Date	**16 December 2025**
Time	**9:30 AM - 1:00 PM**
Location	**Ty Gorwel Large Meeting Room, St David's Park/Microsoft Teams Meeting**

Finance and Performance Committee Meeting

16 December 2025

Agenda - 16 December 2025

1 GOVERNANCE

9:30 AM, 0 min

1.1 WELCOME AND APOLOGIES

9:30 AM, 0 min
Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.2 DECLARATION OF INTERESTS

9:30 AM, 0 min
Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.3 MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025

9:30 AM, 5 min
Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.4 TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025

9:35 AM, 0 min
Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.5 FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

9:35 AM, 0 min
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

1.6 ASSURANCE AND RISK REPORT

9:35 AM, 15 min
Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences)

2 ESCALATION OVERVIEW

9:50 AM, 0 min

2.1 ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

9:50 AM, 10 min
Shaun Ayres (Hywel Dda UHB - Director of Delivery)

---

3 ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

10:00 AM, 0 min

3.1 URGENT AND EMERGENCY CARE AND SIX GOALS UPDATE

10:00 AM, 20 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.2 R1 OPHTHALMOLOGY PERFORMANCE

10:20 AM, 20 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.3 PARTNERSHIP WORKING - COMMISSIONING ARRANGEMENTS

10:40 AM, 20 min
Shaun Ayres (Hywel Dda UHB - Director of Delivery)

3.4 CLINICAL CARE GROUP FINANCIAL SAVINGS ACTION PLANS

11:00 AM, 20 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.5 MEDICAL STABLISATION PROGRAMME UPDATE

11:20 AM, 20 min
Mark Henwood (Hywel Dda UHB - Executive Medical Director)

---

4 FINANCE

11:40 AM, 0 min

4.1 FINANCIAL PERFORMANCE ASSURANCE REPORT

11:40 AM, 15 min
Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

4.2 INVESTMENT AND BENEFITS REALISATION REPORT

11:55 AM, 10 min
Sian Jenkins (Hywel Dda UHB - Deputy Director of Finance)

4.3 PLANNING FOR 2026/27

12:05 PM, 15 min
Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance), Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)

4.4 PROCUREMENT SCRUTINY

12:20 PM, 10 min
Gemma Deverill (NWSSP - Procurement)

5 PERFORMANCE

12:30 PM, 0 min

5.1 INTEGRATED PERFORMANCE ASSURANCE REPORT

12:30 PM, 5 min
Anthony Tracey (Hywel Dda UHB - Digital Director)

5.2 NWSSP PERFORMANCE REPORT QUARTER 2 2025/26

12:35 PM, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

6 FOR APPROVAL

12:40 PM, 0 min

6.1 FINANCIAL PROCEDURES

12:40 PM, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

6.2 BUSINESS CASE: 7-DAY CLINICAL STREAMING AND SDEC BUSINESS CASE SUMMARY

12:45 PM, 15 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7 FOR INFORMATION

1:00 PM, 0 min

7.1 ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

1:00 PM, 0 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7.2 **JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS**

1:00 PM, 0 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7.3 **NHS PRODUCTIVITY COMMISSION 'FROM DIAGNOSIS TO DELIVERY'**

1:00 PM, 0 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7.4 **FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26**

1:00 PM, 0 min
Michael Imperato (Hywel Dda UHB - Independent Board Member)

---

8 **ANY OTHER BUSINESS**

1:00 PM, 0 min

---

9 **DATE OF NEXT MEETING**

1:00 PM, 0 min

Table of contents

2025-12-16 9:30 AM - 1:00 PM

1 - GOVERNANCE 11

1.1 - WELCOME AND APOLOGIES 12

1.2 - DECLARATION OF INTERESTS 13

1.3 - MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025 14

Attachments

Unapproved Minutes FPC 21 October 2025 15

1.4 - TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025 42

Attachments

FPC Table of Actions 21 October 2025 43

1.5 - FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE 45

Attachments

Terms of Reference FPC 16 December 2025 46

Appendix 1 Finance and Performance Committee Terms of Reference v4 49

1.6 - ASSURANCE AND RISK REPORT 62

Attachments

Assurance and Risk Report FPC 16 December 2025 63

Appendix 2 FPC Audit Inspections November 2025 83

Appendix 1 FPC Corporate Risk Register Summary 120

2 - ESCALATION OVERVIEW 138

2.1 - ESCALATION OVERSIGHT AND HIGHLIGHT REPORT 139

Attachments

Escalation Oversight and Highlight Report FPC 16 December 2025 140

3 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES 154

3.1 - URGENT AND EMERGENCY CARE AND SIX GOALS UPDATE 155

Attachments

UEC and Six Goals Update FPC 16 December 2025 156

3.2 - R1 OPHTHALMOLOGY PERFORMANCE 168

Attachments

R1 Ophthalmology Performance FPC 16 December 2025 169

3.3 - PARTNERSHIP WORKING - COMMISSIONING ARRANGEMENTS 177

Attachments

Partnership Working - Commissioning Arrangements FPC 16 December 2025 178

3.4 - CLINICAL CARE GROUP FINANCIAL SAVINGS ACTION PLANS 205

Attachments

CCG Financial Savings Action Plans FCP 16 December 2025 206

Appendix 1 Blue and Red Savings Schemes 212

3.5 - MEDICAL STABLISATION PROGRAMME UPDATE 214

Attachments

Medical Stabalisation Programme Update FPC 16 December 2025 215

Medical Stabalisation Programme Action Plan FPC 16 December 2025 231

4 - FINANCE 233

4.1 - FINANCIAL PERFORMANCE ASSURANCE REPORT 234

Attachments

M8 2025-26 Financial Performance Assurance Report FPC 16 December 2025 235

Appendix 1 P08 2025-26 Finance Performance Report 245

Appendix 2 2025-26 In-Year Financial Position Letter from Hywel Jones 10 December 2025 290

Appendix 3 2025-26 Target Control Total Letter from Hywel Jones 10 December 2025 291

Appendix 4 2025-26 Strategic Cash Request Letter 5 December 2025 292

4.2 - INVESTMENT AND BENEFITS REALISATION REPORT 294

Attachments

Investment and Benefits Realisation Report FPC 16 December 2025 295

Appendix 1 Investment and Benefits Realisation Report 300

4.3 - PLANNING FOR 2026/27 304

Attachments

Planning for 2026-27 FPC 16 December 2025 305

Appendix 1 FY27 Annual Financial Plan 310

4.4 - PROCUREMENT SCRUTINY 346

Attachments

Procurement Scrutiny FPC 16 December 2025 347

5 - PERFORMANCE 353

5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT 354

Attachments

IPAR FPC 16 December 2025 355

M8 December 2025 IPAR Overview 362

5.2 - NWSSP PERFORMANCE REPORT QUARTER 2 2025/26 392

Attachments

NWSSP Performance Report Quarter 2 2025-26 FPC 16 December 2025 393

HDdUHB NWSSP Summary Performance Report Quarter 2 2025-26 399

6 - FOR APPROVAL 422

6.1 - FINANCIAL PROCEDURES 423

Attachments

Financial Procedures FPC 16 December 2025 424

FP1049 Use of Consultancy 427

FP1049 EqIA Screening Tool 440

6.2 - BUSINESS CASE: 7-DAY CLINICAL STREAMING AND SDEC BUSINESS CASE SUMMARY 445

Attachments

7-Day Clinical Streaming and SDEC Business Case Summary FPC 16 December 2025 446

7 - FOR INFORMATION 463

7.1 - ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE 464

Attachments

Capital Update FPC 16 December 2025 465

7.2 - JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS 475

Attachments

JCC PPF Sub-Committee Highlight Report 23 October 2025 476

7.3 - NHS PRODUCTIVITY COMMISSION 'FROM DIAGNOSIS TO DELIVERY' 480

Attachments

NHS Productivity Commission From Diagnosis to Delivery Report 481

7.4 - FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26 546

Attachments

FPC Work Plan 2025-26 547

8 - ANY OTHER BUSINESS 552

9 - DATE OF NEXT MEETING 553

1

9:30 AM, 0 Mins

1 - GOVERNANCE

1.1 **9:30 AM, 0 Mins**

1.1 - WELCOME AND APOLOGIES

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.2 **9:30 AM, 0 Mins**

1.2 - DECLARATION OF INTERESTS

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.3 **9:30 AM, 5 Mins**

1.3 - MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025

Michael Imperato (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

Unapproved Minutes FPC 21 October 2025.pdf

UNAPPROVED MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE MEETING

DATE OF MEETING: **9:30 AM, Tuesday 21 October 2025**
VENUE: **Ystwyth Boardroom/Microsoft Teams Meeting**

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

IN ATTENDANCE:
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)
Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience) (part)
Richard Jenkins (Hywel Dda UHB - Assistant Finance Director Commissioning, BI & Value)
Siân Jenkins (Hywel Dda UHB - Deputy Director of Finance)
James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science) (VC)
Andrew Spratt (Hywel Dda UHB – Deputy Director of Finance)
Katie Stuart-Robson (Hywel Dda UHB - Assistant Finance Business Partner) (VC)
Jennifer Thomas (Hywel Dda UHB - Senior Finance Business Partner (Accounting & Statutory and Reporting)) (VC)
Douglas Wilson (Hywel Dda UHB - Senior Performance Management Analyst) (VC) (part)
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)76 **WELCOME AND APOLOGIES**

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

Apologies had been received from:

- Mr Mark Henwood, Medical Director
- Mr Shaun Ayres, Director of Delivery

FPC(25)77 **DECLARATION OF INTERESTS**

UNAPPROVED

There were no declarations of interest.

MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 26 AUGUST 2025

The minutes of the FPC meeting held on 26 August 2025 were reviewed and agreed as an accurate record of proceedings.

Decision: The minutes of the Finance and Performance Committee meeting held on the 26 August 2025 were **APPROVED** as a correct record of proceedings.

FPC(25)78 **MINUTES OF EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE HELD ON 15 SEPTEMBER 2025**

The minutes of the Extraordinary FPC meeting held on 15 September 2025 were reviewed and agreed as an accurate record of proceedings.

Decision: The minutes of the Extraordinary Finance and Performance Committee meeting held on the 15 September 2025 were **APPROVED** as a correct record of proceedings.

FPC(25)79 **TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 26 AUGUST 2025**

The Table of Actions from the FPC meeting held on August 2025 was reviewed.

Mr Andrew Carruthers advised that in relation to **FPC(25)67 ('Policies')** Llais has been engaged at a national level in the development of the All-Wales Patient Access Elective Care policy and arrangements were in place to brief the West Wales Llais group on the local implementation of the policy and that the action could be closed.

Decision: The Finance and Performance Committee **REVIEWED** and **NOTED** the Table of Actions from the Finance and Performance Committee meeting held on 26 August 2025.

FPC(25)80 **ASSURANCE AND RISK REPORT**

Mr Huw Thomas presented the Assurance and Risk Report to the Committee and advised that Principal Risk 1199 ('Achieving

UNAPPROVED

financial sustainability') had been reviewed in September 2025 and formed the basis on the Financial Road Map item on the current agenda.

Mr Thomas advised that the operational risk scores would be reviewed by the Operational Allied Health Professions and Health Sciences Clinical Care Group (CCG) to reassess the current risk score and believed that there was feedback required to be undertaken in relation to the risk scores that had been recorded as high on the operational risks. Mr Thomas advised that the Lead of the CCG would be invited to attend a future FPC meeting to explain the rationale for the risk scores to the Committee. In response toa question from Cllr Rhodri Evans on the process of reviewing the risk scores, Mr Thomas advised that the risk scores would be scrutinised at the Operational Allied Health Professions and Health Sciences CCG escalation meeting and further reviewed with the CCG Lead, Ms Sara Quarrie, to be requested to attend a future meeting of FPC to explain the rationale for the CCG risk scores aligned to FPC. **HT**

In response to a question from Ms Anna Lewis on Risk 2040 ('Risk of decommissioning of current FCP Physio Primary care service due to funding uncertainty from April 2026') and the process for approving the decommissioning, Mr Thomas advised that a Quality Impact Assessment on the decision to decommission the First Contact Physiotherapy (FPC) primary care service with the outcome determining the process for proceeding with the decommissioning determining the process. Mr Thomas advised that a number of areas of work within primary care were funding through non-recurrent funding streams such as cluster funding or Regional Integration Fund (RIF) funding that presented a broader risk that would be raised in future planning discussions.

In response to a question from Ms Lewis on the ability to report risks grouped into themes, Mr Thomas advised that the themes of significant risks were being examined by the CCGs as part of the planning process for 2026/27. Mrs Joanne Wilson advised that the limitations of the Health Board's incident reporting and risk management system, Datix, meant that the risk could only be categorised against one domain per risk, so each risk was categorised against the domain where the greatest risk impacted.

In response to a question from Mr Winston Weir on the relatively high target risk scores for risks such as Risk 1231 ('Risk of overspend due to cost pressures related to Everlight radiology') and Risk 1232 ('Risk of overspend due to cost pressures related to variable pay') Mr Thomas advised that the high target risk scores had been fed back to the CCG for them to reflect upon in future iterations of the risk report. Mrs Wilson advised that the target risks scores had been discussed at the Executive Risk Group and believed that the relatively high level of risk would have to be tolerated for a period of time.

UNAPPROVED

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

- **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.

FPC(25)81 ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

Mr Andrew Spratt presented the Escalation Oversight and Highlight Report to the Committee that would provide an introduction to the Escalation Response section of the meeting agenda.

Mr Spratt advised that the Health Board's financial position had formally been revised from a planned annual deficit of £31.5m to to £30.0m and further to the work aligned to the Q2 2025/26 focus of de-risk the plan, the outcome from the 9 September 2025 In-Committee Board endorsed actions and Public Board on 25 September resulted in a £2.2m improvement to the forecast position, to a reported end of year forecast of £27.8m in Month 5.

Mr Spratt advised that although the Health Board had not identified the full £6.0m in line with Welsh Government (WG) expectations to achieve £24.1m forecast deficit, the improvements were a positive step forward with further work to be undertaken in the coming weeks to progress the choices and actions proposed to achieve this, which are reflected within a separate report on the agenda on the Financial Deficit Savings Category Update with communication with WG appended to the Financial Performance Assurance Report.

Mr Spratt advised that the key risk to the delivery of the financial plan was the ability to deliver the savings plan with CCGs struggling to deliver the level of savings that were assumed in the financial plan. Mr Spratt advised that the under-identification of savings by CCGs was being offset by the over-performance by Executive Functions who were over-delivering against savings targets.

Mr Spratt advised that Planned and Specialist Care CCG performance exhibited an improved outlook compared to the previous report presented to FPC on 26 August 2025 with the only area being alerted to the Committee being within high-risk eye care patient performance where the Health Board remained significantly adrift from its targeted intervention (TI) de-escalation target.

UNAPPROVED

Mr Spratt advised that the Community and Integrated Medicine CCG performance data was as of September 2025 and advised that in October 2025 a 'system reset week' has been undertaken that had resulted in significant improvements to ambulance hand-over performance that would be provided by the Chief Operating Officer's Ambulance Handover Performance update through the escalation response section on the meeting agenda.

Mr Spratt highlighted two new alerts within the Mental Health and Learning Disabilities (MHLD) CCG relating to child neurodevelopment waits and adult psychological therapy waits that were both significantly breaching TI de-escalation criteria that were also identified as areas of concern through the Integrated Performance Assurance Report (IPAR).

Mr Spratt advised that within the Operational Allied Health and Health Sciences CCG, radiology waits over 8 weeks were an advise to the Committee with therapy waits over 14 weeks exhibiting a concerning trend.

In response to a question from Ms Lewis on the sustainability of Executive Function over-performance of savings realisation offsetting CCG under-performance, Mr Thomas believed that this was the impact of holding corporate roles and vacancies and believed that there was a quality impact that was not being described in the data that was a result of a tactical response to the situation as opposed to a strategic drive and advised that such a strategic response would need to be incorporated within the Health Board's three year financial road map.

In response to a question from Cllr Evans on the ophthalmology performance, Mr Andrew Carruthers advised that starting from the initial plan at the start of the year, additional investment had been allocated to deliver an improvement in performance however there had been a delay to the recruitment of consultant and Speciality, Associate Specialist (SAS) doctors resulting in a six month delay with compliance with the target anticipated within 12 months with improvements exhibited each month through this year. It was agreed that Mr Carruthers would provide an update on the Ophthalmology position at the FPC meeting on 16 December 2025. **AC**

Decision: The Finance and Performance Committee **CONSIDERED** and **NOTED** the Escalation Oversight and Highlight Report as a basis for consideration of the Escalation Response.

FPC(25)82 AMBULANCE HANDOVER PERFORMANCE (VERBAL UPDATE)

UNAPPROVED

Mr Carruthers provided a verbal update on ambulance handover performance following the decision taken at Board on 31 July 2025 to commence a 60-Day Challenge for the service to be ready for the change to the ambulance handover target from 1 October 2025 with the implementation of a 'system reset week' starting on the 8 September 2025 whereby the proposed changes to the system were implemented to improve the flow of patients through the acute hospital setting such as the introduction of criteria-led discharge to support timely discharge out of hours and at weekends and not just week days and the optimisation of the use of discharge lounges to support to discharge before midday and the launch of the 'Your Next Patient' initiative to reduce handover delays by ensuring immediate allocation of patients to clinical areas.

Mr Carruthers advised that recent Getting It Right First Time (GIRFT) reports had highlighted the need for a whole-system ownership of the ambulance handover challenge and that it was not solely an emergency department (ED) problem and that improvements had been noted by follow-up GIRFT visits and NHS Wales Performance and Improvement Team reviews. Mr Carruthers believed that the 'Your Next Patient' approach in particular had driven improvements through a whole-system approach.

Mr Carruthers advised that an Operational Delivery Unit (ODU) had been established to coordinate the Health Board's flow and site positions through the day and follow up on any actions relating to patient flow to ensure that all necessary actions are taken to mitigate the risk during a given 24 hour period and that by having a dedicated centralised unit it freed up general managers and site teams to provide them with the capacity to undertake their substantive duties at each site.

Mr Carruthers advised that this had been achieved by standing down all non-essential meetings during the reset week that was extended to a second week, coupled with the implementation of a set of internal professional clinical standards, predominantly for medical staff on how they engage with patient flow and referrals to their specialty from EDs, on how they engage in ward rounds and engage in supporting discharges.

Mr Carruthers advised that the Health Board had been testing the implementation of a redirection policy at the ED front door to provide clinicians with the support to either admit the patient to the ED or redirect them to a more appropriate service such as primary care, a minor injuries unit (MIU) or to return to ED at a later time as opposed to waiting within the ED for a prolonged period of time.

Mr Carruthers advised that the result of the system week was to see a significant improvement in the Health Board's ambulance handover performance from a Health Board position of under 40%

UNAPPROVED

of patients handed over under 45 minutes and some sites as low as 20-30% to Glangwili Hospital (GGH) performance improving to over 90% performance that had been maintained.

Mr Carruthers advised that improvement had been exhibited at all four acute sites that received ambulances despite WG not including Prince Philip Hospital (PPH) due to the absence of an ED, the Health Board included PPH in its reporting due to ambulances being received at its Acute Medical Assessment Unit (AMAU).

Mr Carruthers advised that within the past fortnight there had been an increase in pressure linked to a decrease in the number of discharges undertaken, delayed pathways of care and a rise in infection control issues linked to respiratory virus-related issues and staffing challenges that impacted upon surge and boarding processes. Mr Carruthers believed that there was a question over whether the actions undertaken as part of the reset week were sustainable as they relied upon senior resource capacity with the challenge becoming how practices could be embedded as part of a 'business as usual' position to maintain the progress made.

In response to a question from Cllr Evans on how the redirection policy was being implemented, Mr Carruthers advised that it was known that there were patients waiting within EDs for prolonged periods of time overnight that did not need to be there and would be better served by going home and returning in the morning to attend a review clinic or whether a patient could be better seen at a MIU and that further work would be undertaken with clinical teams. Mr Carruthers advised that a second reset week was planned for November 2025 that would focus on the back door as opposed to the front door with a focus on discharge with an update on discharge being provided to FPC on 16 December 2025. **AC**

In response to a question from Ms Lewis on the quality and safety implications of improvements made at the front door and whether any issues had been moved to a different part of the system, Mr Carruthers advised that the Health Board was currently at the start of the journey of transforming urgent and emergency care (UEC) and that experiences observed at other Health Boards all started with resolving the front door issues such as ambulance handover performance and then tacking the issues that were subsequently exhibited elsewhere in the system. Mr Carruthers believed that there was still work to be undertaken on the consequential areas and that the quality and safety impact on patients within the waiting room could be explored further at Quality, Safety and Experience Committee (QSEC). **AC**

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Ambulance Handover Performance verbal update.

UNAPPROVED

FPC(25)83 **CLINICAL CARE GROUP FINANCIAL SAVINGS – PLANS AND MILESTONES TO CLOSE GAP TO TARGET**

Mr Carruthers presented the CCG financial savings update to the Committee and advised that despite a £5.4m improvement in the savings position, the operational directorate were still adrift from its savings identification and delivery target and the impact on the wider financial position.

Mr Carruthers advised that despite significant operational pressures experienced by CCGs confirmed in-year delivery of amber and green cash releasing schemes has also increased by a further £6.1m to a current total of £23.1m compared to the position reported at the last FPC meeting on 26 August 2025.

Mr Carruthers advised that there was a reliance on non-recurrent actions derived from banking monthly underspends as savings that left the recurrent position as a challenge with significant challenges within the operational space such as pressures on surge capacity across Pembrokeshire and Carmarthenshire having a total cost of over £1.2m, a deteriorating medical staffing workforce availability costing £3.4m and increased referral to treatment (RTT) delivery costs including actions to mitigate the operational impact of theatre cancellations at GGH due to significant theatre staffing workforce challenges, costing over £2.3m. Mr Carruthers advised that due to the impact on urgent cancer, ophthalmology and ear, nose and throat (ENT) cases, a proportion of the underspend within the Planned and Specialist Care CCG had been used to insource additional theatre staff for GGH theatres.

Mr Carruthers advised that operational teams had been involved in the process of reviewing the savings categories to progress the identification of the additional £6m of savings required to attain the £24m annual deficit position and advised that there were significant amount of savings classed as red and blue schemes particularly within the Community and Integrated Medicine CCG and believed that there was a significant reliance on reconfiguration opportunities that would arise from the Clinical Services Plan (CSP) consultation and were unlikely to be realised by the end of March 2026.

Mr Carruthers advised that there was further work required and that there would be monthly escalation meetings with each CCG to encourage a shift from red and blue savings schemes to amber and green schemes both within the current financial year and as part of the planning cycle for 2026/27 to have an impact from 1 April 2026. In response to a question from Cllr Evans on the impact of the savings schemes on the end-of-year forecast, Mr Thomas advised that red and blue savings schemes were not included within the forecast of savings plan for the year with

UNAPPROVED

projections not banking on the realisation of those savings schemes to deliver the annual forecast and to improve the forecast those red and blue savings schemes needed to be translated into amber and green to provide increased assurance that those savings schemes would be delivered and be included within the revised forecast. Mr Thomas believed that the Health Board were reliant on the larger savings schemes that were not being delivered in 2025/26 to be delivered in 2026/27.

In response to a question from Mrs Elenor Marks on how much of the savings schemes needed to be delivered for the Health Board to meet its TI de-escalation criteria to break even by the end of 2027/28, Mr Thomas believed that given the challenging allocations received by the Health Board there was a need to deliver a significant level of savings just to maintain the underlying deficit position despite some increase in the level of recurrent savings schemes. Mr Thomas believed that although the Health Board did not need to deliver all of its savings schemes to achieve its desired break-even position, a significant level of improvement of savings delivery was required and would be considered as part of the three-year financial road map discussion.

