the longer-term financial risks, Mrs Wilson advised that the Strategy and Planning Committee had resolved to review the longer-term risks on a more regular basis and suggested that she would discuss with Mr Imperato adding a more regular review of principle risks, long-term risks and the BAF to the FPC Committee Work Plan. **JW**

In response to a question from Mr Winston Weir on the target risk score of Risk 2086 ('Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total'), Mr Thomas advised that the Health Board was anticipated to meet its target control total (TCT) for 2025/26 and that a letter had been submitted to WG requesting strategic cash support and should this be formally recognised and supported, the target risk score will be achieved, with the impact

Reduced, at which stage the risk would be de-risked.

In response to a question from Mr Weir on Risk 2104 ('Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 2025/26 due to demand exceeding capacity') identified a number of specialties and what confidence there was to meet the ministerial priorities, Mr Carruthers advised that challenges to specialities varied from month-to-month and that the greatest current risk to meeting the 104-week target for no patient to wait longer than 104 weeks or treatment lay within Glangwili Hospital (GGH) theatres impacting ear, nose and throat (ENT) and complex ophthalmology cases.

In response to a question from Mr Weir on the ministerial direction on the delivery of autism services and Corporate Risk 1032 ('Risk of timely Autistic Spectrum Disorder (ASD) diagnostic assessment for Children and Young People (CYP) due to increasing demand') that had a risk score of 20 and the two associated Operational Risks of Risk 1287 ('Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD') and Risk 1290 ('Risk of increased Adult Attention Deficit Hyperactivity Disorder waiting list due to referrals exceeding service capacity') that both had a risk score of 16, advised that they related to neurodevelopmental services that had been a significant capacity challenge to the Health Board with attempts made to source additional capacity with funding provided by WG and agreed to present a report to a future FPC meeting. **AC**

Mrs Wilson highlighted the number of overdue recommendations within audit and inspection reports under the responsibility of the Community and Integrated Medicine Clinical Care Group (CCG) that would need to be reviewed at the next FPC meeting on 24 February 2026. **AC**

Ms Sara Quarrie presented an update on the finance risks within the Operational Allied Health Professions and Health Science CCG and the rationale for the risk scores of risks aligned to FPC. Ms Quarrie advised that 12 of the CCG's risks sat within the finance domain and had been reviewed in accordance with the Health Board's risk scoring matrix. It was agreed that the presentation be circulated to members of the Committee for consideration. **CSO**

In response to a question from Ms Lewis on the consistent application of scoring of risks across CCGs, Mrs Wilson advised that all risks were scored in accordance with the Health Board's risk management framework and policy to deliver consistent and comparable risk scoring with a member of the Risk and Assurance Team aligned to each of the CCGs to provide training and support however individual CCG Directors may have differing levels of risk tolerance.

In response to a question from Mr Weir on whether it was sufficient to view the risks solely through a financial perspective, Mrs Wilson advised that the risks were scored against the finance domain with other risks within the CCG being reported to the Quality, Safety and Experience Committee (QSEC) dependent on which domain the risks were scored against.

Mr Peter Skitt joined the meeting

Mr Thomas believed that there was a need to transition to a new approach to reviewing risks within the next financial year given the lack of additional resources that were available to be allocated to addressing risk within service areas that required a discussion on what were the areas of highest risk that required intervention and the converse discussion on what areas were of the lowest risk and how resources could be transferred from the low-risk areas to the higher-risk service areas to address the high-level risk areas.

In response to a question from Mrs Eleanor Marks on how an assessment of low risk and low value areas of expenditure to explore what services could be prioritised and resources reallocated, Mr Carruthers believed that the framework for undertaking such assessments had not currently been developed and advised that work had been undertaken with the Value-Based Healthcare (VBHC) Team to explore where efficiencies could be made. Mr Carruthers cited a recent example within the Women's Health Psychology of a value project where a spend of £0.5m was envisaged to deliver £1.6m of low value activity however advised that given the CCG was at heightened internal escalation for financial planning and savings delivery, advised that such efficiency and productivity was not necessarily generating cash-releasing savings.

Mr Mark Henwood believed that the Health Board would never be able to identify procedures or conditions that it was simply going to be able to stop treating however would focus on pathways and parts of pathways that could create efficiencies that was more likely to improve performance as opposed to releasing large sums of cash-releasing savings.

Decision: The Finance and Performance Committee, in relation to the areas presented in this paper:

RISK MANAGEMENT

- **RECEIVED ASSURANCE** that identified controls are in place and working effectively; and
- **RECEIVED ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

AUDITS, INSPECTIONS AND REGULATORY REPORTS

- **RECEIVED ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted.

MINISTERIAL DIRECTIONS

- **RECEIVED ASSURANCE** that the Health Board is compliant with the Ministerial Directions issued by Welsh Government.

FPC(25)112 ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

Mr Shaun Ayres presented the Escalation Oversight and Highlight Report to the Committee to inform the escalation responses to the issues highlighted.

Mr Ayres noted the Health Board had received an additional non-recurrent allocation from WG to address the increased Welsh Risk Pool (WRP) pressure and funding to address the Healthcare Support Worker (HCSW) Band 2 and Band 3 position that had resulted in a revised TCT of £22.1m from WG. Mr Ayres highlighted that the Health Board retained an underlying deficit of £59.3m and the need to make recurrent savings to address the underlying deficit.