Mr Carruthers believed that in relation to the Community and Integrated Medicine CCG savings schemes, a significant number of the CCG red and blue savings schemes related to bed-related savings and there was a challenge to understand how those savings interacted with any potential discussions arising from the CSP process and the UEC transformation business case given that the business case presented more of a reallocation of existing resources and the impact on the configuration of the Health Board's bed plan across acute and community sites and what capacity was required within the community setting being the significant driver to converting the red and blue savings schemes to green and amber.

In response to a question from Mr Imperato on what shift in thinking was required to bring about the desired changes, Mr Carruthers believed that there was a need to change the focus of the savings discussion from a binary invest or savings discussion to a consideration of how existing resources could be used differently and believed that the initial shift had occurred through the Executive-led Financial Control Sub-Group (FCSG) process that encouraged CCGs to implement local controls on how requests for posts were made with the CCGs effectively filtering many of the requests that progressed to FCSG. Mr Thomas believed that as the CCG structure matured the process would enable the CCGs to examine the challenges that they are facing more strategically. Mr Carruthers advised that in the November round of escalation meetings with CCGs, two or three topics from a planning perspective for 2026/27 would be considered for their impact on performance, quality, safety and finance.

UNAPPROVED

Decision: The Finance and Performance Committee **NOTED** the further progress achieved by Clinical Care Groups in respect of confirmed savings plans as at M6 2025/26 and the additional opportunities being explored by Clinical Care Groups to further improve this position.

FPC(25)84 **ELECTIVE REFERRAL TO TREATMENT AND CANCER PATHWAY – TRIANGULATION OF DEMAND AND CAPACITY ACTIVITY TRAJECTORY FROM FUNDING BASKETS WITH PERFORMANCE TARGETS**

Mr Carruthers presented the Elective Referral to Treatment and Cancer Pathway report to the Committee and advised that in relation to performance, the funding for the service had either been ring-fenced by WG or had been applied by the Health Board across the range of its performance targets. Mr Carruthers advised that within Planned Care and Cancer at the end of Q2 2025/26 there were 41 patients waiting over 104 weeks for planned treatment and advised that there was a plan to reduce that number to 10 by the end of Q3 2025/26, predominantly within ENT with solutions to further reduce that figure to zero currently being examined with confidence that the zero breaches being attained by the end of Q4 2025/26 at the latest.

Mr Carruthers advised that for patients waiting 52 weeks for their first outpatient appointment was on track to reach zero by the end of Q4 2025/26 following the outsourcing and insourcing work that WG funded as part of their plan to reduce the overall waiting list in Wales by 200,000 patients, that equated to 15,000 Hywel Dda University Health Board (HDdUHB) patients.

Mr Carruthers believed that there was confidence in meeting the 52-week target with a degree of risk being managed in relation to the 104-week target however following positive dialogue with WG, there was assurance that WG would assist with the provision of approximately 200 patients should the need arise.

In relation to cancer performance, Mr Carruthers advised that performance remained above 60% of patients starting treatment within 62 days of the first suspicion of cancer, rising to above 65% in August 2025. Mr Carruthers believed that a significant obstacle to further improvement was the need to address a backlog in diagnostics, particularly in neurology and advised that the Health Board had a clear plan to address the diagnostic backlog by the end of December 2025 that would have an initial short-term negative impact on cancer performance and see a drop below 60% performance in December 2025 and January 2026 before enabling recovery to above 70% and towards 80% by the end of Q4 2025/26. Mr Carruthers advised that WG had been made aware of the Health Board's plans to address the diagnostic backlog, the anticipated short-term reduction in cancer

UNAPPROVED

performance as a consequence before expected recovery before the end of 2025/26 and believed that providing the recovery in cancer performance was exhibited in February 2026 there would be no adverse consequence from WG scrutiny or from a TI perspective.

In response to a question from Mrs Marks on what form the WG support would take, Mr Carruthers advised that the support was predominantly cash support to enable additional activity to be undertaken by HDdUHB staff on weekends or to outsource additional capacity from external providers. In response to a question from Cllr Evans on the arrangements for contracted activity, Mr Carruthers advised that the Health Board contracted with external providers for the provision of a level of activity and that the Health Board only paid of the level of activity that was undertaken on its behalf and believed that the challenge was that if only a proportion of the contracted activity was undertaken, the challenge then became sourcing the provision of the activity that had not been undertaken from a differing provider.

Decision: The Finance and Performance Committee is **NOTED** the summary and **TOOK ASSURANCE** from progress achieved to date in applying the additional elective recovery allocations and forecast performance for the remainder of 2025/26.

FPC(25)85 NEURODIVERGENT AND PSYCHOLOGICAL THERAPIES PATHWAYS – PERFORMANCE AND MILESTONES TO TARGETS

Mr Carruthers presented the Neurodivergent and Psychological Therapies Pathways update to the Committee and advised that the Neurodevelopmental Service performance was not at a desired level with the service examining how the £980k of WG allocation of ring-fenced monies for children's neurodevelopmental services received could be used to eradicate three-year waits for assessment with the allocation also being used to fund transformational work to develop a more sustainable model for the provision of assessments using digital solutions. Mr Carruthers advised that an updated trajectory for anticipated performance had been requested to assess the impact of the investment received on performance.

Mr Carruthers believed that a more positive update had been received from Psychological Therapies through their escalation meeting, Mr Carruthers advised that in recent months the trend in performance deterioration had stabilised and August 2025 had exhibited the first monthly improvement since October 2024 with performance anticipated to remain variable until December 2025 until the impact of the new group therapy model implemented in June 2025 was realised.

UNAPPROVED

Mr Carruthers advised that due to a group therapy model having a 26-week cycle and the number of patients waiting over 26 weeks for therapy, the activity undertaken was to reduce the number of patients waiting with a short-term deterioration in performance anticipated with an expectation that following the completion of the first 26-week cycle sustained improvement in performance was anticipated with a recalculation of the performance trajectory to reflect the expectation of the new model would result in an improved performance trajectory.

In response to a question from Ms Lewis on whether there were any impacts associated with the waiting time for neurodevelopmental assessments on other associated services, Mr Carruthers advised that patients with an anticipated long waiting time were signposted to other support services and counselling services, and a wider deep dive would be required to explore the impact on associated services. Mr Carruthers believed that the target for assessment that the Health Board was being measured on was not the target that made a difference to patients and believed that patients needed to be placed on the appropriate treatment pathway following a confirmed diagnosis and agreed to present a report on neurodevelopmental assessment and treatment performance to a future FPC meeting. **AC**

In response to a question from Mr Imperato on the target to eliminate 3-year waits for neurodevelopmental assessments by the end of March 2026, Mr Carruthers advised that the target was a basis on which the additional WG allocation was given and for what the Health Board had sought to procure activity to deliver.

Decision: The Finance and Performance Committee **CONSIDERED** and **NOTED** the current performance and further actions currently being progressed by the Mental Health and Learning Development Clinical Care Group to support improvements in neurodevelopmental and psychological therapies pathway performance.

FPC(25)86 RADIOLOGY AND THERAPIES – TRIANGULATION OF DEMAND AND CAPACITY ACTIVITY TRAJECTORY WITH RESOURCE PLANNING AND ROSTER STRUCTURES WITHIN FINANCIAL ENVELOPE

Mr Carruthers presented the radiology and therapies demand and capacity report to the Committee and advised that the additional investment that the Health Board had undertaken within radiology had resulted in an improvement in performance, in particularly in support of sustained improvement in cancer performance with a 50% reduction in 8-week wait for radiology diagnostic services with a plan to eliminate all 8-week waits by the end of Q4 2025/26.

UNAPPROVED

Mr Carruthers advised that an additional £1.4m funding had been received from WG to support the Health Board eliminate 8-week waits for radiology diagnostics and had been utilised to resource an additional mobile magnetic resonance imaging (MRI) solution, additional computed topography (CT) scanning and reporting capacity and additional non-obstetric ultrasound (NOUS) insourcing capacity.

Mr Carruthers highlighted the current forecast delivery risk for 798 patients within NOUS due to concerns re insource supplier capacity to deliver required volumes by March 2026 and advised that discussions were continuing with an insource supplier to mitigate that risk. Mr Carruthers advised that of the 798 scans planned to be delivered by the external provider, there was a risk to the delivery of 500 of those with efforts underway to source additional ultrasound capacity to reduce the gap to zero.

Mr Carruthers advised that the therapies position was more challenging and had continued to deteriorate with particular challenges within dietetics, podiatry and physiotherapy due to the lack of availability of any outsourcing or agency staffing solution availability with a need to recruit substantively to address the 14-week waiting target for access to the therapy service within dietetics and podiatry with no confidence that the 14-week waiting target breaches would be reduced to zero but the end of Q4 2025/26 with an estimated target of 12 months to achieve that position following recruitment.

Mr Carruthers advised that physiotherapy had the greatest volume of therapy patients and that agency staffing was available to address the backlog however attracted a resourcing implication that was not provided for within the current forecast with dialogue undertaken with WG to ascertain what support could be available to the Health Board to improve the 14-week waiting target breaches as there was currently no plan in place to mitigate performance deterioration with the position anticipated to deteriorate further without additional capacity.

In response to a question from Mrs Marks on whether there was any regional solution to be explored to the therapies capacity issue, Mr Carruthers advised that the therapy specialities of every Health Board in Wales was equally challenged however further investigations into regional working would be undertaken to review the position and advised that a potential solution for dietetics through GP surgeries utilising cluster funding was being explored.

Decision: The Finance and Performance Committee **CONSIDERED** and **NOTED** the Radiology and Therapy demand and capacity activity trajectory with resource planning and roster structure within its current financial envelope.

UNAPPROVED

FPC(25)87 **BUSINESS CASE: URGENT AND EMERGENCY CARE TRANSFORMATION**

Consideration of the Urgent and Emergency Care Transformation Business Case was deferred.

FPC(25)88 **FINANCIAL PERFORMANCE ASSURANCE REPORT**

Mr Spratt presented the Month 6 Financial Performance Assurance Report to the Committee and advised that in September 2025 the Health Board had delivered an in-month financial position of a deficit of £2.0m against a revised plan of £2.5m resulting in a £0.5m improvement against the plan.

Mr Spratt advised that the current organisational forecast was that there was a line of sight towards an end-of-year annual deficit position of £31.1m that was £3.3m adrift of the Health Board's reported position of £27.8m however believed that the risk was diminishing each month as the Health Board recognised and delivers the broad quantum of savings required albeit in a different manner as described at the start of the year within the financial plan.

Mr Spratt believed that in relation to the underlying deficit position ahead of the 2026/27 planning cycle, a positive attempt to achieve the annual savings target of £19m had seen a shortfall of £4.6m that would provide a challenge to mitigate within the next planning cycle. Mr Spratt advised that the Health Board's underlying deficit at the start of the 2025/26 financial year stood at £58.5m with a significant level of non-recurrent savings yet to be converted into recurrent savings, the Health Board's underlying deficit was currently over £60m that would inform the discussion of the three-year road map towards financial sustainability and believed that there was a need to move towards a more medium-term outlook of the financial position as the Health Board was struggling to erode the underlying deficit and needed to move away from simply pausing spending to support the bottom line.

Mr Spratt advised that there was a material risk that would be recognised in the Month 7 reporting relating to the Welsh Risk Pool that NHS Wales Shared Services Partnership (NWSSP) was anticipated to have a minimum impact of £4.2m and a maximum impact of £5.3m with on-going dialogue with NWSSP to ascertain the latest position with discussions held nationally with Directors of Finance to coordinate national alignment on recognising the position with conversations underway with WG on managing expectations.

Mr Spratt advised that the Health Board would be reliant on the WG response to a strategic cash request, with a response on

UNAPPROVED

whether WG would be willing to support the Health Board's revised deficit anticipated in November 2025.

Mr Spratt advised that in line with Ministerial Priorities, the Health Board was free from off-contract agency usage across all services of the Health Board and were ahead of target for reduction of on-contact agency usage. Mr Spratt advised that there was an expectation to cease healthcare support worker (HCSW) agency usage by the end of September 2025 however as of the start of October 2025 there was still a small element of HCSW agency usage within Mental Health Services with work being undertaken to understand the impact of the cessation of HCSW agency usage on the service.

Mr Spratt advised that capital had moved from an assure to an advise space as there was currently a significant amount of capital expenditure that still needed to occur before the end of 2025/26 with a consequential increased risk of an underspend that would need to be confirmed with WG by the end of October 2025 with a new risk being discussed that would be reported to FPC on 16 December 2025.

Mr Spratt advised that an internal escalation framework had been revised and implemented and aligned to the CCG and Executive Functions with escalation meetings having been undertaken for all escalated services who have been reminded of the need to deliver financial recovery plans to convert savings opportunities into deliverable savings plans. Mr Spratt advised that grip and control measures covering recruitment, training and procurement were being overseen by the Financial Control Sub-Group (FCSG) to provide scrutiny to vacancies.

Mr Spratt highlighted the items of correspondence attached to the finance report between the Director General of NHS Wales and the Chief Executive of the Health Board regarding the Health Board moving towards a forecasted financial position in line with WG expectations, while not reported within the Month 6 reporting, it was hoped that a line of sight towards the WG expectation of a £24.1m position could be provided within the Month 7 position, however that position would deteriorate should the Health Board recognise the full value of the implication of the Welsh Risk Pool liability.

In response to a question from Mrs Marks on the Welsh Risk Pool, Mr Thomas advised that there had been a significant increase in the amount paid out by the NHS for clinical negligence claims and that NHS Wales Directors of Finance would me meeting nationally to recognise the financial position with the transfer of the required resources from Health Boards to the Welsh Risk Pool to be made by NHS Wales.

In response to a question of the levels of variable pay from Mrs Marks, Mr Thomas believed that the Health Board's reduction in

UNAPPROVED

the reliance on agency had been significantly positive however there had been an increase in the spend on overtime and while off-contract agency usage had been eradicated, there had been an increase in on-contract agency premium and the Health Board was reliant on additional hours and waiting list initiative spending to provide the recovery actions within the Health Board. Mr Thomas believed that the challenges that the Health Board was facing such as the CSP, and fragility of services and workforce were being exhibited financial through an increase in agency premium. Mr Spratt advised that the figures were an absolute of spending however they did not report how much additional funding support had been received by the Health Board to support the recovery actions through pay expenditure.

In response to a question from Cllr Evans on the run rate forecast, Ms Siân Jenkins advised that there were meetings arranged with CCGs to understand their forecast end-of-year position and how their plans fed into the forecast that were not subjective.

In response to a question from Cllr Evans on whether the Health Board's cash position needed to be an alert to the Committee, Mr Thomas advised that the Health Board were in an active conversation with WG on the strategic cash support that WG could offer the Health Board with a decision anticipated before the end of December 2025 and advised that the Health Board had an established cash management strategy that would be reviewed by the Committee.

Decision: The Finance and Performance Committee:

- **RECOGNISED** that the Health Board's forecast deficit remains as £27.8m in Month 6, with a savings target of £46.4m, and commitment to improving beyond the latest forecast of £27.8m, towards £24.1m in line with Welsh Government expectation;
- **RECEIVED ASSURANCE** on progress of savings actions to bridge the recurrent and non-recurrent savings gap from those Executive portfolios that have yet to identify their full target;
- **NOTED** that the Amber savings scheme judgement around future run rate conversion, total of £6.0m has been included within the Month 6 position, evidenced by past performance but in lieu of formal 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;
- **ENDORSED** the Financial planning cycle timelines, principles, approach and focus areas for the 2026-29 planning exercise; and
- **NOTED** the work that is ongoing to provide more insightful and relevant reporting to the committee through the Financial Performance Report development.

UNAPPROVED

FPC(25)89 FINANCIAL DEFICIT SAVINGS CATEGORY UPDATE

Mrs Sharon Daniel joined the meeting

Mr Thomas advised that a review of the Financial Deficit Savings Category 2 schemes that had previously been reviewed by the Quality, Safety and Experience Committee (QSEC) was presented to FPC for review.

Ms Jenkins advised that as of Month 6, £750k of Category 1 savings were included within the end-of-year forecast with the two key elements being a pause of recruitment of Band 1 apprentice roles and the transacting of an underspend within the strategic planning consultancy budget as a saving and £75k of Category 2 savings.

Ms Jenkins believed that there were anticipated improvement within Category 2 in Month 7 following negotiations with one of the Health Board's constituent Local Authorities in respect of commissioned services that could release £450k of savings in addition to opportunities related to variable pay spend reduction with the latest feedback from budget holders having indicated some potential spend reductions which need to be further tested against existing forecast assumptions.

Mrs Sharon Daniel advised that a Quality Impact Assessment (QIA) Panel had been held on 26 September 2025 to review all the Category 2 proposals with further information requested from CCGs for a number of the proposals. In relation to the overtime reduction, Mrs Daniel believed that there had been a significant variation in the submissions. In relation to the Local Authority commissioned services, discussions had identified that the savings could be made without any impact on the quality of the service so had been identified as a cash-releasing saving.

In relation to the non-renewal of contracts and digital licences, Mrs Daniel advised that a separate QIA had been requested for each of the contracts and licences proposed for non-renewal as the impact of each would be different depending on what system the non-renewal applied to. Ms Daniel advised that no QIA had been received for the Swansea Bay Long Term Agreement (LTA) however recognised that there were established LTA governance arrangements in place and requested that the Director of Delivery review each bid as they arose.

Mrs Daniel advised that a QIA had been reviewed for the delay of recruitment linked to an approved mental health and learning disabilities (MHLD) business case that highlighted a significant negative impact and was considered incongruent with the efforts made within the annual planning process to review the staff establishment levels within the MHLD service with the Panel

UNAPPROVED

resolving to continue with the FCSG process to control variable pay within the service.

Ms Daniel advised that in relation to a proposed travel ban within the Health Board, the Panel found that there were highly variable impacts and were unable to quantify the financial benefit of the proposal due to the inability to define precisely what was considered essential and non-essential travel.

Ms Lewis explained the role of QSEC in the process and advised that QSEC had focussed on taking assurance on the process and the scrutiny of the QIAs with the line-by-line scrutiny of the Category 2 savings schemes considered for FPC to undertake whether any of the savings schemes represented an overestimation of the savings considered possible or whether more work was required to be undertaken to encourage savings identification from schemes that suggested no savings were identified.

In response to a question from Ms Lewis on the significant gap between the original opportunity estimate and the figure actually included in the end-of-year forecast, Mr Thomas advised that the initial estimate was inevitably going to be significantly higher and gave the example of the overtime ban estimating the total cost of all overtime within the Health Board for the second half of the year when there was never any suggestion that all overtime would be ceased and that further scrutiny of overtime spending was being put in place through the FCSG process. Mr Thomas believed that the reduction of overtime would form part of the 2026/27 planning cycle with an aim to reduce variability.

Mrs Sharon Daniel left the meeting

Decision: The Finance and Performance Committee **DISCUSSED** and **CONSIDERED** the level of progress made in delivery of savings against the saving categories supported in the context of improving the financial forecast towards £24.1m.

FPC(25)90 INVESTMENT AND BENEFITS REALISATION REPORT

Ms Jenkins presented the Investment and Benefits Realisation Report to the Committee and advised that the majority of the investment cases had been through the initial review process and were either approved and in the process of being undertaken or released as a temporary savings scheme.

Ms Jenkins advised that there were 4 investment cases for which updated proposals were currently being waited for determination.

In response to a question from Cllr Evans on the £150k of costs associated with the reinforced autoclaved aerated concrete

UNAPPROVED

(RAAC) issue at WGH and whether the costs would be reclaimed from WG, Ms Jenkins advised that the £150k were on-going revenue costs associated with the cost of inspections for which there was no WG funding and was a recurrent financial commitment for the Health Board to manage.

In response to a question from Cllr Evans on the Public Health Childhood Obesity spending, Ms Jenkins advised that the costs associated was above the quantum allocated within the annual plan with the Executive Team making the decision to pause potential investment until the latter stages of 2025/26 with non-recurrent savings transacted as a saving with the health coaching business case spending deferred until the latter stages of 2025/26 dependent on the availability of value based healthcare (VBHC) funding.

Mr Thomas highlighted areas of concern in-year such as health and safety related spends that had been deemed necessary to undertake with discussions undertaken at Executive Team regarding medical staffing at WGH and nurse staffing at Bronglais Hospital (BGH) that were not included within the 2025/26 planning cycle however had become an issue in-year that would require to be managed in-year and form part of the 2026/27 planning cycle.

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. Also that this process has incorporated the consideration of essential proposals to enable key quality and safety priorities for the Health Board in respect of fire enforcement notices and review of nursing workforce in particular areas; and
- **NOTED** that the process for investment cases is being reviewed to inform the 2026/27 annual planning cycle in a bid to standardise the approach both in respect of business cases and benefits realisation.

FPC(25)91 BALANCE SHEET REPORT

Mr Thomas presented the Balance Sheet report to the Committee and believed that the NHS Public Sector Payment Policy (PSPP) totals were not as high as they should be and would investigate further with the Finance Team to ascertain the reasoning for the discrepancy in addition to the balances that external bodies owe the Health Board showing an increasing trend since April 2025 despite being an improved position compared to the same stage in 2024/25.

UNAPPROVED

Mr Thomas believed that the Health Board needed to ensure that its internal processes were as robust as possible to collect balances owed to it in a timely manner.

Decision: The Finance and Performance Committee **NOTED** the Balance Sheet as at the end of Quarter 2 2025/26

FPC(25)92 PROCUREMENT SCRUTINY

Mr Thomas presented the Procurement Scrutiny report to the Committee for consideration of a number of items for scrutiny ahead of onward submission to Board. Mr Thomas advised that the items had been through a robust procurement exercise.

In response to a question from Cllr Evans on why several of the procurement items required onward submission to Board despite being below the £1m level required to do so, Mr Thomas advised that the application of VAT took the amounts over the £1m mark and therefore required Board approval and onward submission to WG for approval. Mr Thomas advised that there were limited circumstances when the VAT was able to be reclaimed by the Health Board. Mr Thomas further advised that where the cumulative impact of an award with a supplier was over £1m, Board approval was also required as was the case with Circle Health Group for the outsourcing of trauma and orthopedic and multi-parametric prostate MRI scans.

Decision: The Finance and Performance Committee scrutinised and recommend for Board to:

- **APPROVE** the award of an All-Wales Standard and Custom Procedure Packs Framework Agreement for the period 1 January 2026 to 31 December 2030, with the option to extend to the 31 December 2031. This framework agreement 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 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;
- **NOTE** and **APPROVE** that the Health Board has a cumulative current contract value which exceeds £1 million including VAT with Circle Health Group (BMI Werndale);
- **NOTE** and **APPROVE** that the Health Board has a cumulative current contract value which exceeds £1 million including VAT with Spa Medica;
- **NOTE** and **APPROVE** that the Health Board has a cumulative current contract value which exceeds £1 million including VAT with Healthcare Business Solutions; and

UNAPPROVED

- **NOTE** and **APPROVE** that the award of an Insourcing of Dermatology Procedures contract for the period 1 August 2024 to 31 March 2025 with the option to extend to the 31 March 2027. This contract was not previously put to Board as excluding VAT it was below £1 million.

FPC(25)93 PLANNING OBJECTIVES Q2 2025/26 UPDATE REPORT

Mr Thomas presented the Planning Objectives (PO) Q2 2025/26 update report to the Committee and advised that a deep dive into PO2 Financial Recovery and Road Map would be covered in the following item on the meeting agenda.

Mr Thomas highlighted that all four POs aligned to FPC were considered to be on-track.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **RECEIVED ASSURANCE** and note the progress of the Planning Objectives which are aligned to it; in order to assure the Board that the Planning Objectives are progressing and are on target, and to raise any concerns where a Planning Objectives is identified as behind in its status and/or not achieving against its key deliverables.

FPC(25)94 PLANNING OBJECTIVE 2: FINANCIAL RECOVERY AND ROUTE MAP

Mr Thomas presented a deep dive into PO2 Financial Recovery and Route Map to the Committee and believed that the production of a route map was always a challenge due to income assumptions made at the commencement of the route map often did not accord with the subsequent reality and believed that 2026/27 would be a challenging year for the Health Board.

Mr Thomas advised that the Health Board's financial allocation from WG would not be known until November or December 2025 resulting in the production of an indicative three-year plan ahead of the allocation announcement that included a novel approach to incorporating the cost of the prevalence of disease within the community with an attempt to cost the growth of the cost of ill-health within the communities the Health Board serves as an inevitable driver of cost for the Health Board to recognise within the financial baseline of the Health Board's financial position and that this approach had never been undertaken previously. Mr Thomas advised that this approach increased the costs that the Health Board was recognising and the preventative work that the Health Board sought to undertake as a savings delivery challenge.

UNAPPROVED

Mr Richard Jenkins advised that the forecast out-turn for the Health Board for 2025/26 is £27.8m with an underlying deficit of £60m with a requirement to achieve a break-even position in 2027/28 and a break-even in-month position by March 2027 to meet the WG requirements in order to receive the £26m conditionally-recurrent funding support linked to the Health Board's TI status.

Mr Jenkins advised that the route map presented represented an improved trajectory year-on-year with a Year 1 (2026/27) £14m annual deficit with an improvement trajectory across all four quarters of the year leading to a break-even position in 2027/28 and a recurrent break-even position in 2028/29.

Mr Jenkins advised that the level of savings required to achieve that position was £49.4m in 2026/27, £46.4m in 2027/28 and £38.1m in 2028/29 maintaining the level of recurrent savings delivered in 2025/26. Mr Jenkins believed the Health Board needed to focus on working on its efficiency schemes as part of the financial planning process to enable the delivery of savings from Day 1 of 2026/27.

Mr Jenkins advised that the route map contained an allowance for prevalence of disease as outlined by Mr Thomas containing demand growth pressures with measures to be undertaken to mitigate those demand growth pressures to enable the utilisation of funding in different ways to deliver more patient care.

Mr Jenkins advised that the financial forecast modelling assumed an uplift of 4.8% of WG allocation funding with local investment choices and CSP options as consulted upon that would need to be updated pending the outcome of the review of the full consultation options.

Mr Jenkins cautioned that should the WG allocation be held at the same level as the 2025/26 allocation of a 1.7% uplift then there would be a consequential need to increase the Health Board's annual savings position by £3.4m in 2026/27, £6.8m in 2027/28 and £10.2m n 2028/29 to maintain the trajectory.

In response to a comment by Ms Lewis on the need to consider a broader population approach that seek to answer broader population health, strategic and systemic challenges and partnership working to seek to undertake the broader societal changes required as opposed to the NHS simply operating by itself to affect change, Mr Thomas advised that the production of the route map was the start of the first iteration of the route map that would be updated periodically and encompass wider pieces of work such as the strategic refresh work and CSP consultation process and the public health agenda to achieve a sense of how the various opportunities align and coalesce around a financial trajectory, Mr Spratt advised that the route map would be a

UNAPPROVED

continually-evolving process with the next version of the financial plan to be reported to FPC on 16 December 2025 when it is anticipated that an indication would have been received from WG on what the financial settlement for 2026/27 was likely to be.

Mr Spratt advised that it was proposed to present the final three-year plan to FPC on 24 February 2026 for scrutiny ahead of the plan being signed-off to enable budgets to be delegated as part of Year 1 of the plan with the subtle difference between the current process in that the three-year plan submitted to WG would not be an integrated medium-term plan (IMPT) that it would be a three-year plan to return to financial balance by the end of 2027/28 as part of the Health Board's TI expectation. In response to a question from Mr Imperato on the wider engagement with the Health Board of the financial plan, Mr Thomas advised that the first iteration would be presented to Board on 27 November 2025 for an initial consideration and would then form part of the Health Board's internal processes.

Decision: The Finance and Performance Committee:

- **NOTED** that the Health Board is progressing the development of a 3-year financial roadmap to support delivery of a recurrent breakeven financial plan by financial year 2028/29;
- **DISCUSSED** and **CONSIDERED** the approach taken in developing the assessment to date, particularly the savings challenge presented, in the context of recurrent savings delivery to date; and
- **SUPPORTED** the ongoing work to further develop and refine the financial roadmap in the coming months, alongside the annual planning cycle and in line with Welsh Government guidance, as it becomes available.

FPC(25)95 INTEGRATED PERFORMANCE ASSURANCE REPORT

Mr Thomas presented the Month 6 2025/26 Integrated Performance Assurance Report (IPAR) to the Committee and believed that most issues contained within the IPAR had already been discussed within other sections of the meeting agenda.

Mr Carruthers highlighted delayed pathways of care (DPOC) performance and advised that there had been a deterioration in the number of pathway care delays and advised that he had escalated the concerns with Local Authority partners due to the majority of the delays relating to social worker allocation, package of care start delays and care home placements. Mr Carruthers advised that Local Authorities have received grant funding from WG through the Building Community Capacity programme and believed that schemes coming online in October and November 2025 would have an impact on reducing pathways of care delays across the Health Board's area.

UNAPPROVED

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

- **DISCUSSED** the Integrated Performance Assurance Report – Month 6 2025/2026 report; and
- **RECEIVED ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

FPC(25)96 PUBLIC SECTOR EMISSIONS REPORTING

Mr Douglas Wilson joined the meeting

Mr Thomas presented the Public Sector Emissions Reporting update to the Committee and believed that the level of continuity provided in the report enabled meaningful comparisons to previous reporting.

Mr Thomas highlighted the rise in the cost of street lighting due to a change of supplier that relied on purely renewable energy sources to a low-carbon supplier that included nuclear energy as part of its supply chain that resulted in the energy supply no longer qualifying for the renewable energy guarantee of origin (REGO) tariff and advised that while the Health Board was not producing any additional carbon emissions, the cost of the energy supply had increased.

In response to a question from Cllr Evans on how HDdUHB compared to other Health Boards in Wales per head of population, Mr Douglas Wilson advised that while there were no direct comparisons with other Health Boards in Wales, HDdUHB compared favorably to other Health Boards on the level of waste produced through recycling. Mr Wilson advised that HDdUHB had the second-highest transportation usage of Welsh Health Boards due to the obvious rural nature of the Health Board.

Mr Wilson advised that of the five years of public sector emissions reporting, this was the first year where there had been no alteration of the reporting requirements that enabled more consistent comparisons to be made to the previous year.

Decision: The Finance and Performance Committee **NOTED** the Health Board's 2024/25 public sector emissions reporting.

FPC(25)97 FINANCIAL PROCEDURES

Mr Thomas presented the review of four Financial Procedures to the Committee and the approval of the extension of Financial

UNAPPROVED

Procedure 070 ('Hospital Travel Cost Scheme') until its review at the FPC meeting on 24 February 2026 to enable the on-going work on the all-Wales procedure to be incorporated into the Health Board's procedure.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

- **APPROVED** the following updated financial procedures:
  - Financial Procedure 050 - Cash Imprest Accounts – Rehabilitation Monies;
  - Financial Procedure 051 - Income and Cash Collection;
  - Financial Procedure 078 - Patient Property and Monies;
  - Financial Procedure 1032 - Treatment of Private Patients - Control of Admission and Collection of Income; and
- **APPROVED** an extension to the review date of the following procedure:
  - Financial Procedure 070 - Hospital Travel Cost Scheme

FPC(25)98 FINANCIAL POLICIES

Mr Thomas presented the updated Individual Patient Funding Request (IPFR) and Prior Approval Request (PAR) policy to the Committee to approve the updated policies. Mrs Wilson advised that both policies were all-Wales policies that had undergone a period of engagement, consultation and development, involving all Health Boards and NHS Wales Joint Commissioning Committee (NWJCC).

Mrs Wilson advised that the IPFR policy would be reported to Board on 27 November 2025 for approval.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **APPROVED** and **ENDORSED** the implementation of the updated NHS Wales Individual Patient Funding Requests policy and Prior Approval Request policy for operational use within Hywel Dda University Health Board as part of the All-Wales implementation for onward submission to Board for approval.

FPC(25)99 PERFORMANCE POLICIES

Mr Thomas presented the updated Policy 534 ('Patient Access – Elective Care') policy to the Committee for approval. Mrs Wilson

UNAPPROVED

advised that the updated policy had been subject to consultation within the Health Board and had been through all the appropriate governance channels ahead of submission to FPC for approval.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **APPROVED** the following updated policy:

- Policy 534: Patient Access – Elective Care Policy

FPC(25)100 ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

Mr Thomas presented the All-Wales Capital Programme 2025/26, Capital Resource Limit (CRL) and Capital Financial Management update to the Committee for information.

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
- NOTED the project updates

FPC(25)101 JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

Mr Thomas presented the Joint Commissioning Committee (JCC) Planning, Performance and Finance Sub-Committee highlight report from the sub-committee meeting on 17 September 2025 to the Committee for information.

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 17 September 2025.

FPC(25)102 WELSH NHS CONFEDERATION RESPONSE TO THE FINANCE COMMITTEE'S SCRUTINY OF THE WELSH GOVERNMENT 2026-27 DRAFT BUDGET PROPOSALS

UNAPPROVED

Mr Thomas presented the Welsh NHS Confederation's response to the Finance Committee's scrutiny of the WG 2026-27 draft budget proposals to the Committee for information.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **NOTED** the Welsh NHS Confederation response to the Finance Committee's Scrutiny of the Welsh Government 2026-27 draft budget proposals.

FPC(25)103 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)104 ANY OTHER BUSINESS

There was no other business transacted at the meeting.

FPC(25)105 DATE OF NEXT MEETING

The next meeting of FPC will be held on Tuesday 16 December 2025.

UNAPPROVED

1.4

9:35 AM, 0 Mins

1.4 - TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 21 OCTOBER 2025

Michael Imperato (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

FPC Table of Actions 21 October 2025.pdf

FINANCE AND PERFORMANCE COMMITTEE / PWYLLGOR CYLLID A PHERFFORMIAD
21 OCTOBER 2025
TABLE OF ACTIONS / TABL GWEITHREDOEDD

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
FPC(25)80	**21 October 2025**	**Assurance and Risk Report**	To invite the Lead of the Operational Allied Health Professions and Health Sciences CCG [Ms Sara Quarrie] to a future FPC meeting to discuss the rationale for the CCG risk scores aligned to FPC.	**HT**	**16 December 2025**	Complete. Sara Quarrie to attend for Assurance and Risk item at FPC meeting on 16 December.
FPC(25)81	**21 October 2025**	**Escalation Oversight and Highlight Report**	To provide an update on the R1 Ophthalmology performance as part of the Escalation Response – Recovery Action Plans and Improvement Trajectories section.	**AC**	**16 December 2025**	Complete. Added to draft FPC agenda ahead of agenda setting meeting on 4 November 2025.
FPC(25)82	**21 October 2025**	**Ambulance Handover Update**	To provide an update on discharge following second reset week in November 2025.	**AC**	**16 December 2025**	Complete. To be included within UEC System Flow update at FPC meeting on 16 December 2025.
FPC(25)82	**21 October 2025**	**Ambulance Handover Update**	To explore the quality and safety impact of ED front door changes on patients within ED waiting rooms.	**AC**	**16 December 2025.**	Complete. Action highlighted to QSEC CSO for consideration.
FPC(25)85	**21 October 2025**	**Neurodivergent and Psychological Therapies Pathways –**	To present a report on neurodevelopmental services assessment and	**AC**	**16 December 2025.**	Complete. Discussed at agenda setting meeting on 4 November 2025. Forward planned for FPC meeting on 24 February 2026.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
		Performance and Milestones to Targets	treatment performance to a future FPC.			

1.5

9:35 AM, 0 Mins

1.5 - FINANCE AND PERFORMANCE COMMITTEE TERMS OF REFERENCE

Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)

For approval

Attachments

Terms of Reference FPC 16 December 2025.pdf

Appendix 1 Finance and Performance Committee Terms of Reference v4.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance and Performance Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to ensure that the Finance and Performance Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

Cefndir / Background

According to its terms of reference, the Committee must review its terms of reference and operating arrangements on at least an annual basis to ensure they remain fit for purpose. These must be subsequently approved by the Board and will form part of the Health Board's Standing Orders.

Asesiad / Assessment

The Committee last reviewed its terms of reference and operating arrangements in August 2025, and these were subsequently approved by the Board, on 25 September 2025. The Finance and Performance Committee Terms of Reference and operating arrangements (**Appendix 1**) have been reviewed since Board approval on 25 September 2025, and two changes and amendments to terms have been made. These are clearly marked on Appendix 1 and relate to the following:

Section	What has changed?	Why?
4.2	Membership – section amended	Removal of the "Director of Primary Care, Community & Long Term Care" as an In-Attendance member, following changes to Executive Team and senior management team portfolios.

5.1	Quorum and Attendance – section amended	Quoracy changed from two to three Independent Members.

Argymhelliad / Recommendation

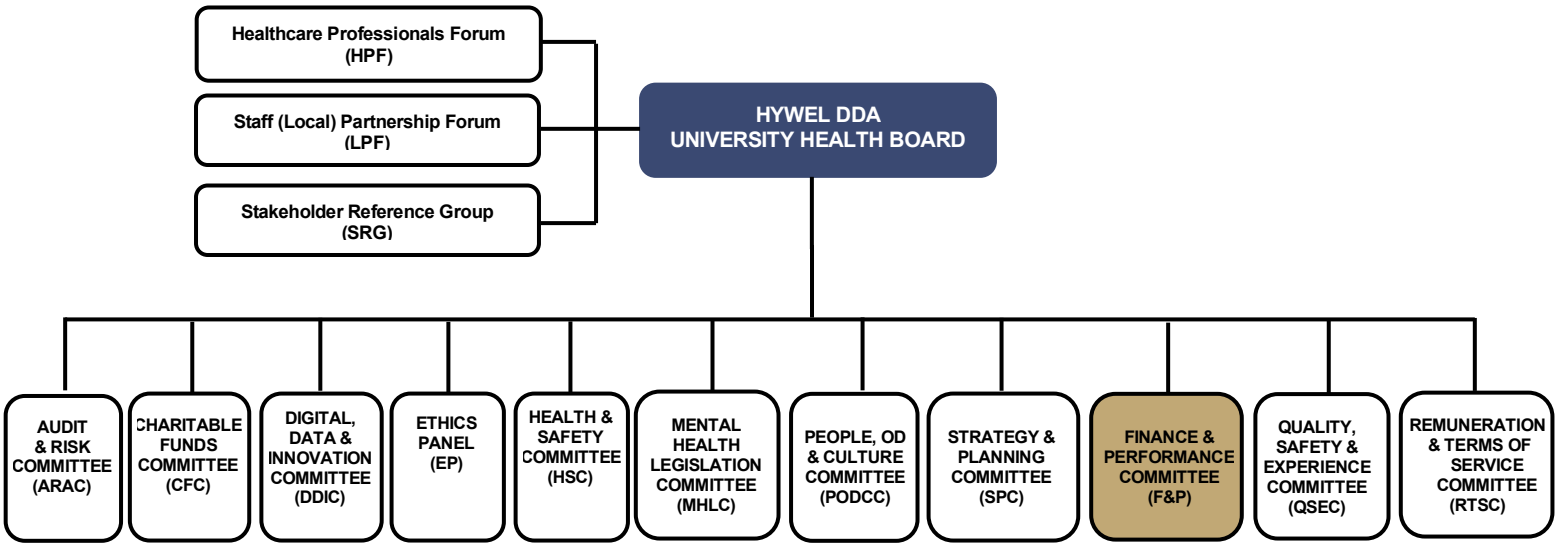
The Finance and Performance Committee are asked to **APPROVE** the Finance and Performance Committee's Terms of Reference (version 4) for onward ratification by the Board on 29 January 2026.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Standing Orders
Rhestr Termau:	Contained within the body of the report

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	Director of Corporate Governance/Board Secretary Executive Director of Finance

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



TERMS OF REFERENCE

FINANCE AND PERFORMANCE COMMITTEE

Version	Issued to:	Date	Comments
V1	Board	30/01/2025	Approved
V2	Finance and Performance Committee	29/04/2025	Approved
V2	Board	31/07/2025	Approved
V3	Finance and Performance Committee	28/08/2025	Approved
V3	Board	25/09/2025	Approved
V4	Finance and Performance Committee	16/12/2025	For Approval

FINANCE AND PERFORMANCE COMMITTEE

1. Constitution

1.1 The Finance and Performance Committee (the Committee) was established as a Committee of the Hywel Dda University Local Health Board (the Health Board) and constituted from 1 April 2025.

2. Principal Duties

2.1 The purpose of the Finance and Performance Committee is to provide *advice* and *assurance* to the Board on the following:

2.1.1 The financial performance and delivery against Health Board financial plans and objectives and

- give early warning of potential performance issues,
- make recommendations for action to continuously improve the financial position of the organisation,
- focus on the financial impact of in-year and medium-long term plans, the impact of financial issues on service delivery, quality and patient experience, and any specific issues where financial performance is showing deterioration or there are areas of concern.

2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern.

3. Operational Responsibilities

3.1 The Committee will, in respect of its provision of advice and assurance to the Board:

3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board:
3.1.1.1 Workforce
3.1.1.2 Non-pay and procurement
3.1.1.3 Medicines value and sustainability
3.1.1.4 Commissioned care
3.1.1.5 Clinical variation and service configuration

3.1.2 Receive an understanding of the existing deficit and key drivers. This will be achieved through scrutiny of an annually refreshed report on the drivers of the deficit.

3.1.3 Receive assurance on the development and realisation of opportunities. This will be achieved through scrutiny of the bi-monthly savings and opportunities report to the Committee.

3.1.4 Receive assurance on the development of a clear financial strategic plan. This will be achieved through scrutiny of a medium term financial recovery plan which demonstrates clear alignment into the in-year financial plan.

3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in:

- 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers;
- 3.1.5.2 Performance against the savings requirement;
- 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.

3.1.6 Seek assurance that financial systems are robustly embedded.

3.1.7 Maintain oversight of, and obtain assurances on, key financial risks. This includes risks against the delivery of Health Board financial targets, the robustness of key income sources and contractual safeguards.

3.1.8 Receive assurance on the delivery against the areas of targeted intervention (Appendix 1), and the required elements for de-escalation, that are aligned to the Committee.

3.1.9 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of significant revenue expenditure (all those over £1million requiring Board approval), business cases (except those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board.

3.1.10 Scrutinise major procurements plans and tenders, and provide assurance to the Board as part of its approval process.

3.1.11 Commission regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.

3.1.12 Seek assurance on the reporting and monitoring of contracts with providers such as Swansea Bay and Cardiff and Vale, focusing on financial performance, over and under performance, and providing regular financial updates.

3.1.13 Review any investment/ disinvestment strategy, including Procurement and Contracting Strategy, maintaining oversight of the investments and disinvestments, ensuring compliance with policies by:

- 3.1.13.1 Establishing the overall methodology, processes and controls which govern investments and disinvestments, including the prioritisation of decisions;
- 3.1.13.2 Ensuring that robust processes are followed; and

3.1.13.3 Evaluating, scrutinising and monitoring subsequent investments/ disinvestments.

3.1.14 Subject to the Board's direction and approval, develop and regularly review the performance management framework and reporting approach, ensuring that it includes meaningful, appropriate, integrated and timely performance data and clear commentary relating to the totality of the services for which the Board is responsible.

3.1.15 Seek assurance on the development and implementation of a comprehensive approach to performance delivery and quality management, to incorporate all performance requirements set by the Board, WG, regulators and inspectors, that enables all staff with managerial responsibility to strive for excellence whilst effectively delivering the basics.

3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery.

3.1.17 Seek assurance on delivery against all Planning Objectives (Appendix 2) aligned to the Committee in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans, including the medium term financial plans, and savings plans, that are developed and implemented, supporting and endorsing these as appropriate.

3.1.18 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.

3.1.19 Seek assurance that the management of risks within the Corporate Risk Register (CRR) and Directorate Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.1.20 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.1.21 Review and approve financial procedures on behalf of the Health Board.

3.1.22 Approve relevant corporate policies and plans within the scope of the Committee.

3.1.23 Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Finance and Performance Committee and oversee delivery.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
3 x Independent Members

4.2 The following should attend Committee meetings:

In Attendance
Executive Director of Finance
A Clinical Executive Director
Chief Operating Officer
~~Director of Primary Care, Community & Long Term Care~~
Other Lead Executives to be invited to attend for relevant Planning Objectives aligned to the Committee or relevant agenda items.

4.3 The membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than ~~two~~ three of the membership and must include as a minimum the Chair or Vice Chair of the Committee, and ~~one~~ two other Independent Member(s), together with the Director of Finance, or deputy, and a Clinical Executive Director and a Chief Operating Officer or deputy.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board – taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5.3 Any senior officer of the Health Board or from a partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer Member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.

5.6 The Chairman of the Health Board reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

5.8 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.9 The Committee may ask any or all of those who normally attend but who are not Members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and the Lead Director (Executive Director of Finance) at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Committee Members. Following approval, the agenda and timetable for request of papers will be circulated to Committee Members.

6.3 All papers must be approved by the relevant Lead Director.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions action log will be circulated to the Lead Director within **seven** days to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next **seven** days.

6.6 Members must forward amendments to the Committee Secretary within the next seven calendar days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet bi-monthly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:

10.1.1 Joint planning and co-ordination of Board and Committee business.

10.1.2 Sharing of information

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf.

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.

10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

10.5 The Director of Corporate Governance/Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1: Targeted Intervention areas relating to financial intervention and focus

The **finance intervention and focus** whilst in targeted intervention covers the following five areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Financial governance and control environment
    - The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
    - The financial committee structure is clearly articulated and addresses key risks.
    - Financial reports and supplementary presentations include the analysis and narrative explanation required to enable management and board to discharge their duties.
    - Financial controls at the health board are robust in both design and implementation, including a self-assessment against model frameworks, review implementation of the Standing Financial Instructions, internal audit reviews or other control reviews.
    - The finance function has the necessary capacity and capability to support the needs of the wider organisation.
    - Budget holders and managers are held to account for delivering their financial plans.
    - That as a result of the above, it has developed and is delivering an action plan to improve the financial governance and financial control environment.

2. Understanding the existing deficit and key drivers
    - There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
    - It has reviewed prior year investments to assess whether the planned benefits have been delivered.
    - Has a robust process for challenging underlying deficits reported at local divisional levels.
    - The drivers and investment decisions responsible for the growth in workforce are well understood; are reviewed for ongoing value; and are monitored through the Integrated Performance Report.
    - The integrated performance reports clearly identify and monitor metrics against key activity cost drivers;
    - That as a result of the above there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

3. Development and realisation of opportunities
    - Has a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.

- Development of a comprehensive opportunities framework with a constant pipeline of opportunities, and establish clear roles and responsibilities for developing opportunities into saving schemes and subsequent delivery of these saving schemes.
- Is translating national opportunities identified through the Value and Sustainability Board into local savings.
- Has clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- Value based health care principles have been embedded across the organisation.

4. Clear financial plan and strategy
   - An integrated and triangulated plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.
   - A clear engagement plan to communicate the necessity for financial improvement across the organisation.