Mr Ayres believed that the Health Board's R1 Ophthalmology performance was a concern despite a recent improvement in performance by 1.2% with the current trajectory suggesting that it would be September 2027 until the Health Board met its 65% performance target at the current rate assuming a linear trajectory not assuming any additional capacity.

Mr Ayres advised that within Urgent and Emergency Care (UEC) performance the Health Board had achieved three consecutive months of meeting its under 1-hour ambulance handover targets however Delayed Transfers of Care (DTOC) performance and 12-hour Emergency Department (ED) waits remaining significantly off-target despite an improving trend. Mr Ayres advised that there was a worsening trend in clinical assessment times with all sites failing the 60-minute target.

Mr Ayres believed that there were on-going pressures within commissioning.

Decision: The Finance and Performance Committee:

- **NOTED** the integrated position across finance, urgent and emergency care and R1 ophthalmology – including:
    - that ambulance handover performance has met de-escalation criteria for three consecutive months;
    - that escalation targets for R1 ophthalmology and delayed transfers are unlikely to be achieved by March 2026 on current trajectory; and
    - that the underlying deficit of £59.3m and the Revised Target Control Total of £22.1m
- **RECEIVED ASSURANCE** on the:
    - delivery of the medical stabilisation programme (including agency reduction, rostering and rate-card implementation milestones);
    - implementation of recent Board decisions impacting UEC flow and LTA exposure (including coding improvement and challenge to over-performance); and
    - Actions being taken at Withybush ED and within Carmarthenshire DToC to address persistent outlier performance.
- **ENDORSED** the development of realistic multi-year recovery trajectories for R1 ophthalmology and delayed transfers, with clear interim milestones, capacity and resource assumptions, and
- **SUPPORTED** their inclusion within the three-year context of the Annual Plan and Targeted Intervention de-escalation framework for discussion with Welsh Government.

FPC(25)113 URGENT AND EMERGENCY CARE AND SIX GOALS UPDATE

Mr Carruthers presented the UEC and Six Goals update to the Committee to provide an overview of UEC performance within the Health Board.

Mr Carruthers believed that the Health Board was performing well in relation to its WG targeted intervention metrics with ambulance handover performance a highlight however believed that there was pressure being felt elsewhere within the system with 12-hour waits within ED having improved only slightly from the position 12 months previous.

Mr Carruthers advised that the additional pressure placed on EDs as a result of the measures taken to improve the ambulance handover performance had increased the level of risk spread over other areas of the UEC system and advised that at any given time there was an excess of 150 patients located in non-core bed spaces that was being managed over and above the Health Board's existing bed space.

Mr Carruthers believed that there were actions currently being undertaken to improve performance and the improve the flow of

patients through the system and referenced the business case for the 7-day clinical streaming and same-day emergency care (SDEC) that aimed to deliver the desired level of performance on a consistent basis and to deliver the services required to manage demand at the front-door and support the flow of patients out of the acute hospital setting, to reduce pathway of care delays and prevent delays to patient discharge.

Mr Carruthers advised that there were 207 reported pathways of care delays in November 2025 that was an improved position on October 2025 however noted that there had been an infection control issue on a ward at Withybush Hospital (WGH) that excluded that ward from the census with the revised number of pathway of care delays being 219 as opposed to the reported 207 figure.

Mr Peter Skitt advised that performance in the areas that the Health Board was being measured on had improved however the waiting time for clinical assessment within EDs was a concern particularly at WGH where the medical staffing infrastructure was considered fragile with gaps on the medical rota being managed with agency usage having a high financial cost in addition to a challenge with demand for the physical space to undertake clinical assessments.

Mr Skitt believed that the move to spread risk across the system as opposed to concentrating the risk within EDs was causing pressure within the system with more patients boarded outside of the core bed space resulting in quality and safety challenges.

Mr Skitt advised that this was currently the second week of the WG ‘Winter Sprint’ fortnight and advised that a Business Continuity situation had been declared at Glangwili Hospital (GGH) on 11 December 2025 due to the significant number of patients within the GGH ED however advised that the situation had recovered within 24 hours, and Mr Skitt believed that it was an indication of the improved environment within the system that previously it would have taken a week to recover from a similar position.

Mr Skitt believed that there were good relationships with the Health Board’s constituent Local Authority partners to expedite patient discharges with work undertaken through the Six Goals programme with calls undertaken with nursing homes ahead of ambulance conveyance to hospital, improved falls response and improvements to monitoring patients within their domiciliary setting.

Mr Skitt believed that the Health Board remained risk adverse at weekends in supporting patients to remain within their homes and believed that the 7-day streaming and SDEC business case would address such concerns to enable more patients to remain within

their homes and be monitored to enable patients to receive the support to remain at home.

Mr Skitt advised that significant improvements had been made to environmental considerations within EDs to improve the patient experience with the Digital Team working with clinical staff to improve communication within EDs.

In response to a question from Mrs Marks on the financial cost of delayed pathways of care, Mr Carruthers advised that it cost four times as much to keep a clinically optimised patient within an acute hospital setting than it does to support the patient within a community-based setting.

In response to a question from Mr Imperato on what the milestones towards an improved position were, Mr Skitt believed that the first milestone was the presentation of the 7-day clinical streaming hub and SDEC to Board on 25 January 2026 that Mr Skitt believed would see a reduction of the number of patients entering the front door of the Health Board's acute hospitals. Mr Skitt believed there was a need to provide alternative options to hospital settings as a destination for patients who did not need to be treated within the acute setting.