5. Delivery of Plan
   - It is delivering clear improvement in the planned financial trajectory for 2024/25 (i.e. significant progress towards delivery of the Target Control Total), including further progress around identification and delivery of recurring opportunities.

De-escalation criteria for finance

1. The health board must demonstrate that there are robust financial governance and robust financial control environment in place with risks minimised.
2. Substantial progress to be made in delivering the targeted intervention action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.
   60% performance maintained for 3 months against the SCP target.

The **performance and outcomes intervention and focus** whilst in targeted intervention covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Establish baseline and agree improvement plans
   - Undertake a current situation report to highlight the baseline and opportunities. This will be repeated at agreed milestones to provide assurance to Welsh Government and the Board that progress is being made or where further interventions are required.

- Review, for assurance purposes, progress the health board has made against previous external and internal reviews and implementation plans with a performance lens.
- Consolidate previous performance reviews and improvement plans into one core document, reducing the risk of duplication, with the intention of adding value to a clear way forward.
- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.

2. Implement improvement plans
   - Improve unscheduled care performance to ensure that patients access safe, timely and clinically effective unscheduled care services, reducing waiting times, delays and improving quality.
   - Improve access to planned care with reduced waiting times in line with national requirements.
   - Improve the timeliness of access to cancer services and demonstrate improved compliance with the suspected cancer pathway, prioritising improvement in the most at risk tumour sites.
   - Ensure that cancer backlog reduces to agreed levels and site-specific plans are in place for tumour sites of concern.
   - Implement an outpatient's transformation plan that supports a move towards the requirements of the planned care programme.
   - Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.

3. Work with national programmes and respond to external reviews such as GIRFT
   - Work with and implement the recommendations from national programmes including but not limited to Strategic Programme of Primary Care, Six Goals for Emergency Care, Planned Care Improvement and the National Diagnostic and Endoscopy Programmes.
   - Support the implementation and realisation of the GIRFT opportunities as highlighted through the programme reviews.
   - Develop and implement an integrated approach to theatre scheduling and management, working with the GIRFT programme to develop and embed the agreed theatre reporting metrics on a bi-weekly basis.
   - Develop agreed plans in response to the GIRFT speciality reviews and recommendations.
   - Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

4. Communications and engagement
   - Ensure there are plans in place for all long waiters with a clear communication strategy with appropriate support to keep them well.
   - Implement the requirements of the three Ps policy.
   - Ensure that patients are clear where they can and should access support, signposting away from emergency services.

- Ensure that the benefits of new pathways such as straight to test, primary care management, self-management and see on symptoms pathways are communicated effectively.

De-escalation criteria for performance and outcomes

De-escalation criteria are set out below and should be maintained for at least 3 months before de-escalation will be considered. De-escalation will be to the next level of the escalation framework. Performance data will be enhanced by a monthly progress report from the health board across a range of measures.

Planned Care and Cancer

1. 100% of open outpatient pathways to be waiting less than 52 weeks and maintained for 3 months.
2. 100% of open pathways to be waiting less than 104 weeks and maintained for 3 months.
3. 80% of open pathways to be waiting less than 52 weeks and maintained for 3 months.
4. 15% reduction in the number of patients delayed by 100% for their follow-up appointment in three consecutive months and maintained for 3 months (Based on the November 2023 baseline.)
5. 65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment and maintained for 3 months.
6. 80% of patients waiting for a diagnostic test to be waiting less than 8 weeks and maintained for 3 months.
7. 80% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks and maintained for 3 months.
8. 80% of patients waiting for a NOUS and non-cardiac MRI to be waiting less than 8 weeks and maintained for 3 months.
9. 85% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 3 months.

Urgent and Emergency Care

1. A continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months and maintained for 3 months (Based on the Oct-Dec 2023 baseline).
2. Continuous improvement towards no more than 7% of patients waiting over 12 hours at each individual site and across the health board.

The above metrics, and monthly reports will form the basis of an assessment by the Welsh Government and NHS Executive as to the confidence levels of the health board's ability to maintain and sustain improvements.

Appendix 2: Finance and Performance Committee Planning Objectives 2025/26

Planning Objective		Lead	Class
2	Financial recovery and route map	Executive Director of Finance	Statutory duty
3	Transforming urgent and emergency care	Chief Operating Officer	Ministerial priority
4	Planned care, diagnostics and cancer	Chief Operating Officer	Ministerial priority
5	Mental health and CAHMS	Chief Operating Officer	Ministerial priority

1.6

9:35 AM, 15 Mins

1.6 - ASSURANCE AND RISK REPORT

Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sara Quarrie (Hywel Dda UHB - Service Director for Allied Health Professions and Health Sciences)

For assurance

Attachments

Assurance and Risk Report FPC 16 December 2025.pdf

Appendix 2 FPC Audit Inspections November 2025.pdf

Appendix 1 FPC Corporate Risk Register Summary.pdf



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Assurance and Risk Report

Finance and Performance Committee – 16 December 2025

Situation

This report provides the Finance and Performance Committee (FPC) with the current status of corporate risks, audits and inspections recommendations and Ministerial Directions (MDs) within its remit. The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from audit and inspections and MDs are being implemented by the Health Board.

Principal risks, operational risks and Welsh Health Circulars aligned to the Committee will be presented to the next meeting.

Corporate Risks:	Audit and Inspection Reports	Ministerial Directions
3	14	1

Risk Management - Overview

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

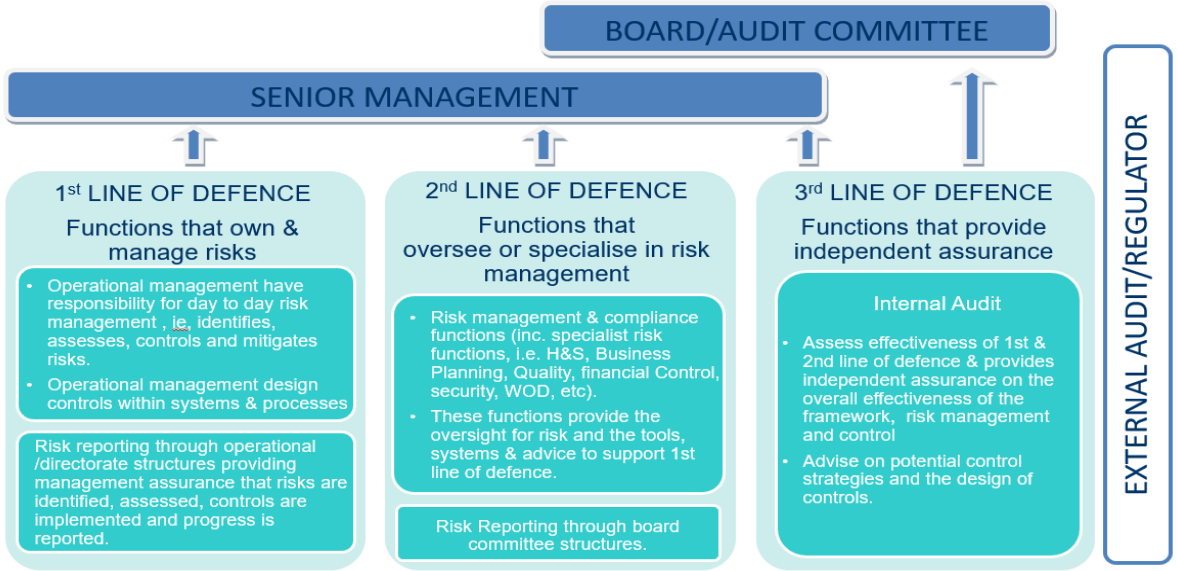
The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocate for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group (CCG) or Executive Function ('Functions'), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (e.g. where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Corporate Risks Assigned to FPC

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 3 risks currently aligned to FPC (out of the 23 that are currently on the CRR), with a decrease noted in the current 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* since the previous report presented to FPC in August 2025.

The following slides provides a summary of the reportable corporate risks aligned to FPC. The Corporate Risk Register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, and sources of assurance.

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
IMPACT ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5			2086 ↓		
Major 4			2104 →	1350 →	
Moderate 3					
Minor 2					
Negligible 1					

Corporate Risks assigned to FPC (1 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
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 Centre	**Chief Operating Officer**	**16 → (Reviewed 24/11/25)**	**12**	**31/03/26**

Rationale for Current Risk Score

The service has been de-escalated by Welsh Government (WG) from Level 4 to Level 3 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at July 2025 performance 61.4%

Due to recovery actions within radiology and urology there may be variation in performance and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026.

Rationale for Target Risk Score (TRS)

The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026.

The target risk score will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Corporate Risks assigned to FPC (2 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	**Director of Finance**	**15 ↓ (Reviewed 16/11/25)**	**12**	**31/12/25**

Rationale for Current Risk Score

Correspondence received from WG during Q1 of 2025/26 confirmed that the current deficit plan is not supportable, with a revised and clear requirement to achieve a Target Control Total (TCT) of £24.1m. The focus is therefore:

1. To improve the assurance over recurrent and non-recurrent savings delivery to achieve the original plan of £31.5m, and the now revised annual plan of £30.0m;
2. To take choices to reduce the position further to £24.1m, requiring action over August and September for Board Seminar in September 2025 to submit actions for improvement to WG by 11 September. Actions undertaken by 11 September enabled the forecast financial deficit to improve to £27.8m. WG recognised the positive progress, however reaffirmed their expectation of realising a £24.1m deficit.
3. In a communication on 13 October 2025, the Health Board committed to progressing further actions from the opportunities, with a desire to improve the forecast deficit in Month 7.
4. The Health Board's exposure to a Welsh Risk Pool (WRP) risk is a minimum of £4.2m and maximum of £5.3m. It is assumed that WG's expectation is to achieve £24.1m excluding this impact.
5. The Health Board improved the reported forecast deficit to £24.1m (excluding WRP), in Month 7, following clarity on a £6.1m Aseptic Unit Drugs accountancy gain.

The Month 7 reported position is now aligned to the TCT of £24.1m, and the likelihood score of the risk reduced from 4 to 3 in November 2025.

Corporate Risks assigned to FPC (2 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2086 - Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	**Director of Finance**	**15 ↓ (Reviewed 16/11/25)**	**12**	**31/12/25**

Rationale for Target Risk Score (TRS)

The Health Board had a historic challenge of controlling its cost base and delivering change. While significant improvements have been made to our control environment, significant challenges remain in our change management capabilities. These need to be addressed to achieve the target risk score.

By 11 September 2025, the Executive Team sought to de-risk the financial plan to ensure its successful delivery, at which point we would envisage the current risk score being reduced to 15 if the savings gap has been materially closed with robust and deliverable schemes. A 'Financial Choices and Decisions' paper was presented to Public Board on 25 September, outlining the choices for the Health Board to achieve the £24.1m Target control total.

By 31 October 2025, the Executive Team sought to have fully de-risked the financial plan to ensure its successful delivery, in order to allow the organisation to focus on planning for delivery of the medium-term financial roadmap into 2026/27.

Assurance from Clinical Care Groups that they have sufficient plans in place to deliver their savings target was not fully received through this process and has resulted in the target risk score date being delayed to 31 December 2025, to allow the Executive Team more time to finalise their savings plans. Executive Improving Together meetings are scheduled for November 2025 to review progress where the expectation is that all areas will coordinate recurrent plans to address any remaining savings gaps.

WG will receive a Strategic Cash Request by 8 December 2025, and should this be formally recognised and supported, the target risk score will be achieved, with the impact reduced.

TRS and expected date to achieve agreed by Formal Executive Team in November 2025.

Corporate Risks assigned to FPC (3 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 2025/26 due to demand exceeding capacity	**Chief Operating Officer**	**12 → (Reviewed 21/11/25)**	**9**	**~~30/09/2025~~ 31/03/2026**

Rationale for Current Risk Score

The combined impact of cohort demand in key specialties and workforce limitations all pose a risk to full achievement of ministerial planned care recovery targets by March 2026. Additionally, theatre cancellations due to staff shortages in Glangwili Hospital (GGH) have negatively impacted core capacity. Specifically in Orthopaedics, there is an additional demand in longer waiting patients (cohort) verses recurrent demand.

Recovery funding for 2025/26 has been prioritised for areas where high level demand and capacity modelling identified capacity gaps. The Annual Plan, approved by the Board in March 2025 highlighted delivery risks in Ear, Nose and Throat and Rheumatology (Stage 1) and Ophthalmology, Dermatology, Gynaecology, Urology and Cardiology at S4. The WG recovery allocation (£2.8m) has been split accordingly to progress delivery solutions in these areas. Since approval of the annual plan additional risks to delivery have arisen in General and Geriatric medicine.

Whilst delivery plans for 2025/26 reflect positive progress in increasing outpatient activity and treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in the above specialties. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status.

Opportunities have been explored to maximise capacity across Hywel Dda University Health Board (HDdUHB) and Swansea Bay University Health Board (SBUHB) in Ophthalmology and Orthopaedics to support further recovery of waiting times. Both specialties have been prioritised for active exploration of regional solutions, in partnership with SBUHB, to expand available capacity and address forecast shortfalls against anticipated demand including the utilisation of Neath Port Talbot theatres for Orthopaedic activity.

Notwithstanding these delivery risks, breach volumes in respect of the Stage 1 52-weeks are expected to be resolved by March 2026. Forecast breach volumes in respect of the Total Pathway 104-week target remain in Orthopaedics in Q1 although monthly breach performance shows continued improvement after Q2.

Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and, whilst delivery risks remain, the current risk score has been scored a 12.

Corporate Risks assigned to FPC (3 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2104 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 2025/26 due to demand exceeding capacity	Chief Operating Officer	12 → (Reviewed 21/11/25)	9	~~30/09/2025~~ 31/03/2026

Rationale for Target Risk Score (TRS)

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indications for future improvements in waiting times in 2025/26 onwards. The clinical care group propose to be in balance by the end of the financial year.

Opportunities to make further progress towards the Ministerial targets in 2025/26 will continue to be explored, including exploration of the regional opportunities referred to.

Audits and Inspections - Overview

The Health Board remains in Targeted Intervention (TI) (Level 4) status with WG as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Governance' from TI (Level 4) to Enhanced Monitoring (Level 3), the Health Board must meet the revised set criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to HDdUHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s – *which has replaced the previous criteria of 'Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.'*
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked via the **AMaT (Audit Management and Tracking)** system, with progress updated by relevant service leads against each recommendation and evidence required to be uploaded to demonstrate implementation.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored using a categorisation system based on performance against original completion dates, with several new categories introduced since the previous meeting (shown on the next slide).

Recommendations that have exceeded original timescales, along with the management responses, completion dates and barriers to implementation as provided by the lead officer on AMaT are included in **Appendix 2**.

Audits and Inspections – New Tracker Statuses

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are 17 open reports aligned to FPC to enable them to undertake the following responsibility set out in their Terms of Reference:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.

Each recommendation raised within audit and inspection reports are assigned a status category. Since the previous report to FPC, three new status categories have been introduced to provide enhanced analysis on the progress being made in implementing recommendations. Definitions for these new categories are included in the table below.

Status Category	Definition	Number of recommendations
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.	103
Unable to Complete (NEW)	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the Clinical Care Groups / Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	6
Pending Decision (NEW)	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	2
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.	38
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	7
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and currently awaiting formal approval to close.	44
Complete	The recommendations has been confirmed as completed by the Clinical Care Groups / Function Lead and formal approval to close has been received.	160

Audits and Inspection Reports assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following reports have been assigned to FPC to enable them to undertake the following responsibility set out in their Terms of Reference:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies.

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Peer Review	Colorectal Cancer (Third Cycle), **(issued Jan 22)**	Planned & Specialist Care	Chief Operating Officer	Mar-22	~~Mar-23~~ ~~Mar-24~~ Mar-28	8	0	0	7	0	1	0	0	Awaiting a regional approach for Pathology via ARCH
Peer Review	GIRFT - Gynaecology Review **(issued Sep 22)**	Planned & Specialist Care	Chief Operating Officer	N/K	Sep-26	17	3	0	13	0	1	0	0	Engagement required with stakeholders outside the Clinical Care Group (CCG)
Peer Review .	Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability **(issued Jun 23)**	Mental Health & Learning Disabilities	Chief Operating Officer	Jun-24	~~Jun-24~~ ~~Jul-25~~ Oct-25	16	1	0	15	0	0	0	0	None- Awaiting evidence to be uploaded AMaT for the remaining overdue recommendation.
Peer Review	Getting It Right First Time (GIRFT) Ophthalmology Review **(issued Aug 23)**	Planned and Specialist Care	Chief Operating Officer	Apr-24	~~Nov-24~~ Jan-27	59	3	5	35	16	0	0	0	Linked to Clinical Services Plan (CSP) in GGH and BGH
Peer Review	GIRFT - Urology Review **(issued Apr 24)**	Planned & Specialist Care	Chief Operating Officer	Jan-27	Jan-27	29	2	6	15	3	3	0	0	Linked to CSP, and reliance on the National Urology Clinical Implementation Network (CIN) rolling out agreed Coding criteria.

Audits and Inspection Reports assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion Noted
Peer Review	GIRFT - Emergency Medicine **(issued Jun 24)**	Community & Integrated Medicine	Chief Operating Officer	Oct-25	Oct-25	35	19	1	11	2	0	0	2	Awaiting outcome of CSP and capital funding from WG. Workforce challenges and ageing infrastructure.
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site **(issued Oct 24)**	Community & Integrated Medicine	Chief Operating Officer	Nov-25	Nov-25	58	39	0	13	4	0	0	2	Digital constraints to the service requirement. Awaiting All Wales approval of Redirection Policy.
Ministerial Advisory Group (MAG)	MAG Observations following the site visits of health boards – Hywel Dda UHB - Planned and Specialist Care (January 2025) **(issued Jan 25)**	Planned & Specialist Care	Chief Operating Officer	Mar-26	Mar-26	32	8	11	4	7	2	0	0	Dependent on recruitment and funding being agreed through the Annual Planning process, and awaiting outcome of tender process for standardised Pre-Operative Assessment Criteria process and pathway.
Ministerial Advisory Group (MAG)	MAG Observations following the site visits of health boards – Hywel Dda UHB - Allied Health Professions and Health Sciences **(issued Jan 25)**	Operational Allied Health Professions and Health Sciences	Chief Operating Officer	Sep-25	Jan-26	10	1	0	0	9	0	0	0	Workforce challenges
Ministerial Advisory Group (MAG)	MAG - Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care **(issued Jan 25)**	Community & Integrated Medicine	Chief Operating Officer	Mar-26	Mar-26	15	7	5	2	1	0	0	0	Workforce and funding challenges

Audits and Inspection Reports assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Any Barriers to Completion Noted?
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site **(issued Jan 25)**	Community & Integrated Medicine	Chief Operating Officer	Aug-25	Aug-25	19	6	0	11	0	0	0	2	None noted
NHS Wales Executive	NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site **(issued Mar 25)**	Community & Integrated Medicine	Chief Operating Officer	Apr-26	Apr-26	38	15	1	18	4	0	0	0	None noted
Internal Audit	Contract Management Advisory Report **(issued Mar 25)**	Director of Finance	Director of Finance	Dec-25	Dec-25	6	0	2	4	0	0	0	0	None noted
Internal Audit	Financial Management Final Internal Audit Report 2024/25 **(issued Mar 25)**	Director of Finance	Director of Finance	Jan-26	Jan-26	5	1	2	2	0	0	0	0	None noted
Audit Wales	Tackling Planned Care Challenges- Hywel Dda University Health Board **(issued May 25)**	Planned & Specialist Care	Chief Operating Officer	Mar-26	Mar-26	6	1	2	1	1	0	1	0	Unable to create a post for the Head of Planning and Programmes due to funding constraints. Post approved in principal but decision pending regarding funding of the post.
Internal Audit	Continuing Healthcare – Database Maintenance & Finance Processes Final Internal Audit Report 2024/25 (Substantial rating) **(issued June 25)**	Director of Finance	Director of Finance	Oct-25	Oct-25	1	0	0	0	1	0	0	0	None noted

Audits and Inspection Reports assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Report issued by	Report Title	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendat-ions in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Any Barriers to Completion Noted?
Internal Audit	Validation of Emergency Department Waiting Time Data Final Internal Audit Report 2025/26 **(issued Sep 25)**	Community & Integrated Medicine	Chief Operating Officer	Dec-25	Dec-25	6	0	5	1	0	0	0	0	None noted

Ministerial Directions - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as of November 2025, summarised over the next slides. To provide a more accurate reflection of MD's progress, three new status categories have been introduced since the last Committee report to mirror those used on AMaT. Definitions for these new categories are included in the table below.

Status Category	Definition	Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	0
Unable to Complete (NEW)	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG / Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision (NEW)	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval (NEW)	The Service / Function have completed the MD and currently awaiting formal approval to close.	1
Complete	The MD has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	2

MDs included within this report are based on the following criteria:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of MDs are extracted fr[illegible] system.

Ministerial Directions Assigned to FPC

The following Ministerial Direction is **Complete – Pending Approval**:

Direction Number	Name of Direction	Date issued	Lead Director
WG21-59	The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021	26/07/2021	Chief Operating Officer

The Health Board is exercising its functions in accordance with the relevant provisions of the Code of Practice on the Delivery of Autism Services (2021). However, lengthy waiting times remain and there is uneven progress in relation to adults eligible for support from Mental Health services and the need for primary/secondary care-facing web sites with direct links to resources and referral forms. In respect of the latter, work is continuing to improve this.

The risk of lengthy waiting times is being monitored/managed by the CCG with 1 corporate risk and 2 operational risks on their risk register: -

- Corporate Risk 1032 - Risk of timely Autistic Spectrum Disorder (ASD) diagnostic assessment for Children and Young People (CYP) due to increasing demand. Current risk score of 20.
- Operational Risk 1287 - Risk of clients not being provided with timely interventions due to waiting lists for assessment & diagnosis of ASD. Current risk score of 16.
- Operational Risk 1290 - Risk of increased Adult Attention Deficit Hyperactivity Disorder waiting list due to referrals exceeding service capacity. Current risk score of 16.

Extensive outsourcing of diagnostic assessments for CYP, and adults has taken place over a 3-year period (2022-2025) to help reduce waiting lists, however, demand continues to outstrip capacity across Wales, as evidenced in the national publication of the "Review of Demand, Capacity and Design of Neuro-developmental services (WG; 2022)"

The Health Board continues to work with the Regional Partnership Board in the development and delivery of the Code of Practice Implementation Plan (which requires a multi-agency approach) and the Welsh Government's 3-year Neuro-divergence Improvement Programme (2025/26). As part of this work, the Health Board has been the first in Wales to be awarded an Autism Understanding Organisation in 2024.

Ministerial Directions Assigned to FPC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Since the previous report to FPC, the following MDs have been confirmed as implemented and formally approved as closed (**Complete**):

Direction Number	Name of Direction	Date issued	Lead Director	Update
WG25-38	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 4) Directions 2025	22/07/2025	Director of Finance	Implemented - required changes have been made and are in full use now.
WG25-39	Directions to Local Health Boards as to the Statement of Financial Entitlements (Amendment) (No. 5) Directions 2025	06/08/2025	Director of Finance	Implemented - required changes have been made and are in full use now.