Mr Skitt believed the second milestone was to ensure that the Health Board had a robust medical staffing position with improved medical leadership and middle-grade doctors to ensure the provision of senior decision-making.

Mr Skitt believed that the third milestone was to see the number of surge boarding and number of patients cared for outside of the core bed base reduced and envisaged summer 2026 as a timescale for seeing the number of patients removed from the acute setting as a reasonable timeframe.

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Urgent and Emergency Care and Six Goals Programme Update.

FPC(25)114 R1 OPHTHALMOLOGY PERFORMANCE

Mr Carruthers presented the R1 Ophthalmology Performance report to the Committee and advised that R1 Ophthalmology had been identified as a risk area for the Health Board in 2025/26 and was an area of TI where it was considered that a plan was required to meet the TI target of 65% by September 2026.

Mr Carruthers advised that there was a six-month delay in the delivery timeline for improvements within the service and that the Health Board would achieve the 65% target by September 2026 as opposed to March 2026 as envisaged within the plan.

Mr Carruthers advised that an increase in planned capacity had resulted in more patients having been treated in November 2025 than in any previous month with three joint consultant appointments with Swansea Bay University Health Board (SBUHB) being progressed on a regional approach.

Mr Carruthers believed that the Health Board was on track to meet its 65% TI target however advised that the national target was to treat 95% of patients within their clinical target date of within 25% of their clinical target date for their care or treatment with an additional capacity gap existing that would be required to be met to meet the national target.

In response to a question of the source of funding for the additional capacity from Cllr Evans, Mr Carruthers advised that the additional funding was a local investment within the Health Board's budget and did not form part of the WG referral-to-treatment (RTT) allocation or planned care recovery funding intended to close the gap to meet the TI de-escalation criteria.

In response to a question from Cllr Evans on the confidence in meeting the TI performance target, Mr Carruthers believed that following the implementation of the planned increase in activity that the trajectory to meet to 65% target was reasonable and that the position that the Health Board envisaged being at by the end of March 2026 would be met by the end of September 2026 with the increase in activity helping to drive the increase in performance.

Decision: The Finance and Performance Committee **RECEIVED ASSURANCE** that the R1 delivery plans are progressing towards the outlined trajectory and will recover the R1 position to the TI target of 65% by September 2026.

FPC(25)115 PARTNERSHIP WORKING - COMMISSIONING ARRANGEMENTS

Mr Ayres presented a report on the Health Board's partnership working and commissioning arrangements to the Committee and advised that in Month 7 2024/25 there was a £1.5m overspend compared to a £1.815m overspend in Month 7 2025/26, representing a £307k additional overspend this year, a 20% increase in the overspend within the current year compared to the same point last year.

Mr Ayres believed that the reason for the increase was linked to patient services with a significant level of growth of cost and volume of emergency clinical oncology, uncoded general surgery and vascular general surgery and within the neurology day case position linked to the cost and administration of high-cost drugs.

Mr Ayres advised that there was a correlation between the increase in high-cost drugs and day cases and advised that there was a dispute between Hywel Dda University Health Board (HDdUHB) and SBUHB in relation to day cases that HDdUHB believed should be classified as a regular day attender with a lower cost associated.

Mr Ayres advised that there has been a 12.6% increase in reported emergency cases (232 cases) compared to the same period in the previous year, a 12.1% increase in day cases, neurology patient bed days has increased by 69.5% and the greatest driver in additional costs was within outpatients had seen an increase in 71.8% alongside an increase of 43.9% of radiology cases (119 procedures).

Mr Ayres believed that the mitigating actions needed to take into account the regional relationship with SBUHB however an option with uncoded activity not coded within a 30 to 60 day period was to withhold payment for that activity that would reduce the financial impact.

Mr Ayres believed that an option in relation to the zero-day emergency tariff the cost was significantly disproportionate to the level of activity and the application of the NHS England short-stay tariff of 10% to 20% would represent a cost reduction of between £0.9m and £1.4m.

In response to a question from Cllr Evans on whether payment could be withheld for uncoded activity undertaken on behalf of the Health Board by SBUHB, Mr Thomas advised that discussions had been undertaken with SBUHB who had advised that coding of HDdUHB activity undertaken by SBUHB would be prioritised and suggested that there was a role for internal audit to investigate the issue that spanned the two Health Boards and suggested that he, Cllr Evans, Mrs Wilson discuss to ascertain whether there was merit in seeking internal audit support. **RE/HT/ JW**

In response to a question from Ms Lewis on whether the Health Board was satisfied with the current commissioning arrangements with SBUHB, Mr Thomas believed that the commissioning and provider tools that existed did not reflect the evolved nature of the partnership working between the two Health Boards and that further reflection was needed to consider pathways of care that spanned the two Health Boards that considered the new structures such as the Regional Joint Committee (RJC) to enable assurance that spanned both Health Board boundaries. Mr Ayres believed that there was a natural tension between the two organisations, with HDdUHB as the commissioner seeking to reduce costs and SBUHB as the provider seeking to maximise its income return for the provision of those services.

In response to a question from Mrs Marks on the demand for service space at Amman Valley Hospital, Mr Carruthers advised

that there was an operational challenge for space at the site with work being undertaken to seek to examine what services could be relocated to localised community settings with the aim to free space at Amman Valley Hospital to enable the site to be developed as a specialist eye care site that would support the improvement of the R1 Ophthalmology Performance and enable other services to be delivered closer to the patients' home as part of the Health Board's strategic direction.

Decision: The Finance and Performance Committee:

- **NOTED** The Long Term Arrangements financial position as of M6 2025/26, including Hywel Dda University Health Board's identified challenges and the counter-positions held by provider organisations operating under the same financial pressures;
- **DISCUSSED** the balance between robust contract enforcement and maintaining collaborative relationships with partner Health Boards, recognising that resolution may require compromise on some issues;
- **SUPPORTED**, with conviction, Emergency tariff reform and coding enforcement as clear contractual matters and, through negotiation, Orthopaedic and Neurology arrangements via jointly agreed methodology where possible;
- **RECEIVED ASSURANCE** that the approach to commissioning challenges were robust and pursued legitimate interests whilst recognising provider perspectives and the wider context of NHS Wales financial sustainability;
- **ACKNOWLEDGED** that negotiations will become harder in 2026/27 and beyond, and that escalation to all-Wales forums may be required where bilateral resolution proves impossible.

FPC(25)116 CLINICAL CARE GROUP FINANCIAL SAVINGS ACTION PLANS

Mr Carruthers presented the CCG Financial Savings update to the Committee and advised that as of Month 7 2025/26, the planned savings position had improved by £2.0m to a position of £29.3m against a target of £39.0m.

Mr Carruthers advised that amber and green savings schemes had been improved by £2.5m to £25.6m however highlighted that 20% of the total related to in-month underspends being transacted as savings and that the full-year estimate of recurrent savings schemes was £22.0m.

Mr Carruthers advised that a number of significant risks were being managed by CCGs such as the increase in surge capacity within Carmarthenshire and Pembrokeshire, a deteriorating medical staffing workforce position and mitigating actions that had to be undertaken to maintain the referral-to-treatment (RTT)

delivery performance as a result of increased theatre cancellations at Glangwili Hospital (GGH).

Mr Thomas believed that there was still an over-reliance on non-recurrent savings measures that did not address the underlying savings challenge with the Health Board has over-delivered on it overall savings requirements as an organisation with savings within Executive Functions having contributed a significant proportion of the over-delivery of savings however most were non-recurrent savings with the Health Board under-delivering against its recurrent savings target by approximately £4m resulting in a deterioration of the Health Board's underlying deficit position.

In response to a question from Ms Lewis on whether the improvements to the Health Board's financial position was as a result of improvements driven by the CCGs to tackle inefficiencies and improve productivity, Mr Thomas believed that the growing maturity of the CCGs had supported the Health Board to improve cost controls through the improvement of scrutiny of grip and control measures within the CCG functions however they had not yet addressed the structural challenges within the Health Board, the issue of clinical variation and productivity issues that supported the quantification of recurrent savings.

Mr Carruthers believed that as part of the growing maturity of the CCGs there was a need to examine how CCGs could be given the space to reallocate resources across services and between high and low value schemes within their delegated accountability and believed that the reliance on non-recurrent savings was a result of it being easier to deliver in-year savings as opposed to delivering transformational change that delivered a recurrent benefit and believed that programmes of work such as the UEC Transformation Business Case would result in the delivery of recurrent savings in future years and would align with the structural direction of the Health Board.

Mr Thomas believed that there was a tension between the grip and control measures that had demonstrated in-year savings and the desire of CCGs to receive additional freedom to reshape their services that could result in the delivery of recurrent longer-term savings and system reconfiguration that would result in a relaxing of the grip and control measures that had resulted in the delivery of non-recurrent savings and controlled spending in-year.

Mr Shaun Ayres left the meeting

Decision: The Finance and Performance Committee **NOTED** the further progress achieved by Clinical Care Groups in respect of confirmed savings plans as at Month 7 2025/26 and the continuing focus of CCGs to further improve this position.

FPC(25)117 MEDICAL STABLISATION PROGRAMME UPDATE

Ms Carly Hill joined the meeting

Mr Henwood presented the Medical Stabalisation Programme Update to the Committee and advised that the programme was anticipated to be a long-term project to right-size the medical workforce position in a similar manner to the nurse stabalisation programme that was ten years in progress and not yet complete.

Mr Henwood believed that ensuring that the Health Board had the appropriate number of senior decision-makers within the medical workforce would significantly improve the level of the quality of care received by patients.

Mr Henwood believed the initial work undertaken had reduced the number of agency doctors used by the Health Board and reduced the number of high-cost individuals within the medical workforce however there had been a reliance on agency doctors within emergency care.

Ms Carly Hill presented an overview of the progress made through the Medical Stabalisation Programme and advised that an initial aim of the programme was to implement a Health Board-wide rostering system, to standardise the medical rate card within the Health Board and to enhance the Health Board's recruitment strategies for national and international recruitment to provide enhanced sustainability.

Ms Hill advised that the implementation of a Health Board-wide rostering system had begun in January 2025 with the implementation of the 'Allocate' system and the use of the 'Bank Staff+' and 'Medics on Duty' modules of the system to monitor additional duty hours and for staff to book locum shift cover. Ms Hill advised that the second phase was the implementation of the 'Activity Manager' with Phases 1 and 2 complete with roll-out of Phases 3 to 7 on track to be completed by 31 March 2026.