Recommendations

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

RISK MANAGEMENT

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively; and
- **RECEIVE 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

- **RECEIVE 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

- **RECEIVE ASSURANCE** that the Health Board is compliant with the MDs issued by Welsh Government.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Inspection Title	Recommendation	Action	Clinical Care Group/Executive Function	Lead Director	Original Due Date	Current Due Date	Barriers
Audit Wales- Tackling the Planned Care Challenges – Hywel Dda University Health Board	R6. The Health Board should strengthen its monitoring and reporting processes for managing clinical risks associated with long waits. • 6.1 develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties (Exhibit 7). • 6.2 develop a routine report to be presented at the Quality, Safety and Experience Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment	Patients on a waiting list are referred as urgent or routine. The proportion of patients triaged as urgent has increased post pandemic due to longer waits. Once RTT times have improved to pre-pandemic levels the urgent referral proportion will likely reduce as patients are less likely to come to harm waiting 36 weeks compared to 2 years.	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	
Audit Wales- Tackling the Planned Care Challenges – Hywel Dda University Health Board	R6. The Health Board should strengthen its monitoring and reporting processes for managing clinical risks associated with long waits. • 6.1 develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties (Exhibit 7). • 6.2 develop a routine report to be presented at the Quality, Safety and Experience Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment	Patients referred are graded as routine or urgent upon Triage. Patients requiring urgent treatment, not able to wait are seen sooner within urgent capacity. This is separate to Cancer or routine capacity. This is monitored by the Clinical Care Group Governance structure	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	

Audit Wales- Tackling the Planned Care Challenges – Hywel Dda University Health Board	R6. The Health Board should strengthen its monitoring and reporting processes for managing clinical risks associated with long waits. • 6.1 develop and implement a consistent methodology for assessing the risk of harm to patients caused by long waits across specialties (Exhibit 7). • 6.2 develop a routine report to be presented at the Quality, Safety and Experience Committee that effectively reports risks and actual incidents of harm resulting from delays in access to treatment	The planned care directorate (General Manager Lisa Humphrey with CD and Head of Nursing) will develop a routine report to be presented at the QSEC that includes risk and actual incidents of harm resulting from delays in access to treatment.	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	
Internal Audit - Financial Management Final Internal Audit Report 2024/25 (Reasonable)	R4. Identification of Savings There is a shortfall in identified savings for 2024/25. There is scope for greater monitoring of the extent to which opportunities in the compendium are explored, transacted into savings or rejected. Opportunities remain on the compendium indefinitely even where a variation has been explored and either taken forward or written off. There is limited evidence for how the sampled directorates manage and review the identification of savings ideas within their business management teams, with no formal agenda or actions captured to demonstrate all cost areas are routinely reviewed and tested for value for money.	Whilst items of variation will not be removed from the compendium, we will establish a record of what items have been explored and capture the outcome, to be coordinated within Finance by the BI & Value team with input from Business Partners and operational teams. Maintain monitoring of operational teams reviewing opportunities and ensure this is on the radar of new Care Group leadership teams so that they can track progress.	Director of Finance	Chief Operating Officer	31/07/2025	31/07/2025	

Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R3. Ensure day case and IP activity is maximised at Bronglais.	With funding, open and expand further theatre sessions (as noted in Bronglais Strategy and IMTP submission of Nov21). Would need to fully re-scope anaesthetics and theatre staff profile. Would need to scope specialty expansion and procedure baskets	Planned & Specialist Care	Chief Operating Officer	31/10/2025	31/10/2025	Barriers to implementation? Currently patients are travelling significant distances on day of surgery; timely arrival and fitness to travel home will impact on patient cohort as day case.
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R16. Implement best practice in theatre productivity, capped theatre utilisation set at 85%, day case rates combined with RPRP (procedures undertaken outside theatre in procedure rooms) aspire to 85%.	Continue to work with Swansea Bay UHB to consolidate current practice and further scope opportunities via regional working	Planned & Specialist Care	Chief Operating Officer	31/10/2025	31/10/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R27. Adopt the GIRFT 16 OPD playbooks.	Re-establishing and attending the OPD Transformation Board Utilising the 16 OPD play book Attending OPD Focus Webinar	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R28. Standardise OPD templates.	Continue to work with specialties to support any changes within their templates	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	

Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R29. Conduct an audit of FIT testing to assess its impact and integrate findings into health pathways for further optimisation.	Continue to explore collaborative working across primary and secondary care	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R30. Systematically evaluate and implement alternative diagnostic methods such as capsule sponge and nasal endoscopy to reduce demand on conventional services	Cytosponge - To introduce a cytosponge service, dedicated workforce would need to be recruited and trained. The NHS executive have advised that funding may be available in 25/26 - the Health Board is due to meet with the NHS executive clinical lead for cytosponge in June 2025. A service specification document for the rollout of the service has already been developed at a national level and can be adopted within the Health Board. TNE - Explore options to allocate workforce already dedicated to Endoscopy - however, this could result in key Endoscopy staff being pulled from delivery of other service elements which could present a risk to service delivery plans.	Planned & Specialist Care	Chief Operating Officer	31/07/2025	31/07/2025	Barriers to implementation: 03/10/2025 - TNE - Capital funding for purchase of transnasal endoscope and associated equipment. Funding for dedicated workforce to deliver the service

Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB- Planned and Specialist Care (January 2025)	R32. Expedite the implementation of FIT testing in primary care to alleviate downstream diagnostic pressure.	A task and finish group has been established between Primary & Secondary Care to devise and implement a plan for transition of FIT to Primary Care. The first meeting is taking place on the 26th of March 2025. Timescales to be agreed during the meeting. Engage with DHCW to switch on GP test requesting for FIT within Primary Care - this will allow GP's to request FIT through to the Public Health Wales laboratories. Commence discussions with PHW regarding establishing service level agreement, associated costs, implementation process and associated timelines.	Planned & Specialist Care	Chief Operating Officer	30/09/2025	30/09/2025	
Ministerial Advisory Group - MAG observations following the site visits of health boards – Hywel Dda UHB - Allied Health Professions and Health Sciences (January 2025)	R5. Pathology demand increases with expanded services, but these pressures are not integrated into delivery plans. The health board could incorporate pathology demand into service expansion plans to prevent bottlenecks.	Agreed. Demand is monitored within the service and compared against current capacity. RCPath points are measured monthly to assess gaps in consultant capacity. WLI activity is performed outside core hours and recharged to appropriate service. Monitored demand and capacity will be captured and communicated wider via the Clinical Care Group for escalation. The information will then be utilised to help with future service planning. Pathology and Radiology demand is considered in annual planning paperwork to ensure any change to demand is captured.	Operational Allied Health & Health Sciences	Chief Operating Officer	31/08/2025	31/08/2025	

Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Ambulatory trauma is directed to the Orthopaedic Ward	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Undertake a review of other specialty pathways including Urology, ENT and Gynaecology.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	As part of the UEC Accelerated Transformation work, develop a new model for accessing and navigating the urgent and emergency care system that aims to deliver a 50% reduction in attendances at ED and 75% of emergency activity in a scheduled way, through a shift left to community based service delivery.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Implement a co-ordinated Health Board wide approach to the management of patient flow across the system, eliminating ambulance handover delays over 15 mins and 12 hour ED delays, pathway process delays, and reducing pathway of care delays by enabling discharge within 72 hours of being clinically optimised	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	

Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Plans to be submitted to Welsh Government in relation to the expansion of Medical SDEC within current footprint via capital funding.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	ENT SDEC T&F group to review score and capacity issues within procedure room. 28/08/2025 - Refer to MD1/3 actions. Proposed insourcing of ENT elective work for September is likely to impact on ability to ringfence SDEC capacity. Review to be arranged towards mid-October (following insourcing completion) to discuss further planning for SDEC ringfence. . Revised target date 31/10/2025.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	Requires clinical engagement from ENT Team to utilise treatment room as SDEC.
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Implementation of internal professional standards	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Undertake Carmarthenshire System Review of frailty pathways across the 3rd sector	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R1. The ED is seriously overcrowded, and some clinicians reported that they had not seen patients in cubicles for over 18 months	Undertake review of Rehab Pathway to progress levels of rehab and review current pathway and capacity	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R3. SDEC is good and is taking patients from GP's and ambulances who would otherwise present to the ED. However, throughput and capacity should be monitored to ensure it is achieving the maximum potential	Medical patients are taken earlier in the day and direct, not only via ED Weekly and monthly activity review in place. Further actions to be undertaken include a capital review to expand / relocate SDEC in progress through the T&F Front Door Group, and review of return patients to SDEC and alternatives.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R4. A continuous flow model could be explored to improve flow.	Agreed. Boarding on wards is already in place when space is available, however not all wards are able to board. "Perfect week" has been implemented as of 30 June 2025. We will continue to explore a continuous flow model, noting lessons learnt from SBUHB.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake a review of the acute and community frailty pathway to join the pathways across the system, with a POCS deep dive on Cadog and Dewi wards (long stay frailty)	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake review of Frailty SOP to review current length of stay challenges, pathway of care delays, and to determine immediate actions to improve on pathway review communication	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Undertake length of stay review for Cadog / Dewi wards with community input	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R5. Frailty is challenging. ED staff were not aware of the frailty pathway, despite being award winning. Specific focus on delayed pathways of care in the frailty ward should be prioritised, and improved links between the FAU and the ED to reduce the significant corridor care in the ED.	Complete Six Goals Frailty Assessments	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R6. Executive presence in the ED was reported as low, a survey of staff could be done to gauge if this is consistently felt among staff, and if so look to increase presence of exec team.	Weekly ED big room meetings are in place, chaired by the Executive Director of Nursing. A Glangwili ED staff survey has been undertaken in May 2025, with a review of outcomes to be undertaken and an action plan developed as appropriate. Outcomes will be fed-back to the Clinical Care Group. An additional staff survey is to be scoped and approved.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R10. Review the numbers and locations of urgent treatment centres and ensure that optimum use is made of these to deal with walk-ins.	Possible implementation of 7-day SDUC model and Implementation of UPC model for Hywel Dda. Evaluation Q1, possible implementation phases Q2-3	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	Funding on a short-term basis, need to demonstrate savings in evaluation
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R15. Review the digital infrastructure to ensure that health boards can track the full patient journey.	Operational governance and escalation - SOP to be worked up.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R15. Review the digital infrastructure to ensure that health boards can track the full patient journey.	Influence the design of the new Pt Flow system (Alcidion) and reference site communication/site visits	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Dependant on Alcidion and Informatics as to go-live date
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R15. Review the digital infrastructure to ensure that health boards can track the full patient journey.	Working with Informatics team to streamline useful information flows at daily meetings in parallel with new system design.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	Any Delays in design of Pt flow config may affect timescales

Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R15. Review the digital infrastructure to ensure that health boards can track the full patient journey.	Identification and baselining performance metrics and reporting requirements.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
Ministerial Advisory Group - MAG Observations following the site visits of health boards – Hywel Dda UHB- Urgent and Emergency Care (January 2025).	R15. Review the digital infrastructure to ensure that health boards can track the full patient journey.	Recruitment as part of OCP Phase 2	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	Financial approval of SBAR is needed to progress recruitment
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R5. . Following our previous visit, we recommended that the clinical patient pathways for GP referrals were reviewed to ensure appropriate triage and assessment is undertaken before patients present to the ED. Having returned to the site it is our view that there is scope within the current CDU medical model to undertake this triage role, and we recommend that consideration is given to reviewing the current model that is in place. The current model in place at BGH stands out as an outlier when compared to similar models across Wales. Having a senior decision maker triaging calls from primary care will have a significant impact on the pressures currently experienced within ED resulting in less patients attending the already challenged ED at BGH.	Discussions held with medical consultants – there is a strong feeling that the current model works as they are confident in the decision making of the team leader as the calls that come in are often not just medical, however, the clinicians are not adverse to trying alternative methods and have made some suggestions that could improve i.e calls going to community outreach (clinical streaming hub will help here).	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R7. The site undertakes a retrospective day of care audit assessment and reviews the data to gain a clear picture of true ED activity. When we returned to the site we were informed that there remained a lack of clarity regarding the nature of patient presenting conditions and the audit had not been undertaken.	EUCC team to complete with deadline of mid-August 2025.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R14. We recommend that consideration is given to the clinical model and purpose of the CDU along with the overall bed capacity within the hospital with particular reference to the medical patient cohort.	This is recognised and work is in place CDU functions as required. The Short Stay Treatment (SST) area within the ED footprint was until recently, often bedded. Measures are being taken to ensure the site provides the support to A&E to ensure that SST can flow which reduces the pressure across the department.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R15. We recommend therefore that the final report for this mortality review is shared with us at the earliest opportunity with an update on any of the actions and recommendations from this.	There is a regional mortality review ongoing.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R23. At times of high escalation there needs to a process when senior service group leaders including specialty clinical directors meet with the patient access team to discuss actions required to de-escalate the site with specialty leads held to account for actions pertaining to their areas of responsibility.	Hospital Full Protocol in development	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R24. Whilst following our initial visit we recommended that the site introduces a manager of the day that is supporting patient flow for the site is visible throughout the day and can support the patient flow team and add value by taking additional decisions and actions that will support the site to de-escalate into a safer position. There is an appreciation that the current senior leadership model at BGH is very lean and is not able to support this recommendation.	The Manager of the Day model is currently being reviewed Health Board wide in line with the introduction of the ODU Hub in October. Escalation processes are in place at Bronglais to ensure teams have mechanisms in place – the Senior Leadership Team is supporting this.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R25. At times of high escalation there needs to a process when senior leaders including specialty clinical directors meet with the patient access team to discuss actions required to deescalate the site with specialty leads held to account for actions pertaining to their areas of responsibility.	System GM notifies Senior Leadership Team inclusive of Clinical Directors. It is expected that the clinical directors communicate with the speciality teams to ensure awareness	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R26. We recommended that there is greater senior nursing input and oversight on the wards supporting and challenging ward activity. This needs to be ongoing until such a time that there is assurance that this level of scrutiny and challenge is embedded into the normal practice on the ward.	In line with recent flow improvements which includes the implementation of Senior Decision Maker led board rounds. The Q.I team have the full support of the Senior Leadership Team in delivering the necessary improvements. This will include increased senior nurse viability which includes the System Head of Nursing.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R28. We recommended that the site escalation process and action cards are explicitly clear to all relevant personnel within the hospital to ensure that there is a consistent and clear approach adopted throughout the hospital. Whilst this is being embedded, we recommend senior leadership presence to provide assurance that this in place in all clinical areas.	System GM and System Head of Nursing working on escalation cards in line with Hospital full Protocols	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R33. Following our initial visit, we recommended that the Health Board explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day. We continue to recommend that the discharge profile on the site is explored in more detail.	Work is ongoing to ensure Earlier in the Day Discharge across the System – ongoing workstreams in line with the QI improvement work is addressing board rounds and overall site flow.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R35. Following our initial visit, we recommended that ward sisters are supported by senior leaders to create time for discharge planning as part of their daily routine	As part of initial priorities, the System HON will be exploring the job plan of team leaders to explore ways of ensuring that their capacity provides an ability to lead on discharge co-ordination. This will include exploring ways to include community services in this process to ensure continuity of care and integration of both acute and community skillsets and experience. OCP phase 2 will be reflective of this.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R36. We recommended that there is greater senior nursing leadership presence in all areas until complete assurance regarding the implementation of the optimal flow framework is embedded.	In line with recent flow improvements which includes the implementation of Senior Decision Maker led board rounds. The Q.I team have the full support of the Senior Leadership Team in delivering the necessary improvements. This will include increased senior nurse viability and presence which will also include the System Head of Nursing OCP Phase 2 is considering the development of a corporate function whose primary focus is clinical governance- this will enable Locality based senior nurses the capacity to provide greater presence and visibility in clinical areas.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R37. We recommended that as part of the medical job planning process this is reviewed and discussed, with the use of compelling demand and capacity data to demonstrates the current imbalance between in patient demand and ward based consultant capacity	At present, Bronglais has a number of lone consultant specialty teams – gastro/respiratory/A&E/Diabetes/Stroke. This is recognised at Exec level and the Medical Stabilisation group is undertaking a programme of works to review current resource with Bronglais ED a priority area.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: BGH site	R38. We recommended that the senior leaders within the organisation endorse the implementation of the framework and promote a culture shift within the hospital that sees some current practices and ways of working challenged. Support from senior teams including medical director and chief operating officer is paramount for this to succeed.	It is recognised that a culture shift is required and work is ongoing to support this. OD colleagues are supporting the System GM in ensuring that this is addressed.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R3. We recommend the ED team update their risk escalation tool so that it accurately reflects the current position in ED which can then be escalated through the organisation. There are examples of tools of this nature being utilised in neighbouring Health Boards and we recommend that consideration and time is taken to explore these in more detail. The added value this would bring include: - Provides whole pathway real time data and trends, which are accurate, relevant, and available to the key decision makers - Provides information that can, at a glance, communicate flow status at the system and individual level. - In addition to site escalation, having a tool that demonstrates a clear picture throughout the day could support with responding to and understanding clinical incidents, responding to patient/ family concerns and future capacity and demand planning	Power BI for ED forecast demand now available on Live Ops Dashboard Current ED status available on Live Ops Dashboard ED Crowding Matrix being developed by Data Science Team - timeline for completion end of September	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R4. We recommended that further clarity is sought and a more robust process is put in place to ensure that ED staff are aware of the medical team responsible for the patient awaiting inpatient beds.	4b. Scoping work to be undertaken with QI team re number of PTWR and Med Liaison a/w clerking.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R5. When a medical specialty is unable to accept a 'new' patient from ED, there should be an escalation to a senior clinical decision maker to review the entire caseload and make a risk-based decision on how to balance the current inpatient capacity against the current demand.	5a. Service change to Acute Physician model proposed for 2025 based on recruitment. - Narrative and comms to be disseminated.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R8. We are aware that there have been busiest day reviews undertaken at GGH with findings that mirror the observations made. It would be useful to be cited on what actions have been taken in response to those findings and the impact of any changes that have already been made or will be made in the future.	8a. Implementation of a Redirection Policy - will support re-direction within ED.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R8. We are aware that there have been busiest day reviews undertaken at GGH with findings that mirror the observations made. It would be useful to be cited on what actions have been taken in response to those findings and the impact of any changes that have already been made or will be made in the future.	8b. Review of streaming process at front door to allow early identification of alternative pathways - review of GGH pathways and exit strategies.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R9. We recommend that the Health Board considers using a medical model where there is a senior decision maker at the front door streaming and redirecting patients to the most appropriate areas/ resources.	9. Re-direction/ streaming in RCEM recommendations. Re-direction policy to be approved.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R10. We recommend the Health Board undertakes a review to analysis in more depth any specialties that may be driving this increase and whether there are any further interventions both across primary and secondary care that could help address this demand and reduce the number of patients requiring admission i.e enhancing or fully utilising the virtual ward capacity.	10b. Development of Integrated HomeFirst approach delivered through the Clinical Streaming Hub and Hospital@Home model.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R11. We recommend that the Health Board moving forward to not advocate moving patients backwards through the flow system. However, should there be a need to take this action, we recommend that only patients on a D2RA pathway 0/1 are moved, knowing that they do not have complex needs and will be discharged home without delay.	11a. Review of RTDC to support real time capacity demand to support optimal flow - and review process of escalation around 'heavy' patients requiring CDU specialist room.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R11. We recommend that the Health Board moving forward to not advocate moving patients backwards through the flow system. However, should there be a need to take this action, we recommend that only patients on a D2RA pathway 0/1 are moved, knowing that they do not have complex needs and will be discharged home without delay.	11c. Explore capital bid for additional heavy patient equipment on additional ward areas.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R12. To mitigate this risk outside of the working hours of the discharge lounge, a proactive approach should be taken. We, therefore, recommend that each ward identify a regular cohort of patients who are suitable to 'outlie' for the final part of their inpatient stay whilst discharge home is facilitated and promptly realised. Within this recommendation, the 'final part' of an inpatient stay would be a maximum of 12 hours.	12a. Review of daily process to capture 'Clinically Optimised' patients who are suitable to outlie. On-boarding protocol disseminated to all clinical areas. To incorporate on new patient flow app.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R12. To mitigate this risk outside of the working hours of the discharge lounge, a proactive approach should be taken. We, therefore, recommend that each ward identify a regular cohort of patients who are suitable to 'outlie' for the final part of their inpatient stay whilst discharge home is facilitated and promptly realised. Within this recommendation, the 'final part' of an inpatient stay would be a maximum of 12 hours.	12b. MOD duty to incorporate projected flow numbers for days ahead from ward areas and discharge lounge utilisation.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R16. Enhancing the Sitrep report will improve communication by providing a common framework for communicating all operational pressures by providing a clear and consistent overview of operational pressures and a framework to consider and implement responses consistently enhancing patient-centred decision-making across the whole UEC pathway	16. Recent review of SitRep report relating to Critical Care - strenthening patient centred decision making in particular to L1 (DTOC). Repat/pathway database role out being implemented - to supportclear and consistent overview. Improvement work on current SitRep status to include overall demand (ED and CDU)	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R17. Including a section that focuses on actions identified during each meeting will allow necessary actions to be documented and importantly identify a responsible person to be accountable for those actions. These actions can be followed up in the next meeting to maintain accountability throughout the day.	'17. 'Red Stretch Plans' to be strenthened with key focus within the patient flow discussions. Review of RTDC.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R18. We also recommend enhancing the report to allow the opportunity to highlight specific patient concerns/ risks. Again, this will be followed up in future meetings to ensure action has been taken.	'18. 'Red Stretch Plans' to be strenthened with key focus within the patient flow discussions. Review of RTDC.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R19. Extending the capacity of the sitrep report will enable the report to be used to support any investigations of clinical incidents or concerns as it will capture the picture of the whole day and describe risks and actions taken.	'19. 'Red Stretch Plans' to be strenthened with key focus within the patient flow discussions. Review of RTDC.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R21. For any site sitrep tool to be effective and meaningful the whole system needs to act to relieve pressure as it occurs.	21a. Emergency Pressure and Escalation Policy to be disseminated and followed.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R21. For any site sitrep tool to be effective and meaningful the whole system needs to act to relieve pressure as it occurs.	21b.Full Capacity Protocol to be reviewed and disseminated.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R21. For any site sitrep tool to be effective and meaningful the whole system needs to act to relieve pressure as it occurs.	21c.Review of role of MOD (Manager of the Day)/ Patient Flow Senior Nurse and Clinical Site Manager role (as well as OOH GM cover).	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R22. We recommend that the IDT are present at the morning patient flow meeting with the view that suitable patients can be identified and a prompt decision can be made to 'pull' them out into the community setting. By including this team early, they can promptly review any patients who are potentially suitable for community discharge and help to generate patient flow out of GGH earlier in the day.	22. Review of attendance to Patient Flow meetings to maximise community 'pull'	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R23. We recommend that consideration is given to greater/ increased accountability and responsibility for system flow across the site. This could be achieved by: - Ensuring there is a senior (band 7 and above) representation at all site meetings from all service groups who will be responsible for the actions pertaining to their area (both nursing and operational leads). The expectation would be that they would be in senior roles with an ability to influence and escalate. That individual would feed into the flow meetings actions they have taken to resolve any constraints in their area as well as an accurate and up to date bed state. It is anticipated that this would support the patient flow team and foster a whole site response to system pressure	23.Review of attendance to Patient Flow meetings to support senior operational leadership.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R26. At times of high escalation there needs to be a process when senior service group leaders including specialty clinical directors meet with the patient access team to discuss actions required to de-escalate the site with specialty leads held to account for actions pertaining to their areas of responsibility.	26. Patient Flow meetings to incorporate Emergency Pressures & Escalation Policy based on escalation risk	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R30. We recommend that the HB escalation process and action cards are explicitly clear to all relevant personnel within the hospital to ensure that there is a consistent and clear approach adopted throughout the hospital. Whilst this is being embedded, we recommend senior leadership presence to provide assurance that this is in place in all clinical areas.	30. Focus work on Major Incident action cards specific to role and responsibilities.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R31. We recommend that the HB reviewed the attendance at the patient flow meeting. If the decision is to move to a model whereby there is a representation from each service at the meeting that report actions taken and importantly plans for the remainder of the day, there may not be the need for all ward sisters to attend the 3pm meeting. However, if the model continues to be each area reporting their own position, then there needs to be a mandate that all areas attend this meeting. This will ensure that there is an ongoing commitment across the site to patient flow resulting in an accurate site profile being obtained and reasonable challenge being made	31. Complete-Review of attendance to Patient Flow meetings for both planned meetings - attendance strengthened. Afternoon R2G huddle replaces the requirement of ward managers to attend unless additional support required.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R32. If the HB is content to run two system flow meetings per day, the latter meeting must serve as both a real time review of the current position and also a forward look into the evening and the following morning. The meeting could be expanded to include an update of expected and confirmed discharges the following day and gain a clear picture of the plans for patients to move out of a ward bed the next morning.	32. Review of attendance to Patient Flow meetings for both planned meetings - RTDC review of next day discharges to be strengthened.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R33. We recommend that the IDT and staff from Discharge Lounge attend this meeting to identify patients who may require the input of these teams early, with the aim to arrange an early review from the IDT and/ or a review from the discharge lounge team to review ther suitability of a patient to move to the lounge when it opens the following day.	33. Review of attendance at Patient Flow Meeting.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R34. We recommend the HB enacts a zero tolerance regarding inaccurate information regarding query and confirmed discharge activity from ward areas. We appreciate that there are times when unexpected discharges occur later in the day. However, this should be on the minority of occasions rather than what appears to be the norm. We recommend that there is greater senior leadership presence in all areas where this practice occurs until complete assurance regarding accurate bed positions is achieved.	34a. Review of query and unexpected discharges to be undertaken to identify key themes/missed opportunities.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R34. We recommend the HB enacts a zero tolerance regarding inaccurate information regarding query and confirmed discharge activity from ward areas. We appreciate that there are times when unexpected discharges occur later in the day. However, this should be on the minority of occasions rather than what appears to be the norm. We recommend that there is greater senior leadership presence in all areas where this practice occurs until complete assurance regarding accurate bed positions is achieved.	34b. RTDC Task and Finish Group to be implemented with QIST support for data capture and outcome tools. Invitation extended to Ward Sister Champions.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R35. Utilising the RTDC tool and recording a daily dataset of declared vs total discharges by area would give a high-level indication of the ward areas that require additional support to improve within this area.	35. Review of RTDC Tool as part of RTDC Task and Finish Group.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R36. We recommend the HB share examples whereby data generated by the RTDC tool has led to improvements in practice.	36. Review data with QI Team to determine key improvements and agree next focus steps.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R37. We recommend the HB considers sourcing a larger location for the discharge lounge acknowledging the added value this would bring to system flow.	37. Review Discharge Lounge use/data to determine efficiency and capacity constraints - determine escalation steps if full and no capacity. Discharge Lounge Task and Finish Group to establish more efficient ways of working.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R38. Consider opening the DL earlier and allow patients being discharged to have their breakfast there prior to leaving the site.	38. Review Discharge Lounge use/data to determine efficiency and capacity constraints - determine escalation steps if full and no capacity. Review of opening times based on activity peaks.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R39.Establish a 'pull' model for Discharge Lounge where staff from the unit actively visit wards to review patients with a definite discharge date the following day.	39. Review Discharge Lounge use/data to determine efficiency and capacity constraints - review of next day discharges (as part of MOD rota).	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R40. Ensure all discharge paperwork is completed the day prior to discharge	40. Review Discharge documentation compliance as well as review of DAL completion and sign off. Link in with pharmcy to scope this.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R41. Ensure all patients are spoken to and they are aware of the planned move.	41. review of Discharge Lounge Patient Leaflet	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R42. Communicate on ward boards and patient notes clearly that a patient is being transferred to DL early the next day	42. Review of Discharge Documentation and ward use of Discharge Lounge.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R43. We recommend that a column is added to the sitrep report to input confirmed discharges for the following day, so those identified patients can be 'pulled' to discharge lounge as soon as it opens, releasing early capacity that can be utilised.	43. Complete- Column available on Sitrep to capture next day discharges	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R44. Consider supporting additional portering/ HCSW resource to transfer suitable patients, removing the onus from ward staff.	44a. Review of portering capacity to maximise flow.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R44. Consider supporting additional portering/ HCSW resource to transfer suitable patients, removing the onus from ward staff.	44b. Review of Synbiotix data relating to delays in transfer to Discharge Lounge.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R45. If DL is filled to capacity by 8am, this will release some immediate pre ward round capacity into the site each day, this should be achievable for a 400 bed site.	45. Review Discharge Lounge use/data to determine efficiency and capacity constraints	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R46. The HB could look at the utilisation and occupancy of discharge lounge on a daily basis as a performance KPI to embed the early and proactive use of the facility as much as possible.	46. Review performance capture. Part of Discharge Lounge working group.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R47. Discharge activity occurs later in the day at GGH. We recommend that the HB explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day.	47a. Review of RTDC tool with aim to bring discharges before 12 midday (from 2pm).	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R47. Discharge activity occurs later in the day at GGH. We recommend that the HB explore this in more detail to be able to clearly understand the root cause of this and be able to put measures in place to, where possible ensure that discharge activity occurs earlier in the day.	47b. Review of discharges after 2pm to determine delay reasons to provide feedback and key learning to achieve optimal flow.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R48. In collaboration with informatics colleagues in the NHS executive, we have the ability to provide admission/ discharge modelling data which would highlight the impact that earlier discharge could have on flow capacity throughout the day. We would like the opportunity to work with you to advance this concept further in the future	48. Action to be confirmed by the service	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R49. We recommend that this service is expanded to a 7 day service as a priority, recognising that workforce constraints will be a challenge.	49. Action to be confirmed by the service	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R51. We strongly recommend that this service must continue and further expand.	51. Action to be confirmed by the service	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R52. We recommend that further education and training is undertaken to ensure that all areas within the hospital are aware of the services that Eastgate offer so that the service is fully optimised and additional activity is generated out of hospital.	52. Hospital Director to attend Medical engagement session to communicate key available service and improve overall engagement.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R53. We recommend the HB considers changing the approach it adopts to patient flow. We recommend a model where the patient flow team act as a central hub and the role of information gathering and responding to actions to create capacity is the responsibility of a designated lead for each service group. The patient flow team need to have the capacity to view and co-ordinate the whole site and be able to make timely and appropriate decisions regarding flow through the hospital. Currently they do not have the capacity to do this resulting in time inefficiencies and the potential to lose a grip and control over the site.	53. Review of current patient flow model - central hub approach as well as consideration to B4 patient flow co-coordinators.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: GGH site	R56. We recommend that senior leaders within the organisation endorse the implementation of the framework and promote a culture shift within the hospital that sees some current practices and ways of working challenged. Support from senior teams including medical director and chief operating officer is paramount for this to succeed.	56a. Safe Hospital Care Actions reviewed and discussed monthly for progression and monitoring of Optimal Flow framework.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R6. It is recommended that when there have been 48-hour breaches in AMAU a short investigation is undertaken in collaboration between the AMAU and specialty involved i.e. Respiratory, to review the patient journey as a timeline. This will inform future learning for all departments involved to take forward and share with their teams, again fostering a whole system approach to patient flow.	Action accepted and completed by service	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R8. Ensure all discharge paperwork is completed the day prior.	Awaiting full management response from service to be added to AMaT	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R15. When a medical specialty is unable to accept a 'new' patient from AMAU, there should be an escalation to a senior clinical decision maker to review the entire caseload and make a risk-based decision on how to balance the available inpatient capacity against the current level of demand.	Action accepted and completed by service	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R16. We recommend that a senior clinical decision maker is present at each board round and places an emphasis on exploring alternative options to deliver the clinical care required for each patient outside of a hospital ward through a 'deep dive' approach. We have seen evidence of the proactive approach that the Health Board has in utilising the skills of community based clinical services e.g. District Nursing, ACT/CRT and the Carmarthenshire Intermediate Care Team, we feel that these resources could offer additional options to provide an adequate level of care to some patients who would benefit from an earlier discharge home. • Whilst this describes a risk-based approach to clinical decision making, we are cognisant that this would require careful planning and a clear governance structure in order to be successful, this approach is promoted under the 'right patient, right place' ethos that NHS Wales is advocating. • This approach could be embedded with	Awaiting full management response from service to be added to AMaT	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	

NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R17. Every clinical specialty should have a cohort of patients who are suitable for criteria led discharge to aid decision making and ensure inpatient capacity is only used for patients who have no other clinically viable option to receive care.	Awaiting full management response from service to be added to AMaT	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
NHS Executive Report on Urgent and Emergency Care Opportunities: PPH site	R18. It is recommended that the senior leaders within the organisation endorse the implementation of the framework (board rounds) and promote a culture shift within the hospital that sees some current practices and ways of working challenged. Support from senior teams including medical director and chief operating officer is paramount for this to succeed	Awaiting full management response from service to be added to AMaT	Community & Integrated Medicine	Chief Operating Officer	18/07/2025	18/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Work to improve hospital flow (as also identified in NHS Exec and 6 goals actions) is underway and has been factored into performance trajectories currently awaiting Executive sign off.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	Fragmented care pathways and lack of community capacity. Estate - ageing infrastructure and lack of physical capacity in BGH Undeveloped digital systems Inadequate workforce - delayed decision making, inefficiencies, delayed diagnostics Financial barriers, Ceredigion is currently 509K over Month 2
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Dedicated NOF pathway QI project commenced march 25.	Community & Integrated Medicine	Chief Operating Officer	30/09/2025	30/09/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R1. (BGH) The long waits for admission from the ED are undoubtedly causing harm to patients and should be the main focus of any improvement work.	Revision of nurse staffing position underway to support dedicated triage and ambulance bay nurses to enhance care offered at times of handover delay/ support handover into RATS area- paper for Exec Team currently being prepared (06/03/25)	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	Work to introduce a discharge lounge has now been proposed for 2025/26 with a view to supporting up to 6 patients per day who currently would be delayed on wards – this will have a positive impact on flow.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	31/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R2. (BGH) The delays in ambulance to ED handovers of patients impair the response times for emergency ambulances and thus also cause harm to patients	A review of hospital flow (to include re-allocation of ward spaces) is due in 2025/26 to minimise bed clocking within the trauma / surgical pathway beds- which will improve emergency pathway access.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	If funding is not released this will delay things further.
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R3. (BGH) There are long stays in the ED for all patients that should be reduced	Above workstreams will also positively impact this issue	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	Consultant lead currently employed on a locum basis (only 1 wte). This is currently subject to recruitment to substantiate the post.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R4. (BGH) The lack of ED senior medical staff must be addressed. However, the future viability of the department may require a different model in the long-term	Interim County Director has instigated a review of ED staffing models in March 2025 with a view to generating a proposal to increase consultant cover.	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R5. (BGH) The high catchment attendance level suggests that there are poor alternatives to ED attendance in the local area, probably including primary care	There is no significant local health provision with the exception of primary care services and the 111 system along with community nursing teams. In the south of the county, a Same Day Urgent Care (SDUC) facility has been introduced. The ambition is to launch a phased SDUC model from Aberaeron ICC- which will have a positive benefit/ reduction in ED attendances, and this has been considered in planning and trajectory assumptions for the 2025/6 financial year. Ceredigion is currently supported by a streaming hub- in line with the SDUC expansion, development of a HB wide streaming facility will improve patient flow by signposting to more appropriate resources. Decision making on a HB basis will ensure consistency in approach to advice offered to patients following clinical assessment of need.	Community & Integrated Medicine	Chief Operating Officer	28/02/2025	28/02/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R8. (BGH) There are no housekeepers, dedicated porters or several other non-clinical roles in the ED. With a relative shortage of nursing and other clinical staff, it makes no sense not to have a wide range of supporting non-clinical staff.	2 dedicated domestic assistants currently deployed within dept. Budgetary constraints prevent dedicated porter and housekeeper appointments. Review of nurse staffing position is a priority in terms of any financial considerations at this time	Community & Integrated Medicine	Chief Operating Officer	31/03/2025	31/03/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R9. (BGH) The relatively high number of hospital admissions per WTE consultant (all health board consultants) suggests that there is an insufficient senior medical workforce to “power” the hospital beds in a timely and efficient way that ensures good patient flow.	A medical staffing stabilisation programme has commenced at BGH with the support of the medical workforce team with a view to improving workforce intelligence- to include confirming total locum opportunities and any opportunities to substantiate positions.	Community & Integrated Medicine	Chief Operating Officer	31/08/2025	31/08/2025	

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R10. (BGH)There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope, specialties and hours of availability. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED (currently high at ~85%).	Space within the hospital footprint is significantly constrained. However, there is potential to introduce SDEC areas and principles into the following areas: •ED Rapid assessment area •Medical Day Unit •Oncology triage and assessment in Meurig Ward (X2) when reopen.	Community & Integrated Medicine	Chief Operating Officer	31/07/2025	31/07/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R15. (WGH) There are long stays in the ED for all patients that should be reduced.	WGH do have clear pathways for patients. Medical teams in reach to start the treatment plan from admission. Need to reduce access points to in-patients wards. Need to de- surge assessments units to keep flow active. Boarding protocol in place. Need to consider continues flow.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R20. (WGH) There is definitely a case for an increase in SDEC and urgent clinic spaces. The current SDEC is limited in scope and specialties involved. This is an important way of getting more specialty involvement in emergency care and will reduce the proportion of emergency admissions that traverse the ED and the number of admissions.	SDEC is open form 8-8 Fully staffed Approx 60% of the medical take does attend SDEC. Planning for complex streaming at front door. Frailty SDEC – need to de surge unit. Unit to take direct from ED and will start to take referral direct form WAST, therefore, to avoid ED. HOT clinics in medical specialities already in place (manged by the medical Consultants)	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	It needs financial investment

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R21. (WGH) Transfer arrangements to other hospitals must also be improved. There is no onsite paediatrics, and we were told that visiting paediatricians, working in outpatient clinics, refuse to support the ED in emergency situations. Moreover, children who require transfer to paediatric inpatient units are not accompanied by an anaesthetist, unless an endotracheal tube is in-situ. This lack of support for the ED is unacceptable and does not reflect a positive view of the importance of safe patient care.	Clear pathway already in place for paediatrics. A designated ambulance is on standby outside ED for transfers.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R23. (WGH) Data quality must be improved.	Regarding validation of breaches WGH does have admin staff working with the SNM to undertake this request. SNM to ensure clinical team engagement and discussion relating to thematics surrounding breaches and assurance of correct data validation.	Community & Integrated Medicine	Chief Operating Officer	31/10/2025	31/10/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of ED space completed. Limited capacity within existing footprint. Exploring alternative space within Medical Day (Podiatry) to support increased medical take away from ED. Front Door T&F Group implemented with alternative options being explored.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	30/05/2025	Capital Funding (WG)
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R24. (GGH) The ED is small and cramped and desperately needs more space, if it is to accommodate large numbers of patients waiting for a hospital bed. However, better patient outflow from the ED is obviously required. The current situation is clearly causing increased risk and harm to patients and is distressing for staff.	Review of current GGH space (ED/CDU/MDU and external environment) to explore additionality/re-purpose of space to support and reduce impact at front door (ED).	Community & Integrated Medicine	Chief Operating Officer	16/05/2025	16/05/2025	Workforce challenges/culture/resistant to change/ environmental factors/ equipment.

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R25. (GGH) The ED is used by the hospital as a general waiting room for all specialties and input to the ED by inpatient specialists is poor. The implementation of Internal professional standards is urgently required.	Speciality Pathway Reviews underway. Surgical SDEC (Phase 1 Complete). Pilot of Trauma Ambulatory Care Unit underway. Review of Urology, ENT & Gynae Pathways. Internal Professional Standards have been disseminated by Deputy Medical Director. Formal monitoring arrangements to be agreed. Deputy Medical Director currently aligning speciality specific pathways from ED in line with professional standards. 05/09/2025 - Internal Professional Standards now drafted. Implementation through the Medical Directorate and Clinical Leads required.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R27. (GGH) Ambulances wait outside the ED for long periods.	Boarding protocol implemented with patients boarded against predicted discharges. Safety Huddles, Patient Flow review. Emergency Pressures and Escalation Policy (489) Role of the Senior Nurse Manager, Clinical Site Manager and 'Manager of the Day' strengthened, supporting key escalation of actions, status and risk. Optimal Flow Framework implementation: -OS Reviews & Escalation process review -Board round monitoring & Frontier usage -Criteria Led Discharge -Repatriation Database -POCD monitoring Initiatives to facilitate admission avoidance: -Streaming Hub -Virtual Ward -Re-direction Policy (Draft) -Perfect week (Jan 25) completed with some initiatives adopted as business as usual (GP medical take via SDEC). -Optimised Weekend working Pilot planned (22/23 March).	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R28. (GGH) The departmental configuration makes imaging difficult to access in a timely way. However, the suspected cauda equina syndrome (CES) pathway is good	Review completed and ED & SDEC radiology request prioritisation agreed – requires further measurement of data to determine impact. OOH Cauda Equina pathway review being undertaken.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R31. (GGH) SDEC will take GP referrals (and some ambulance referrals) directly but closes at 8pm and only accepts new patients up to 5pm. There is a poor flow of patients to SDEC from the ED.	Change in pathway for medical referrals from GP to GGH SDEC (embedded since perfect week). SOP being updated. Optimised Weekend working Pilot planned (22/23 March) will include SDEC	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	

Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R32. (GGH) The co-located MIU is ENP-led, with patients streamed from the ED reception. The out-of hours primary care centre will not accept patients from the ED	OOH's primary will accept patients as per re-direction policy – pending sign off.	Community & Integrated Medicine	Chief Operating Officer	31/05/2025	31/05/2025	
Peer Review - Getting It Right First Time (GIRFT) - Emergency Medicine June 2024	R33. (GGH) The shortage of senior medical staff and registered nurses must be addressed.	ED Consultant Recruitment – process underway. Safe Staffing Review (RN) has been progressed over last 18 months with key recruitment. Further reviews planned (B2/B3)	Community & Integrated Medicine	Chief Operating Officer	30/06/2025	30/06/2025	
Peer Review (external review) of Hywel Dda University Health Board (HDUHB) of care delivery to people with epilepsy and learning disability	As part of understanding of the challenges within the service, a multi-stakeholder survey was conducted which has yet to be analysed. There were 37 replies in the first round and three in the second round. The results of these will form a baseline on the current understanding and expectations of the service. These could be presented to all stakeholders including experts by experience. To use the results of the survey to empower workshops involving all stakeholders including experts by experience to discuss meaningful change. The same survey i.e., the Purple Light Toolkit could be rolled out in another 12-18 months' time to understand how things have changed locally in the community and what are the critical gaps remaining. (Medium term plan (6 months to a year))	To liaise with research and development colleagues to establish the stakeholder's current understanding and expectations of the service.	Mental Health and Learning Disabilities	Chief Operating Officer	29/03/2024	29/03/2024	

Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to carry out a full demand and capacity assessment with Primary Care, AHPs and in collaboration with neighbouring Health Boards. Together they need to develop standardised pathways of common gynaecological symptoms that should also include the mutual aid across health boards to enable more effective triage. This will also feature as a National recommendation in the all Wales report.	(EXTERNL) Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	Lack of engagement with primary care and neighbouring health boards
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to establish a robust mechanism for capturing procedure level data of in-patient, day case and out-patient (ambulatory) procedures in gynaecology. HDUHB should also develop a mechanism to capture diagnostic procedure coded operations of emergency Surgery (management of ovarian cysts, miscarriage/ectopic pregnancy and sepsis requiring surgery). This will be a recommendation in our all Wales Report.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) - Gynaecology Review - September 2022	HDUHB to undertake a review of the therapeutic pathway of early pregnancy complications in order to improve timely management of care. The availability of staff able to perform ultrasound scanning to be included in this review.	Awaiting management response from service	Planned & Specialist Care	Chief Operating Officer	30/09/2022	30/09/2022	
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	Introduce standardised risk (in line with College guidance) and priority ratings for cataract surgery and change waiting list forms to support this	1) Review current waiting list forms and agree clear priority ratings. 2) Develop protocol to align with waiting list forms with clear priority ratings. 3) Implement new waiting list forms.	Planned & Specialist Care	Chief Operating Officer	30/04/2024	31/10/2025	
Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	Non-medical MDT staff admitting the cataract patients should be trained and empowered to mark the eye, check or take consent etc – consider whether to involve the clinical nurse and optometrist practitioners and/or train the day surgery staff. Do not do routine obs on the day.	1) Review staff training to mark the eye with Senior Nurse Manager. 2) Review process for baseline obs	Planned & Specialist Care	Chief Operating Officer	30/04/2024	31/07/2025	Staffing sickness levels impacts upon training and development within the ophthalmology roles.

Peer Review Getting It Right First Time (GIRFT) Ophthalmology Review	Establish staggered patient arrival times to reduce the patient journey time. Explore how discharge process can be shorter.	1) Align staggered arrival times in line with consent in pre-assessment (outlined above). 2) Review of current discharge processes across site and standardise documentation and processes.	Planned & Specialist Care	Chief Operating Officer	30/04/2024	31/07/2025	

CORPORATE RISK REGISTER SUMMARY OCTOBER 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Oct-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
2086	Risk that the cash consequences of the Health Board deficit cannot be covered by WG should it exceed our Target Control Total	Thomas, Huw -	Finance inc. claims	**4×5=20**	**3×5=15**	↓	**3×4=12**	31/12/2025
1350	Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	**4×4=16**	**4×4=16**	→	**2×4=8**	31/03/2026
2104	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 25/26 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	**3×4=12**	**3×4=12**	→	**3×3=9**	~~30/09/2025~~ 31/03/2026

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
Detailed review of relevant information	
Medium level review	
Cursory or narrow scope of review	

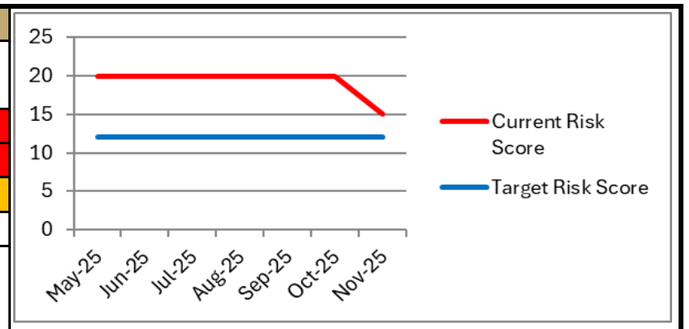
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Apr-25	**Executive Director Owner:**	Thomas, Huw -	**Date of Review:**	Nov-25
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Finance and Performance Committee	**Date of Next Review:**	Dec-25

Risk ID:	**2086**	**Corporate Risk Description:**	There is a risk that Welsh Government are unable to fund the cash consequences of our deficit should it exceed our Target Control Total (TCT) of £24.1m, which is the level indicated of cash coverage available. This is caused by This is caused by the Health Board's potential inability to achieve its required total savings of £52.3m (£46.4m from the £30.0m revised planned deficit, plus an extra £5.9m to achieve £24.1m) for 2025/26 due to: 1. insufficient conversion of the £19m operational and clinical determined recurrent savings plans into deliverable actions 2. insufficient conversion of required £31m non-recurrent savings into budgets in the year 3. the requirement to deliver further £2m of savings to address the Health Board's National Insurance shortfall 4. the requirement to reduce investments by £1.5m 5. The requirement to deliver further savings or cost reductions of £5.9m This could lead to an impact/affect on our ability to meet our statutory targets, but exceeding the TCT would also mean that: 1. We will have insufficient cash available to make payments to suppliers in March 2026; 2. We will have to take actions which may have a detrimental impact on our performance measures, and may mean patients having to wait longer for care; 3. Our reputation with Welsh Government and other stakeholders is adversely affected; 4. Further escalation for finance from Targeted Intervention to Special Measures; 5. Our conditionally-recurrent funding of £26.0m being withdrawn by Welsh Government, impacting our ability to reach a sustainable medium term financial position.