Ms Hill advised that the Allocate system was consistently used for job planning across the Health Board with the job planning compliance rate at 81% as of November 2025. Mr Hill advised that the Allocate system managed 487 doctors with 400 of those doctors having signed off job plans within the 15-month compliance period with monthly compliance reports issued to Operational Teams with escalation meetings undertaken by the Executive Medical Director to maintain and improve compliance.

Ms Hill advised that monthly variable pay reports were shared with CCG Directors to support discussions on rates of pay that had results in a reduction in the maximum rate of pay being paid for additional duty hours with work to develop dashboards being progressed during Q1 2026/27 as the Allocate system was fully implemented that would also integrate job planning with the rotas to develop variable pay management.

Ms Hill advised that the next programme of work to be implemented was the introduction of a standardised medical rate card that had been developed and had been approved by the Value and Sustainability Group and Executive Team. Ms Hill advised that while the rate card was not commensurate with the British Medical Association (BMA) rate card, it would increase the current rates of pay offered, ensure parity of payments across the Health Board, ensure transparency and improve the ability to report on any breaches.

Ms Hill advised that the Health Board would meet with the BMA in January 2026 ahead of the launch of the new medical rate card with associated communications and supported by an escalation framework.

Ms Hill advised that the Medical Stabalisation Programme would support to aim of the Welsh Health Circular (WHC) expectation to reduce agency spend by 30% by 31 March 2026, to ensure that 100% of assignments were compliant with the national price cap and to eliminate all non-direct engagement bookings within the Health Board.

Ms Hill advised that there had been significant success with converting agency staff into substantive employees through the facilitation of an engagement event that had been recorded and was shared with every new agency staff to encourage the take-up of substantive employment with the Health Board and that international recruitment had been considered a success with four confirmed offers undertaken demonstrating effective hiring by the Health Board.

Ms Hill emphasised the importance of medical workforce planning and noted the scope of acute medical wards to understand bed base and acuity and advised that weekly meetings with medical leads were held to model the workforce based on demand.

In response to a question from Cllr Evans on staff engagement for the medical rate card, Mr Henwood advised that the BMA would be engaged on the introduction of the standardised medical rate card however did not anticipate the BMA to approve the Health Board's medical rate card as the BMA medical rate card was significantly higher however noted that the BMA did not generally approve any other Health Board's rate cards for the same reason. Mr Henwood advised that there was not currently a standard all-Wales rate card and that the HDdUHB rate card would be different to other rate cards in South Wales and that where there were incidents of the Health Board paying higher than the agreed rate card position there were robust escalation process in place to manage the process.

Ms Hill advised that the full financial impact of the introduction of the medical rate card would not be known until it had been

implemented however anticipated that due to the revised rate card increasing levels of pay from the current 2017 levels, it was anticipated that the rate card would incentivise the take-up of available shifts and reduce the levels of variable pay significantly. Mr Henwood believed that there would be full oversight as the rate card would be linked to the eRostering system with the rates paid for any additional shifts and approving managers being clearly identified in real-time.

In response to a question from Mrs Marks on the impact on recruitment, Mr Henwood advised that the medical rate card was not intended to be a recruitment and retention tool, it was a means of managing additional duty hours paid and believed that the additional duty hours were not to provide additional services it was to provide core services due to the lack of headroom within the rotas and doctor job plans and absence of prospective cover for any absences and that led to the need for substantive recruitment.

Mr Henwood further believed that the Health Board was unique in Wales in having four medical takes within its area compared to one in SBUHB and one in Cardiff and Vale University Health Board (CVUHB) and that the cost was the cost of providing acute medicine at four hospital sites and that the new system would enable the Health Board to evidence to WG the cost of providing four hospitals within Mid and West Wales.

In response to a question from Mr Imperato on the requirements for medical staffing levels, Mr Henwood advised that initial work had focussed on acute medicine in EDs and that the issue was more complex than a simple calculation on the number of medical staff required due to the various roles undertaken by medical staff such as elective and emergency work with there being no calculation on the number of medical staff required akin to the nurse staffing calculations with Royal College guidelines only providing basic service level guidelines and did not include additional work such as education, training and research and innovation.

In response to a question from Mr Imperato on what the next milestone in the process would be, Mr Henwood believed that within Q1 2026/27 once the acute medicine and ED work had been completed there would be a greater understanding of what further work was required, what the financial resources would be required to right-size the medical workforce, how that would be phased in and how recruitment would be undertaken. Mr Henwood believed that conversations with ED trainees would also include discussions on the structural changes required within the Health Board and what the future working environment of the Health Board would look like.

Decision: The Finance and Performance Committee **NOTED** the Medical Stabalisation Programme Update.

FPC(25)118 FINANCIAL PERFORMANCE ASSURANCE REPORT

Mr Thomas presented the Month 8 2025/26 Financial Performance Assurance Report to the Committee and advised that since the publication of the Month 8 position, WG have confirmed that the Health Board's share of the Welsh Risk Pool liability of £4.2m would be funded and assurances had been received from WG that the Healthcare Support Worker (HCSW) Band 2/Band 3 position would also be funded.

Mr Thomas advised that as a result of these funding decisions, the Health Board's TCT had been revised from £24.1m to £22.1m. Mr Thomas advised that he was able to provide reasonable assurance to the Committee that based on the Health Board's current levels of expenditure and run-rate that the Health Board was expected to achieve the revised TCT for 2025/26.

Mr Thomas advised that there was currently a £3.3m gap to achieve the TCT of £22.1m so there remained a level of risk to the organisation that was required to be managed during the remainder of the financial year and believed that there were operational opportunities that could be realised within the current financial year.

Mr Thomas cautioned that there was still an issue with savings realisation to consider and as part of the plan for 2026/27 there was a need to address recurrent savings and the impact on the underlying deficit.

Mr Mark Henwood left the meeting. From this point onwards the meeting was inquorate.

In response to a question from Mr Imperato on what assurance could be taken from the financial position leading into 2026/27 and the need to deliver recurrent savings, Mr Thomas advised that while assurance could be provided on the bottom-line position for 2025/26, assurance could not be provided on the insufficient level of recurrent savings ahead of 2026/27 other than there were processes in place such as escalation meetings to provide assurance on the process however not the outcome with the discussion linked to the development of the financial plan for 2026/27 and the requirement from WG to provide an improving trajectory towards attaining a breakeven financial position for 2027/28 and beyond.

Ms Gemma Deverill joined the meeting

Mr Thomas believed that the current assessment was that the Health Board was maintaining its current position however was not improving upon it.

Decision: The Finance and Performance Committee:

- **RECOGNISED** that the Health Board's forecast deficit has improved to £22.1m, the revised target control total, following funding allocation confirmation from Welsh Government.
- **SCRUTINISED** the top priority alerts for urgent remedial action plans.
- **ACKNOWLEDGE** that the in-year savings delivery target has been over-achieved.
- **NOTED** that the Amber savings scheme judgement around future run rate conversion totalling £2.0m has been included within the Month 8 position, evidenced by past performance but in lieu of formal commitment and submission across service areas.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and that will only be reduced via robust recurrent savings delivery improvements, in particular those Executive portfolios that have yet to identify their full target.
- **NOTED** the Finance Performance report now includes additional outputs to provide more insightful and relevant reporting to the Committee.
- **NOTED** the strategic cash request has been sent to Welsh Government in December 2025.

FPC(25)119 PLANNING FOR 2026/27

Mr Andrew Spratt presented the Planning for 2026/27 report to the Committee and highlighted that the brought-forward underlying deficit for 2026/27 currently stood at £59.3m and was updated monthly to account for the level of recurrent savings identified within the current financial year.

Mr Spratt believed that the current outlook was one of standstill with an assumed deficit of £38.5m with no confirmation of the 2026/27 financial allocation from WG with political discussions currently on-going within Senedd Cymru on the budget for 2026/27 with recent developments indicating that agreements had been made to enable WG to pass its budget through Senedd Cymru.

Mr Spratt advised that news reports suggested that an additional £180m would be provided for the NHS Wales budget with the precise allocation for HDdUHB not currently formally confirmed with an indicative estimation of an additional £15m to £18m allocation for the Health Board in 2026/27 which when reduced from the current £38m deficit returns the Health Board to a standstill position with the Health Board consuming its own cost pressures that are anticipated to arise through inflation and an element of demand growth for the Health Board's services that were predicted.

Mr Spratt advised that what the allocation did not provide was to erode the Health Board's financial deficit with WG having been clear through the TI deescalation criteria that it expected the Health Board to improve its financial trajectory to deliver a break-even position by the end of the 2027/28 financial year as part of the criteria associated with the receipt of £26m of conditionally-recurrent funding.

Mr Spratt believed that an assessment of the Health Board's medium-term financial forecast was that the Health Board was not envisaged to erode its financial deficit, which he believed would signal a trajectory problem to WG and that the most optimistic outlook he could provide the Committee was that the deficit was not growing following two years where the Health Board had demonstrated that it was able to contain a previously growing deficit, however were not currently aligned with WG expectation to provide a financial road map to break-even, as reiterated by the Cabinet Secretary for Health and Social Care at the Public Accountability Meeting between the Health Board and WG on 11 December 2025.

In response to a question from Mr Weir on developing a greater understanding on the recurrent savings position, Mr Thomas believed that the Health Board had not met its intended milestones for developing recurrent savings plans within 2025/26 and there was a need to provide a clearer savings position at the FCP meeting on 24 February 2026 for the Committee's scrutiny.

Decision: The Finance and Performance Committee:

- **RECOGNISED** that the Health Board is proposing to submit a Three-Year Financial Plan, aspiring to a breakeven position for 2027/28 and beyond;
- **NOTED** this paper represents Year 1 of the Three-Year Financial Plan being developed for submission in March 2026;
- **DISCUSSED** the content of the latest draft Financial Assessment for 2026/27;
- **DISCUSSED** the current Welsh Government expectation of allocating 0.0% as part of the Allocation Letter expected in December 2025, and its impact on the draft financial deficit for 2026/27.
- **DISCUSSED** the approach to be taken to recognise underspends on a recurrent basis and the basis of allocating savings targets to functions.

FPC(25)120 INVESTMENT AND BENEFITS REALISATION REPORT

Ms Siân Jenkins presented the Investment and Benefits Realisation Report to the Committee to provide an update on the funding that had been earmarked thought he 2025/26 Annual Plan

and advised that the majority of the schemes proposed had been progressed through decisions made in Q1 and Q2 2025/26 with less activity following those decisions.

Ms Jenkins advised that the key update related to the funding of the Band 2/Band 3 HCSW funding following a national direction to review the banding having been undertaken and concluded with Workforce and Organisational Development having prepared the detail for payroll to progress payment in February 2026.