Does this risk link to any Directorate (operational) risks?	2212, 2132, 2148, 2131, 2110, 1869, 1631, 975, 2107, 1906, 1892, 971, 2040, 2124, 2045, 1951, 716, 134, 1775, 1773, 1931, 1646.

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	3×4=12
Expected Date To Achieve TRS:	31/12/2025
Trend:	↓



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Correspondence received from Welsh Government (WG) during Q1 of 2025/26 confirmed that the current deficit plan is not supportable, with a revised and clear requirement to achieve a TCT of £24.1m. The focus is therefore: 1. To improve the assurance over recurrent and non-recurrent savings delivery to achieve the original plan of £31.5m, and the now revised annual plan of £30.0m; 2. To take choices to reduce the position further to £24.1m, requiring actions to be taken over August and September for a Board Seminar in September 2025 and submit actions for improvement to WG by 11 September. Actions undertaken by 11 September enabled the forecast financial deficit to improve to £27.8m. WG recognised the positive progress, but reaffirmed their expectation of realising a £24.1m deficit. 3. In a communication on 13 October 2025, the Health Board (HB) committed to progressing further actions from the opportunities, with a desire to improve the forecast deficit in Month 7. 4. The HB's exposure to a Welsh Risk Pool (WRP) risk is a minimum of £4.2m and maximum of £5.3m. It is assumed that WGs expectation is to achieve £24.1m excluding this impact. 5. The HB improved the reported forecast deficit to £24.1m (excluding WRP), in Month 7, following clarity on a £6.1m Aseptic Unit Drugs accountancy gain. The Month 7 reported position is now aligned to the TCT of £24.1m, and the likelihood score of the risk reduced from 4 to 3 in November 2025.	The Health Board (HB) had a historic challenge of controlling its cost base and delivering change. While significant improvements have been made to our control environment, significant challenges remain in our change management capabilities. These need to be addressed to achieve the target risk score. By 11 September 2025, the Executive Team sought to de-risk the financial plan to ensure its successful delivery, at which it was envisaged the current risk score being reduced to 16 if the savings gap has been materially closed with robust and deliverable schemes. A 'Financial Choices and Decisions' paper was presented to Public Board on 25 September, outlining the choices for the HB to achieve the £24.1m Target control total. By 31 October 2025, the Executive Team sought to have fully de-risked the financial plan to ensure its successful delivery, in order to allow the organisation to focus on planning for delivery of the medium term financial roadmap into 2026/27. Assurance from Clinical Care Groups that they have sufficient plans in place to deliver their savings target was not fully received through this process, and has resulted in the target risk score date being delayed to 31 December 2025 to allow the Executive Team more time to finalise their savings plans. Executive Improving Together meetings are scheduled for November 2025 to review progress where the expectation is that all areas will coordinate recurrent plans to address any remaining savings gaps. Welsh Government will receive a Strategic Cash Request by 8 December 2025, and should this be formally recognised and supported, the target risk score will be achieved, with the impact reduced.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1.Working Day 1 principles adopted within the finance function to ensure timely 'Flash reports' provided to the Executive Team. 2.Timely, relevant and understandable reporting provided to budget managers, Executives, Committees, Board and Welsh Government. This will be available live for self-service budget holders via QlikSense and monthly for management information packs. 3.Oversight arrangements in place through Integrated Quality, Financial Performance and Delivery Group, Value and Sustainability Group and the Healthier Mid and West Wales Group. 4.Executive Improving Together meetings and the Escalation Framework embedded across the organisation, which focuses on seven key domains, including Finance as one. 5.Financial Control Sub Group weekly scrutiny of agency medical, agency	There remain areas where there are gaps in controls. These are: 1. The effective management of rostering; 2. The effective management of beds; 3. Effective contract management arrangements; 4. Oversight arrangements over commissioned services. There is also a significant gap in the organisation's ability to deliver change.	The implementation of a rostering system across medical staff, and the extension of rostering to other staff groups.	Henwood, Mr Mark	~~31/07/2025~~ 30/11/2025	Progress update to be provided at next risk review
		Operational adoption of the new patient flow system across the Health Board.	Tracey, Anthony	31/01/2026	Progress ongoing, with roll out envisaged by November 2025.
		Agreement and universal implementation of one consistent medical rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Henwood, Mr Mark	31/01/2026	Progress update to be provided at next risk review

AHP, Admin and Clerical and newly created roles for recruitment and procurement. 6.Opportunities framework in place to identify areas of improvement potential across the Health Board, updated and shared monthly. 7.New operational structures in place since April 2025, providing managerial clarity and consistency that was not in place in historically. 8.Aligned finance support via the Business Controlling team to support, scrutinise and advise CCG/CSG and Executive Function management structures. 9.Accountability agreements issued in March 2025 and all signed and returned.	Agreement and universal implementation of one consistent AHP rate card spanning all locations and all services to align the rates of pay paid to staff irrelevant of specific circumstances.	Severs, James	~~30/09/2025~~ 30/11/2025	Progress update to be provided at next risk review
	Finalise the implementation of the substantive operational management structure via the ongoing COO OCP, ensuring all audit recommendations are completed and accountability structures are consistently deployed.	Carruthers, Andrew	~~30/06/2025~~ ~~31/07/2025~~ 31/12/2025	Updates to Structured Assessment recommendations raised by Audit Wales have been confirmed as completed in June 2025, and will be submitted to Audit Wales for review in July 2025. Consistent deployment of governance arrangements are monitored via the Health Board's Internal Escalation Framework, and a review of the effectiveness of these arrangements is planned to be undertaken by Internal Audit during Q2/Q3 for evidencing the completion of the further action required. Action date has been revised to reflect the completion of noted internal audit.
	Consideration of the organisation's change management capacity and alignment of change and transformation management resources.	Gostling, Lisa	~~31/08/2025~~ 30/11/2025	Progress update to be provided at next risk review
	Embed a monthly routine within the Clinical Care Group and Executive Functions business meetings for the Compendium of Variation, creating a summary report for inclusion within the Financial Performance Report for Executive Team, Financial and Performance Committee and Board.	Jenkins, Sian	~~30/09/2025~~ 31/12/2025	Business Intelligence team are refreshing the Compendium of Variation and reviewing access and reporting arrangements ahead of a re-launch to raise awareness amongst newly formed CCG leadership teams - target completion date 31/10/25. This will enable the subsequent reporting.

				Further actions and choices to be taken based on discussion at Board in July which could deliver £6m of further savings. This requires QIAs to be delivered by 15 August for F&P consideration in August; a Board Seminar in September and submission to WG by 11 September.	Thomas, Huw -	~~30/09/2025~~ 30/11/2025	Further to the discussions held at Executive, Board and Welsh Government level during August and September 2025, a paper outlining the financial choices for the Health Board to be presented at September Board on 25 September 2025. Ongoing work from CCG structures to confirm updates.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through key performance indicators. In-month financial monitoring and forecasting for the remainder of the financial year.	Performance against plan monitored through Executive Improving Together Meetings.	1st			Finance and Performance Committee - October 2025 Board - November 2025	Delivery of limited assurance internal audit reports particularly, in areas which have a financial impact: 1. Discharge management; 2. Bed management; 3. Nursing and healthcare support worker roster management. 4. Medical roster management. Delivery of change is a longstanding issue for the Health Board.	Closure of audit recommendations arising from Discharge Management and Management of Bed Capacity internal audits	Carruthers, Andrew	~~31/07/2025~~ ~~30/09/2025~~ 30/12/2025	The recommendations as raised within the Management of Bed Capacity internal audit, issued in February 2025 were formally closed by internal audit as completed in June 2025. Recommendations as raised within the Discharge Management internal audit have been subject to a follow up review. As at October 2025, one recommendation remains outstanding with a revised date of completion awaited from the service.
	Finance and Performance Committee oversight of current performance	2nd					Closure of audit recommendations arising from Nursing roster management audit	Daniel, Sharon	~~30/05/2025~~ ~~31/08/2025~~ 31/12/2025	Recommendations as raised within the Discharge Management internal audit have been subject to a follow up review, with a revised report presented to ARAC in August 2025. As at October 2025, one recommendation remains outstanding with a revised date of completion noted of December 2025. Risk action date has been amended to reflect this development.

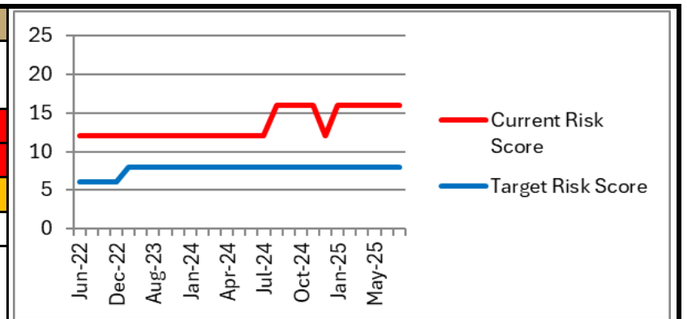
Transformation & Financial Report to Board & Finance and Performance Committee	2nd			Determination of change management capacity through alignment of resources across corporate functions.	Gostling, Lisa	~~31/08/2025~~ 30/11/2025	Progress update to be provided at next risk review
WG scrutiny through revised Monthly Monitoring Returns (specific supplementary templates) and through NHS Exec Financial Planning and Delivery team	3rd			Impact of the Executive Improvement Together sessions and Internal Escalation Framework have not demonstrated an improvement for services that are repeatedly/continuously highlighted as being in Level 3 for the Finance domain for escalation.	Thomas, Huw -	31/12/2025	Agree on the actions to be undertaken for services who are escalated to Level 4, where no progress has been demonstrated for prolonged periods whilst under Level 3 escalation. Board Seminar discussion planned for 11 December 2025.
Audit Wales Structured Assessment process	3rd						

Date Risk Identified:	Feb-22		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Nov-25
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Dec-25

Risk ID:	**1350**	**Corporate Risk Description:**	There is a risk of the Health Board not being able to meet the 80% target by March 2026 for waiting times in the ministerial measures for the Single Cancer Pathway (SCP). This is caused by by reduced capacity to meet the expected demand for diagnostics and treatment delays at our tertiary centre, and the fragility within key tumour sites. This could lead to an impact/affect on on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from Welsh Government. This could lead to adverse reputational damage as a result of inconsistent performance delivery over time.
Does this risk link to any Directorate (operational) risks?		1223, 114, 111, 1537, 1699, 1722, 1723, 797	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Expected Date To Achieve TRS:	31/03/2026
Trend:	⟷



Rationale for CURRENT Risk Score:
The service has been de-escalated by Welsh Government from Level 4 to Level 3 in terms of Targeted Intervention status as there has been the consistent achievement of the 60% de-escalation criteria since February 2025. As at July 2025 performance 61.4% Due to recovery actions within radiology and urology we may see variation in performance as we recover and treat those patients over 62 days, therefore the risk remains that cancer performance will not achieve 80% compliance by March 2026.

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times, which has now been confirmed as 80% non-adjusted March 2026. The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. When the target of 60% for 3 consecutive months is achieved the risk score can be reduced to a 12. The risk score can be further reduced to a 8 once the target of 80% is achieved. There are underpinning trajectories in place which are monitored on a monthly basis and adherence to those will influence the ability to achieve the target risk score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board are using of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitates the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Operational Delivery Group (ODG) meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money. Monitoring of Urology diagnostic improvement trajectory via Cancer Operational Delivery Group. # Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Planned Care and Cancer Services QSH meeting to ensure governance in line with the new operational structures implemented in April 2025.

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Anticipated significant gaps/service fragility within key diagnostic services to address required levels of activity to support SCP. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	Completed	Planning complete, moved to implementation/working with Primary care
	Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	31/01/2026	To be implemented as part of the agreed Radiology investment 25/26 Target date for recruitment January 2026
	Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	31/03/2026	Work on hold until next financial year
	Due to increased demand for dermatology treatments the service need to aquire 2 additional MOP Treatment areas	Wisdom, Ceri	Completed	SBAR being presented to the Care Group Board meeting in June.
	Highest volume of patients awaiting Urology diagnostic procedures. Urgent action required to reduce overall volumes and volumes waiting over 28 days.	Griffiths, Neil	Completed	Detailed demand capacity planning to include the RTT component to identify the actual demand capacity gap to inform the options for solution
	reduce Urology diagnostic volume by 100 patients by reducing cystoscopy and prostate awaiting MRI	Griffiths, Neil	Completed	Work now completed and delivered

# Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and 28 days for Diagnostics. # One to one escalation meetings held with Cancer ODG leads and Tumour Site Service Managers for tumour sites that require intervention. # New Endoscopy booking process which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways. # One Stop Hysteroscopy within Gynaecology implemented in May 2024 at Bronglais General Hospital, with plan to implement across all sites during Q1 of 2025/26. # Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy # Health Board wide internal escalation framework now in place to support the monitoring of performance targets, with a TI de-escalation target of 60% for three months. *Additional radiology reporting sessions in place agreed for 2025/26. *Skin treatment recovery plan in place to end June 25 to reduce overall treatment volumes. To be reviewed quarterly.		Outsourcing of MRI for Urology increasing capacity - from 4 per week to 20 per week	Griffiths, Neil	Completed	Outsourcing for MRI commenced 27th October 2025

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually that have the biggest impact on overall performance Skin Urology	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer	None identified.	Establish Operational improvement group to track improvement projects in line with NOP and Annual Plans	Goode, Paula	Completed	Plans to establish a Cancer Transformation Task and Finish group which reports into the CCG transformation hub. On hold due to formation of Care Group structure

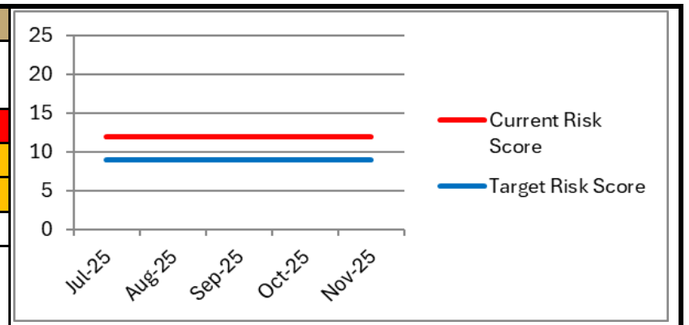
LGI Gynaecology Breast Reducing component waits Patient waiting more than 14 days for first OPA Patients waiting a diagnostic procedure and report more than 28 days Patients with a confirmed diagnosis of cancer waiting more than 62 days	IPAR Performance Report to S&PC & Board	2nd			Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22				
	Monthly oversight by NHS Executive/WG	3rd							
	Revised Governance arrangements in place since April 2025 with matters escalated when required via the CCGs governance arrangement								

Date Risk Identified:	Apr-25		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Nov-25
Lead Committee:	Finance and Performance Committee	**Date of Next Review:**	Jan-26

Risk ID:	**2104**	**Corporate Risk Description:**	There is a risk of non-delivery of planned care ministerial targets by March 2026. This is caused by a mismatch between demand and current/forecast capacity in key specialties, workforce limitations, and the impact of the Health Boards' financial forecast for 2025/26, which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets (No patients waiting over 52 weeks for their first outpatient appointment and no patients waiting over 2 years from referral to treatment). This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence, and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×3=9
Expected Date To Achieve TRS:	31/03/2026
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The combined impact of cohort demand in key specialties and workforce limitations all pose a risk to full achievement of ministerial planned care recovery targets by March 2026. Additionally, Theatre cancellations due to staff shortages in Glangwili General Hospital have negatively impacted core capacity. Specifically in Orthopaedics there is an additional demand in longer waiting patients (cohort) verses recurrent demand. Recovery funding for 25/26 has been prioritised for areas where high level Demand & Capacity (D&C) modelling identified capacity gaps. The Annual Plan, approved by the Board in March 2025 highlighted delivery risks in Ear, Nose and Throat and Rheumatology (Stage 1) and Ophthalmology, Dermatology, Gynaecology, Urology and Cardiology at S4. The Welsh Government recovery allocation (£2.8m) has been split accordingly to progress delivery solutions in these areas. Sine approval of the annual plan additional risks to delivery have arisen in General and Geriatric medicine. Whilst delivery plans for 2025/26 reflect positive progress in increasing outpatient activity & treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in the above specialties. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status. Opportunities have been explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board in Ophthalmology and Orthopaedics to support further recovery of waiting times. Both specialties have been prioritised for active exploration of regional solutions, in partnership with Swansea Bay University Health Board (SBUHB), to expand available capacity and address forecast shortfalls against anticipated demand including the utilisation of Neath Port Talbot theatres for Orthopaedic activity. Notwithstanding these delivery risks, breach volumes in respect of the Stage 1 52 weeks are expected to be resolved by March 2026. Forecast breach volumes in respect of the Total Pathway 104 week target remain in Orthopaedics in Q1 although monthly breach performance shows continued improvement after Q2. Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and, whilst delivery risks remain, the current risk score has been scored a 12.	The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indications for future improvements in waiting times in 2025/26 onwards. The care group propose to be in balance by the end of the financial year. Opportunities to make further progress towards the Ministerial targets in 2025/26 will continue to be explored, including exploration of the regional opportunities referred to.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Quarterly review of job plans, with ongoing recruitment. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals developed to utilise the additional recovery funding committed by the Board # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated	# Workforce staffing availability to support further expansion of theatre capacity # Sufficiency of Anaesthetic medical staffing capacity to support further expansion of required operating lists. # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review. # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Recommence insourcing / outsourcing solutions in July 2025/26 within Orthopaedics and to remain in place for duration of Q2 2025/26	Humphrey, Lisa	Completed	Agreed start date 1st August 2025
		To establish utilisation of NPT theatres as part of joint regional working	Humphrey, Lisa	Completed	Progress update to be provided at next risk review
		Maximise GIRFT recommendations to increase capacity to four joints per list within Orthopaedics	Gregory, Lianne	31/12/2025	Progress update to be provided at next risk review
		Insource theatre staffing within GGH theatres for four lists ENT, and two lists Ophthalmology to commence in July 2025 and to remain throughout Q2	Humphrey, Lisa	Completed	Progress update to be provided at next risk review
		Outsource tonsilectomies - 43 cases to commence in July 2025 and to remain throughout Q2	Lewis, Caroline	Completed	Progress update to be provided at next risk review
		Outsource ocular plastics within Ophthalmology to commence in July 2025, and to remain throughout Q2	Coppack, Victoria	Completed	Progress update to be provided at next risk review
		Q2 recovery actions being pursued to mitigate specialty specific delivery risks in Stage 1 Care of the Elderly (COTE)	Goode, Paula	Completed	Progress update to be provided at next risk review
		Recruit 10 WTE as per theatres plan agreed by ET	Sheldon, James	31/12/2025	In progress

Quality, Financial Performance Delivery (IQFPD) fortnightly, as part of revised Targeted Intervention governance arrangements. # South West Wales Regional Orthopaedic Delivery Programme established # South West Wales Regional Ophthalmology Programme # Assurance monitoring arrangements in place via mechanisms including weekly RTT Watchtower and monthly reviews with NHSE # AI based assessment tool, enhancing risk stratification of patients to be assessed by the POAC (Pre Operative Assessment Clinic) service, enabling improved management of demand and prioritisation of patients to be clinical assessed. # Additional outsource & insource solutions in place to supplement capacity in orthopaedics and ophthalmology.		Explore insourcing/Outsourcing opportunities with alternative providers for Q3 given the deteriorating theatre staffing position and the contracting issues with HBSUK	Humphrey, Lisa	31/10/2025	in progress

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2025/26 Monthly performance is reported at each executive meeting, the Finance and Performance Committee and WG IPQD. Various Theatre papers have been to Board for discussion.	None				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	Welsh Government IQFPD & Enhanced Monitoring Meetings	3rd								

2

9:50 AM, 0 Mins

---

2 - ESCALATION OVERVIEW

2.1

9:50 AM, 10 Mins

2.1 - ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

Shaun Ayres (Hywel Dda UHB - Director of Delivery)

For assurance

Attachments

Escalation Oversight and Highlight Report FPC 16 December 2025.pdf



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Escalation Oversight and Highlight Report

Finance and Performance Committee, 16 December 2025

The Integrated Position: A Story of Contrast Across Five Key Domains

FINANCE

Favourable forecast (**£1.7m**) in M8, before a further non-recurrent allocation for the WRP and Band 2-3 which has now resulted in a revised TCT £22.1m. However, a **£59.3m** underlying deficit.



URGENT & EMERGENCY CARE

Ambulance handovers met (**Green**), but DTOCs and 12-hour waits remain significantly off-target (**Red**).

R1 OPHTHALMOLOGY

Performance at **37.5%** vs. 65% target; recovery plan assessed as **unrecoverable**.



LONG TERM AGREEMENTS

Top financial pressure (**£1.9m**) with significant coding and charging **risks** being actively challenged.

MEDICAL STABILISATION

Key control programme making **progress** but still mitigating a major **£6.6m pressure** from locum/agency spend.

Summary: Balancing Progress Against Structural Challenge

The five domains must be considered as an interconnected system. Success in UEC creates capacity elsewhere; failure in Ophthalmology and Finance constrains the whole organisation.

What's Working

UEC De-escalation Achieved for < 1-Hour Ambulance Handovers

Ambulance handovers <1hr target met for 3 consecutive months — driven by genuine operational improvements at Glangwili and Withybush.

Financial Position Favourable

In-year savings identification (£48.5m) exceeds target.

Workforce Controls Tightening

Zero non-direct agency bookings. £160/hr cap enforced. Allocate rostering and Rate Cards on track.

What Requires Attention

Ophthalmology Recovery Unachievable

37.5% vs 65% target. Would require 10x current trajectory — no historical precedent. 51% of 9,237 pathways >100% breach.

Structural Financial Gap Persists

£59.3m underlying deficit remains stubborn. however, the challenge remains in converting these from non-recurrent to recurrent.

System Flow & LTA Exposure

DTOCs deteriorating (207 vs 174). Withybush 12hr waits double target. £1.9m SBUHB pressure; 83% uncoded.

R1 Ophthalmology Performance (Waits)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Executive Summary

R1 ophthalmology performance remains significantly below both the 65% escalation target and the 95% standard. As of October 2025, only 37.5% of combined R1 pathways are within their target date (plus 25% tolerance), against an escalation framework requirement of 65%. The Committee is asked to note that achieving 65% by March 2026 would require improvement at approximately ten times the current rate, which has no precedent in the service's recorded history. A full-year average of 65% for 2025/26 is no longer mathematically achievable.

Current Position (October 2025)

Category	Total Waiting	Within TD+25%	R1 %	Gap to 65%
Combined R1	17,998	6,757	**37.5%**	4,941
New R1	4,251	1,076	25.3%	1,687
Follow-up R1	13,747	5,681	41.3%	3,254

The combined R1 waiting list currently stands at approximately 18,000 patients, of whom 11,241 (62.5%) are beyond their target date plus 25% tolerance. Notably, 9,237 pathways (51.3% of the total list) are 100% beyond clinical target date; indicating a deep structural backlog that has accumulated over several years.

Year-to-Date Trajectory (April–October 2025)

During the first seven months of 2025/26, combined R1 performance has improved modestly from 34.4% to 37.5%, a gain of 3.1 percentage points at an average rate of approximately 0.5 percentage points per month. The total waiting list has reduced slightly from 18,338 to 17,998 (a reduction of 340 pathways, or 1.9%).