Ms Jenkins advised that an investment case that had been considered that had not been earmarked through the annual planning process as it had emerged in-year related to the Bronglais Hospital (BGH) Emergency Urgent Care Centre in relation to substantiating historic staffing arrangements that were currently being implemented on the rota and funded through variable pay with a view to considering within the planning process to ensure that the appropriate budget was in place in 2026/27.

Decision: The Finance and Performance Committee:

- **ACKNOWLEDGED** that investment cases for 2025/26 are being progressed through a review and scrutiny process to inform a final approval decision at Formal Executive Team; and
- **NOTED** that the process for investment cases is being reviewed in a bid to standardise the approach and support service leads in navigating the process of developing cases for change, presenting the associated business implications and subsequent benefits realisation.

FPC(25)121 PROCUREMENT SCRUTINY

Ms Gemma Deverill presented the Procurement Scrutiny report to the Committee and advised that the Citrix Hardware Replacement tender process was due to close on 18 December 2025 with evaluation to take place on 22 December 2025.

Ms Deverill advised that 13 bids had been received for the Insourcing of Theatre Scrub Team contract and following the evaluation process the proposal was to award the contract to ID Medical Group Ltd. with an indicative cost of £3.7m over 14 months with the potential to deliver savings as indicated within the commissioning documentation however confirmation of savings would be confirmed post-procedure.

Ms Deverill advised that in relation to the car parking management tender, following a mini-competition involving the five main national suppliers, the only bid that had been received was from the incumbent supplier with a slight increase in costs of £14k for signage and body-worn cameras.

In response to a question from Cllr Evans on the car parking management tender, Ms Deverill advised that feedback had been sought from providers however no feedback had been received to date and that consideration had been given to exploring the wider market following the initial three-year period of the contract as opposed to repeating the mini-competition process.

Ms Gemma Deverill left the meeting

Decision: The Finance and Performance Committee scrutinised and were minded to recommend to Board to:

- **APPROVE** the award of Citrix Hardware Replacement to (provider, value and contract term to be confirmed prior to Board). This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of Insourcing of Theatre Scrub Team to (provider, value and contract term to be confirmed prior to Board). This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award of Car Park Management to (provider, value and contract term to be confirmed prior to Board). This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.

FPC(25)122 INTEGRATED PERFORMANCE ASSURANCE REPORT

Mr Thomas presented the Integrated Performance Assurance Report (IPAR) to the Committee and advised that the proportion of patients waiting more than 8 weeks for a specified diagnostic had fallen for the sixth consecutive month with 8,000 having waited in January 2025 having been reduced to 1,600 in November 2025.

Mr Thomas highlighted that RTT was on-track with no patient waiting longer than 52 weeks for their first outpatient appointment, with the exception of Ear, Nose and Throat (ENT) by the end of December 2025 with all patients having received treatment within 104 weeks of the Health Board receiving their referrals.

Mr Thomas advised that there were 207 patients experiencing delayed pathways of care at the end of November 2025.

Mr Thomas highlighted that HDdUHB had the highest number of patients waiting over 14 weeks for a specified therapy in Wales with almost half of those patients waiting for physiotherapy.

Mr Thomas advised that neurodevelopmental services continued to remain challenged with a decline in performance within the number of children and young people waiting over 26 weeks to

start a neurodevelopment pathway assessment, mainly for attention deficit hyperactivity disorder (ADHD).

In response to a question from Mrs Marks on the deterioration in the mental health and neurodevelopmental pathways, Mr Thomas believed that this was a challenging area that the Health Board had struggled to address and was part of a wider national issue. Mr Carruthers believed that the short-term solution related to the procurement of additional capacity with a longer-term solution requiring greater WG support.

In response to an observation from Mrs Marks on the need to address the concerns relating to the service, Mr Imperato suggested that it was an area that a joint meeting of FPC and QSEC needed to examine. Mrs Wilson advised that QSEC had alerted the Board to their concerns on the service and advised that should FPC also alert the Board to its concerns also then the Board would be required to respond, either to each Board Committee individually or a joint meeting of both Committees.

Mr Peter Skitt joined the meeting

In response to a question from Mr Imperato on whether there was a need to examine therapy performance in greater detail, Mr Carruthers advised that there was not currently a plan to recover therapies performance by 31 March 2026 with it envisaged to take up to 9 months to recover the position within some of the sub-specialties with physiotherapy one of the areas where progress was possible however it would require the use of variable pay and agency usage to supplement the substantive workforce and while there was not presently the budget available to fund that additional capacity discussions had been held with WG on providing additional support for increased physiotherapy capacity.

Decision: The Finance and Performance Committee **DISCUSSED** the IPAR – Month 8 2025/2026 report and to **RECEIVED ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

FPC(25)123 NWSSP PERFORMANCE REPORT QUARTER 2 2025/26

Mr Thomas presented the NHS Wales Shared Services Partnership (NWSSP) Performance Report for Q2 2025/26 and believed that performance continued to be relatively well across the metrics measured in this space.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

- **RECEIVED ASSURANCE** from the content of the NWSSP Performance Report for Quarter 2 2025/26 that services provided are being delivered to expected standards; and
- **NOTED** the work being developed regarding outcome measures reporting.

FPC(25)124 FINANCIAL PROCEDURES

Mr Thomas presented the Financial Procedures to the Committee for their approval and advised that Financial Procedure 1049 – Use of Consultancy had been reviewed and was presented to the Committee for approval.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee were minded to **APPROVE** the following updated financial procedures:

- Financial Procedure 1049 – Use of Consultancy

FPC(25)125 BUSINESS CASE: 7-DAY CLINICAL STREAMING AND SDEC BUSINESS CASE SUMMARY

Mr Thomas Alexander joined the meeting

Mr Carruthers presented a summary of the 7-Day Clinical Streaming and Same-Day Emergency Care (SDEC) Business Case to the Committee for approval ahead of onward submission to Board on 29 January 2026.

Mr Carruthers believed that in order to improve performance within urgent and emergency care, Hospital@Home and same-day emergency care a move towards 7-day clinical streaming coverage was required to improve performance on a consistent basis.

Mr Carruthers believed that 7-day clinical streaming was necessary to manage demand, to improve patient flow through the care system and was consistent with the Health Board's strategy and was based on international learning from other similar health systems.

Mr Carruthers believed that the outcomes that the Health Board hoped to deliver would be achieved through the provision of 7-day clinical streaming and the appropriate use of resources to deliver those goals.

Mr Peter Skitt believed that the provision of 7-day clinical streaming and SDEC fitted into both the national strategy and the

local strategy and advised that the current system for the provision of clinical streaming and SDEC was a fragile service with limited resources with the intention through the business case to develop a less fragile and more sustainable service that can continuously operate over longer hours.

Mr Skitt believed that the significant challenge would be in how the Health Board transitions funding with the business case predicated on this being a redirection of existing resources in a better way as opposed to a case for additional investment and a realignment of services over a period of time to deliver the 7-day clinical streaming and SDEC service.

Mr Skitt advised that there was envisaged to be a degree of overspending in the initial stages of the transition that would be balanced out at a later stage of the process through the reduction in surge capacity and improvements to the patient flow process. Mr Skitt advised that there was a need to reduce the Health Board's bed costs and bed occupancy as part of the revised model.

Mr Skitt highlighted that it has been decided to phase the introduction of the SDEC approach to enable readiness with the teams with WGH being part of the first phase as it was the site where it was believed the greatest benefit could be gained from and would demonstrate the performance and financial payback return ahead of BGH in the second phase and GGH being the third site to be phased in. Mr Skitt advised that there were strong clinical and financial reasons for the phasing with consideration given to how the schemes return to financial balance through the phasing with the approach proposed being considered the most cost-effective means of firstly introducing the clinical streaming hub and then phasing in the SDEC model.

Mr Skitt believed that if the option of just introducing the clinical streaming hub then the question would arise of where patients would be streamed to and while some patients could be streamed to their home and supply a level of care within the patients' home, there was also a need to stream patients to somewhere else within the acute setting to enable to diagnostic process and the provision of the high-level acute diagnostics required by some patients.

In response to a question from Ms Lewis on the need for the balance between the current risks being carried by operational teams and the need to allow flexibility to speed up the phasing where operational teams feel it could be, Mr Skitt advised that the timescale of the phasing was open to change and would be included in the business case calculations.

Mr Thomas believed that the need to transform the service was beyond question however there was a tension between transferring a systemic clinical risk into a financial risk given that

there was no certainty over the level of funding that would be required to shift or stop as part of the transformation process

In response to a question from Ms Lewis on the need to have a robust measurement strategy to quickly identify what was and was not working and enable progress to be tracked to enable a quick pivot away from what was not working to a solution that would work, Mr Carruthers believed that there was a need to be agile and learn quickly during the process.

Mr Huw Thomas left the meeting

Decision: The Finance and Performance Committee:

- **NOTED** the 7-Day Clinical Streaming and Same Day Emergency Care Business Case summary; and
- Were minded to **APPROVE** Option B to Board for approval to implement seven-day Clinical Streaming, Hospital@Home and a phased roll-out for SDEC services by site with annual reviews and potential expansion, expedited roll-out or discontinuation.

FPC(25)126 ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

The All-Wales Capital Programme 2025/26, Capital Resource Limit (CRL) and Capital Management Update was presented to the Committee.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

- **NOTED** the 2025/26 Capital Resource Limit (CRL);
- **NOTED** the current risk associated with delivery of 2025/26 CRL; and
- **NOTED** the project updates

FPC(25)127 JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

The Joint Commissioning Committee (JCC) Planning, Performance and Finance Sub-Committee highlight report from its meeting on 23 October 2025 was presented to the Committee.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Highlight Report from the Joint Commissioning Committee Planning, Performance and Finance Sub-Committee

meeting on 23 October 2025.

FPC(25)128 NHS PRODUCTIVITY COMMISSION 'FROM DIAGNOSIS TO DELIVERY'

The NHS Productivity Commission report ‘From Diagnosis to Delivery’ was presented to the Committee.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **NOTED** the NHS Productivity Commission ‘From Diagnosis to Delivery’ Report.

FPC(25)129 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26

Mr Imperato presented the FPC Annual Work Plan for 2025/26 to the Committee for review.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Committee Work Plan 2025/26.

FPC(25)130 ANY OTHER BUSINESS

There was no other business transacted at the meeting.

FPC(25)131 DATE OF NEXT MEETING

The next meeting of FPC will be held on Tuesday, 24 February 2026.

It was noted that the next meeting of FPC will be held in the Dolau Cothi Boardroom at the new Health Board Corporate Headquarters in Picton Terrace, Carmarthen.