However, the trajectory differs markedly between new and follow-up pathways. New R1 performance has deteriorated from 27.5% to 25.3% despite a reduction in list size, indicating that patients are breaching faster than they are being seen. Follow-up R1 performance has improved from 36.9% to 41.3%, though this remains far below target and the [illegible]st continues to grow.

R1 Ophthalmology Performance (Waits)

Achievability of 65% Escalation Target

Full-Year Average

A 65% full-year average for 2025/26 is now mathematically unachievable. With seven months at an average of 35.3%, the remaining five months would need to almost double to achieve the annual figure of 65%.

March 2026 Snapshot

To achieve the 65% target by March 2026, achieving this would require:

- An improvement of 27.5 percentage points over 5 months (from 37.5% to 65.0%)
- A sustained rate of 5.5 percentage points improvement per month
- Approximately 1,000 additional pathways per month to move into the compliant cohort

This required improvement rate is approximately **ten times the current trajectory**. To put this in historical context, the best five-month improvement ever recorded in this service was 7.5 percentage points (January to June 2021). The required 27.5 percentage point improvement would be **3.7 times greater than the best performance ever achieved.** Conversely, using the current rate of improvement of 3.1percentage points, we would need to improve by around the order of 10 -12 times our current rate.

Probability Assessment

Target Scenario	Required Rate	vs Current Rate	Likelihood
45% by March 2026	1.5pp/month	3× current	Possible
50% by March 2026	2.5pp/month	5× current	Unlikely
65% by March 2026	**5.5pp/month**	**10× current**	**Very Low**

Based on current trajectory, the most likely year-end position is between 40% and 45%, representing a shortfall of 20–25 percentage points against the 65% escalation target and annual plan.

R1 Ophthalmology Performance (Waits)

Committee Assurance Requirements

Given the **ALERT** rating and the scale of the performance gap, the Committee should seek assurance on the following:

1. **Escalation Framework Position:** What discussions have taken place with Welsh Government regarding realistic recovery trajectories, and what is the agreed position on the 65% target given that achievement within 2025/26 requires improvement without historical precedent?
2. **Demand Management Impact:** What is the current status of WGOS 4/5 implementation, what reduction in referral inflow has been achieved to date, and what further impact is forecast for the remainder of the year?
3. **Clinical Harm Review:** What systematic review is being undertaken of the 9,237 pathways beyond 100% of target date to identify patients who may be appropriate for discharge, alternative pathways, or prioritised treatment, and what is the governance framework for this review?
4. **Multi-Year Recovery Plan:** When will a realistic multi-year trajectory to 65% and 95% be presented to the Committee, including interim milestones, associated capacity requirements, and resource implications?

Recommendation

The Committee is asked to **NOTE** the current R1 ophthalmology performance position, the assessment that the 65% escalation target for 2025/26 is highly unlikely on current trajectory, and **SEEK ASSURANCE** from the team on the matters outlined above.

1. Executive Summary

Metric	Latest	Target	Gap	Trend	RAG
Ambulance handovers >1hr	606	680	-74 (-11%)	Improving	**GREEN**
12-hour ED waits	8.6%	7%	+1.6%	Improving	**AMBER**
Clinical assessment time	79 mins	60 mins	+19 mins	Worsening	**RED**
Delayed transfers of care	207	174	+33	Improving	**RED**

Ambulance handovers have achieved target for three consecutive months (September–November 2025), meeting de-escalation criteria. This is partly attributable to Prince Philip Hospital's performance, but Glangwili and Withybush have also demonstrated genuine operational improvement. Three metrics remain above target and have never or rarely achieved target in nearly three years of data. Withybush (16.1% 12hr waits) and Carmarthenshire (35% above DPOC target) require focused attention.

Statistical Approach

This paper applies consistent statistical analysis across all four UEC metrics:

Measure	What it tells us
Trend (per month)	The average rate of change over time. A positive trend means worsening; negative means improving.
Coefficient of Variation (CV)	How much a single metric fluctuates month-to-month. Lower CV = more stable and predictable; higher CV = more volatile with bigger swings.
Correlation	Whether two different metrics move together i.e. do months with worse performance on one tend to have worse performance on the other? A 'strong' correlation means they consistently move in step.
Statistical significance	Tests whether a correlation is likely to be real or just coincidence. A p-value below 0.05 means we can be confident the relationship is genuine

How to interpret CV and correlation together:

These measure different things. CV tells us about one metric in isolation (is it stable or volatile?). Correlation tells us whether two metrics move together.

Pattern	What it suggests	Example
Low CV + poor performance	Structural problem - consistently stuck at a bad level	Carmarthenshire DPOC (22% CV, 35% above target)
High CV + poor performance	Inconsistency - big swings, harder to interpret trends	Ceredigion DPOC (30% CV, swings 15-54)
Weak correlation	Two metrics don't consistently move together in monthly data	DPOC ↔ Ambulance (no clear link detected)
Strong correlation	Two metrics tend to rise and fall together	Ambulance ↔ ED waits (move in step)

Note: *When a metric has low CV (doesn't vary much), it is harder to detect correlations because there is less movement to compare. DPOC's relatively low variability (11% CV) means we should interpret the correlation findings with caution – a weak correlation doesn't prove there's no relationship, just that we can't detect one in monthly data.*

Data: 33 months from Welsh Government Targeted Intervention tracking. All metrics include data to November 2025. Same methodology applied to all metrics.

2.1 Ambulance Handovers Over 1 Hour

Site	Latest	Mean	Trend	Note
Hywel Dda	**606**	935	-7/mth	Target: 680 – achieved
Prince Philip	8	85	-1/mth	8-8 model – may be a factor
Glangwili	286	430	-5/mth	Strong improvement
Withybush	149	240	-0.4/mth	Below mean, improving
Bronglais	163	180	-1/mth	Below mean

Glangwili Hospital and Withybush Hospital have improved, suggesting genuine operational gains. Target achieved for 3 consecutive months (Sep–Nov 2025), meeting de-escalation criteria.

2.2 Twelve-Hour ED Waits

Site	Latest	Mean	Trend	Note
Hywel Dda	**8.6%**	9.5%	Improving	Target: 7% (never achieved)
Prince Philip	0.0%	1.8%	-0.1%/mth	8-8 model – consistently at target
Glangwili	9.8%	12.9%	-0.06%/mth	Improved but above target
Withybush	**16.1%**	15.2%	+0.03%/mth	Persistent outlier
Bronglais	9.0%	9.5%	Flat	At historical average

Withybush Hospital at 16.1% is more than double the 7% target and shows a slight worsening trend (+0.03%/month). This is the key site of concern for 12 hour ED performance. Glangwili has shown significant improvement (down from 12.9% mean to 9.8% latest) but remains above target.

2.3 Clinical Assessment Time

Current: 79 mins | Target: 60 mins | Gap: +32% | Trend: worsening (+1.0 mins/month)

All sites are failing the 60-minute target (Bronglais Hospital 80 mins, Withybush Hospital 70, Glangwili Hosital 86 mins as at November 2025). Glangwili shows the steepest worsening trend (+1.3 mins/month). This relates to clinical workforce capacity in ED rather than flow – the time for patients to see a decision-maker. Target achieved only 5 of 33 months.

2.4 Delayed Transfers of Care

Current: 207 | Target: 174 | Gap: +19% | Trend: -0.9/month (improving) | Best ever: 190 (still 16 above target)

County-level breakdown (November 2025 – latest available):

County	Delays	Target	Gap	Trend	CV
Carmarthenshire	**126**	93	+33 (35% above)	+0.3/mth	22%
Pembrokeshire	45	45	At target	+0.3/mth	24%
Ceredigion	28	30	Below target	-0.1/mth	30%

Carmarthenshire continues to show a slow worsening trend (+0.3/month). Its moderate variability (22% CV) suggests a structural problem rather than random fluctuation. Ceredigion's high volatility (30% CV) makes interpretation difficult – the recent improvement to 28 follows significant month-to-month swings. The overall Health Board position has never achieved the 174 target in 33 months.

3. System Relationships – What Does the Data Show?

We tested whether delayed transfers drive ambulance handover delays - a common assumption in UEC planning – against 33 months of data.

Relationship tested	Strength	Significant?
Ambulance handovers ↔ 12hr ED waits	**Strong (r=0.57)**	YES (p=0.001)
Delayed transfers ↔ Ambulance handovers	Weak (r=-0.05)	No (p=0.78)
Delayed transfers ↔ 12hr ED waits	Weak (r=-0.27)	No (p=0.12)

What this shows: Ambulance and ED waits are clearly linked. However, delayed transfers do not show a statistically significant relationship with ambulance performance in monthly data.

Important caveats: Monthly data may mask within-day pressures; threshold effects may apply; compensating actions (escalation capacity, increased discharges) may obscure the relationship. This does not disprove the accepted understanding that exit block affects flow.

Implication: Targeted front-door interventions can succeed – Glangwili and Withybush Hospitals have improved ambulance performance despite Carmarthenshire's worsening delayed transfers. A single 'silver bullet' is unlikely; each part of the pathway needs specific attention.

4. De-escalation Assessment

Metric	Criterion	Status	Likelihood
Ambulance >1hr	11% reduction maintained 3 months	3 months at target	**ACHIEVED**
12hr ED waits	≤7% at each site	Never achieved (0/33)	**LOW**
Clinical assessment	≤60 mins	Rarely achieved (5/33)	**LOW**
Delayed transfers	≤174	Never achieved (0/33)	**LOW**

5. Conclusions

1. **Ambulance target achieved - de-escalation criteria met.** Three consecutive months at target (September–November 2025). Possibly Part reflects Prince Philip Hospital's 8-8 model, but Glangwili Hospital and Withybush Hospital have genuinely improved.

2. **Three metrics remain significantly above target** and have never or rarely achieved target in nearly three years of data.

3. **Withybush ED is a persistent outlier** at 16.1% (more than double the 7% target) and showing a slight worsening trend.

4. **Carmarthenshire now drives the majority of the county-level DPOC gap** as Pembrokeshire and Ceredigion have reached their targets (for November). Carmarthenshire is 35% above target and continues to show a worsening trend.

5. **Monthly data shows no clear link between DPOC and ambulance performance**. This doesn't disprove the accepted relationship but suggests targeted interventions can succeed independently.

6. **Clinical assessment is likely a workforce issue** – all sites failing with a worsening trend (+1.0 mins/month), no correlation with other metrics.

Conclusion and Recommendations

The Finance and Performance Committee is asked to:

NOTE 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

RECEIVE 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.

ENDORSE - the development of realistic multi-year recovery trajectories for R1 ophthalmology and delayed transfers, with clear interim milestones, capacity and resource assumptions, and

SUPPORT - their inclusion within the three-year context of the Annual Plan and Targeted Intervention de-escalation framework for discussion with Welsh Government.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3

10:00 AM, 0 Mins

---

3 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

3.1

10:00 AM, 20 Mins

3.1 - URGENT AND EMERGENCY CARE AND SIX GOALS UPDATE

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

For assurance

Attachments

UEC and Six Goals Update FPC 16 December 2025.pdf



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Urgent and Emergency Care
Six Goals Programme Update

Finance and Performance Committee, 16 December 2025

The Challenge: A&E Units Under Pressure

High demand and complex patient needs continue to strain Accident and Emergency (A&E) services across all sites.

Ambulance handover delays, long waits in an Emergency Department (ED), and delayed discharges disrupt patient flow and impact patient experience.

Systemic bottlenecks: Capacity constraints, delayed pathways of care, and significant variability in performance between sites.

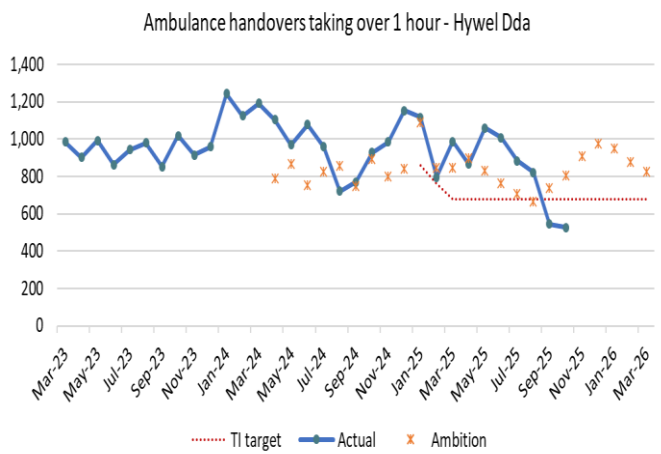
Patient experience:

- Extended waits and overcrowding, especially for vulnerable groups (elderly, complex cases).
- In October, 8.5% of patients waited over 12 hours in ED (target: 6%). This is a slight increase from September (8.0%), showing ongoing pressure despite improvement efforts.
- **Ambulance handover times** have improved overall, but a significant minority of patients still experience waits over an hour at some sites.

UEC Performance, Targeted Intervention Metrics

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ambulance handovers > 1hr

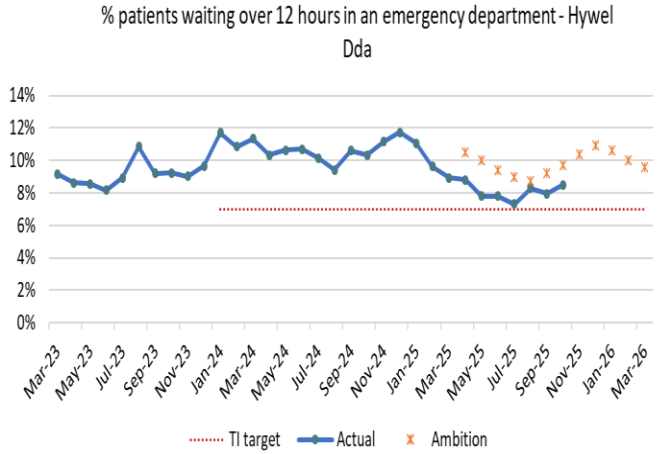


Current Performance:

Ambulance handovers > 1hr are 528 for October and continue to be below TI target of 680. Stats indicative of an improving position from September's data.

Over the last year the trend is indicative of an improving position

Patients waiting > 12 hours in an ED

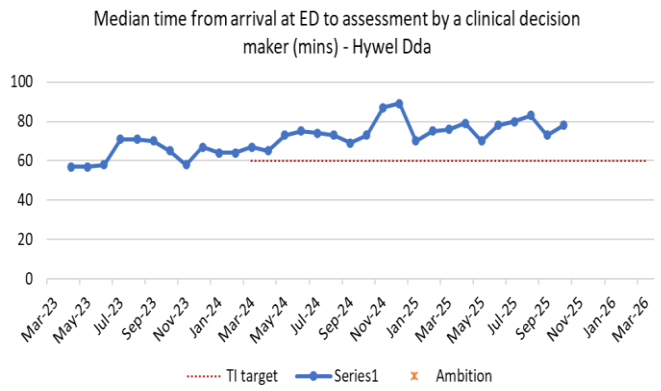


Current Performance:

October has 8.5% of patients waiting > 12 hours in an ED. This is above the TI target of 6% and up from 8% in September.

Over the last year the trend is indicative of an improving position.

Median time ED Arrival to Assessment

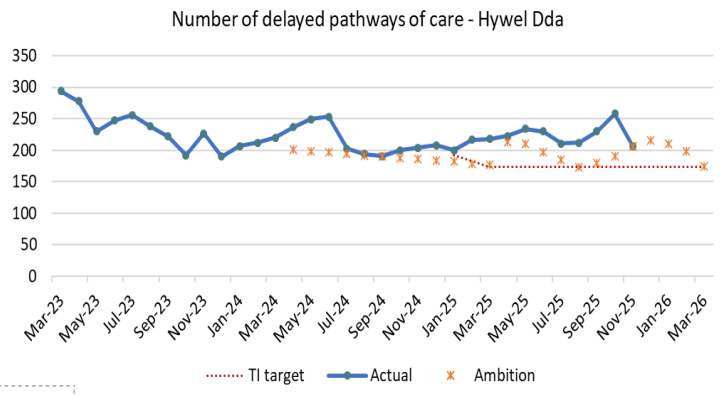


Current Performance:

October's average is 78 mins which is above the TI target of 60 and an increase on September's average.

Over the year the trend has been fairly static and is shown to be consistently above TI targets for this metric.

Number of Pathway of Care Delays

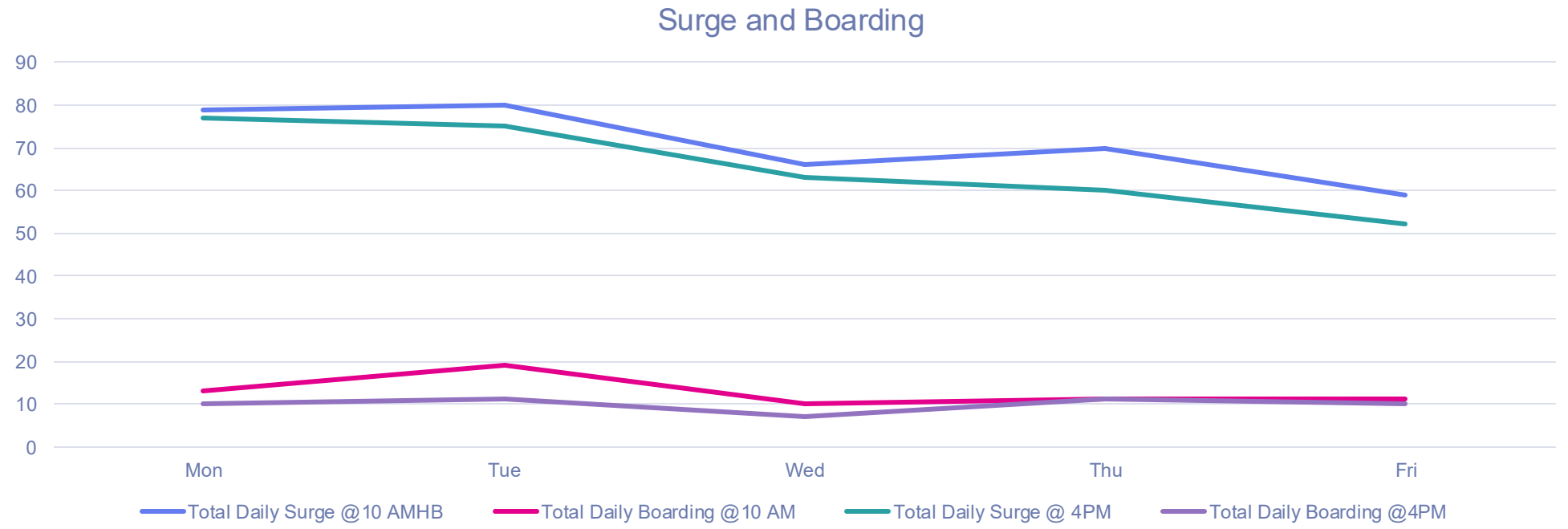


Current Performance:

In November the Health Board had 207 Pathway of Care Delays (POCD) which is above the TI target of 174.

This shows the lowest POCD since January 2025 and is a significant improvement on October 2025 data.

Surge and Boarding



The above graph presents surge and boarding counts at 10 AM and 4 PM across Bronglais Hospital, Glangwili Hospital, Prince Philip Hospital, and Withybush Hospital.

Surge Volume Patterns

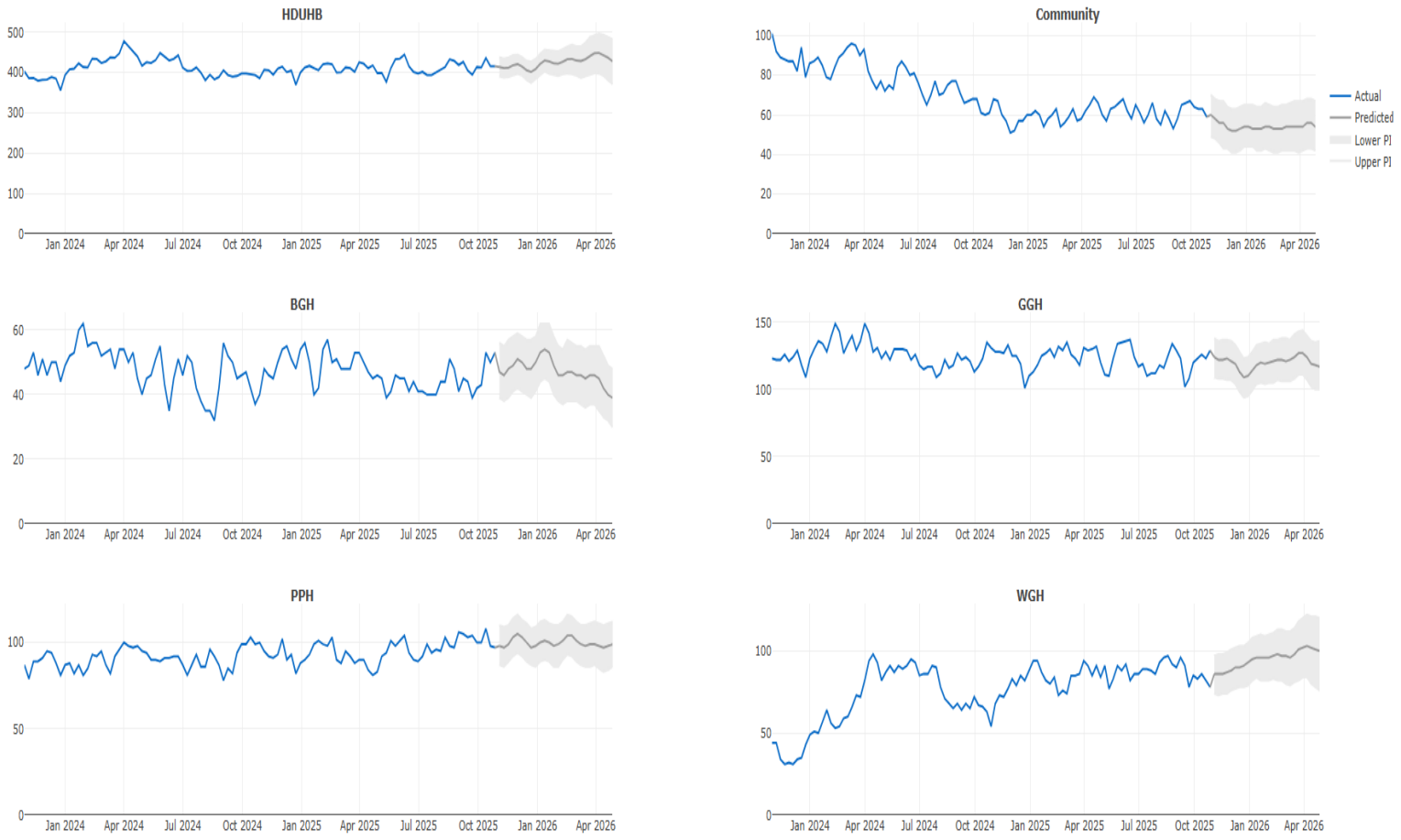
Glangwili Hospital consistently experiences the highest surge volumes, with morning counts ranging from 18 to 28 and afternoon figures from 10 to 27, indicating significant patient influx and potential capacity challenges

Boarding Count Trends

Boarding counts are generally low across all hospitals, with Glangwili Hospital showing the highest variability (4–8 AM, 4–8 PM), while Bronglais Hospital, Prince Philip Hospital, and Withybush Hospital maintain minimal boarding figures. These metrics are essential for understanding patient flow dynamics and identifying peak times that require enhanced staffing and resource allocation to manage patient surg

Average Length of Stay

Emergency Admissions with a Length of Stay (LOS) > 21 days, patients aged 18+



Patients with a LoS >21 Days
The graphs indicate a fairly static position over the last year for the Health Board in terms of average length of stay.

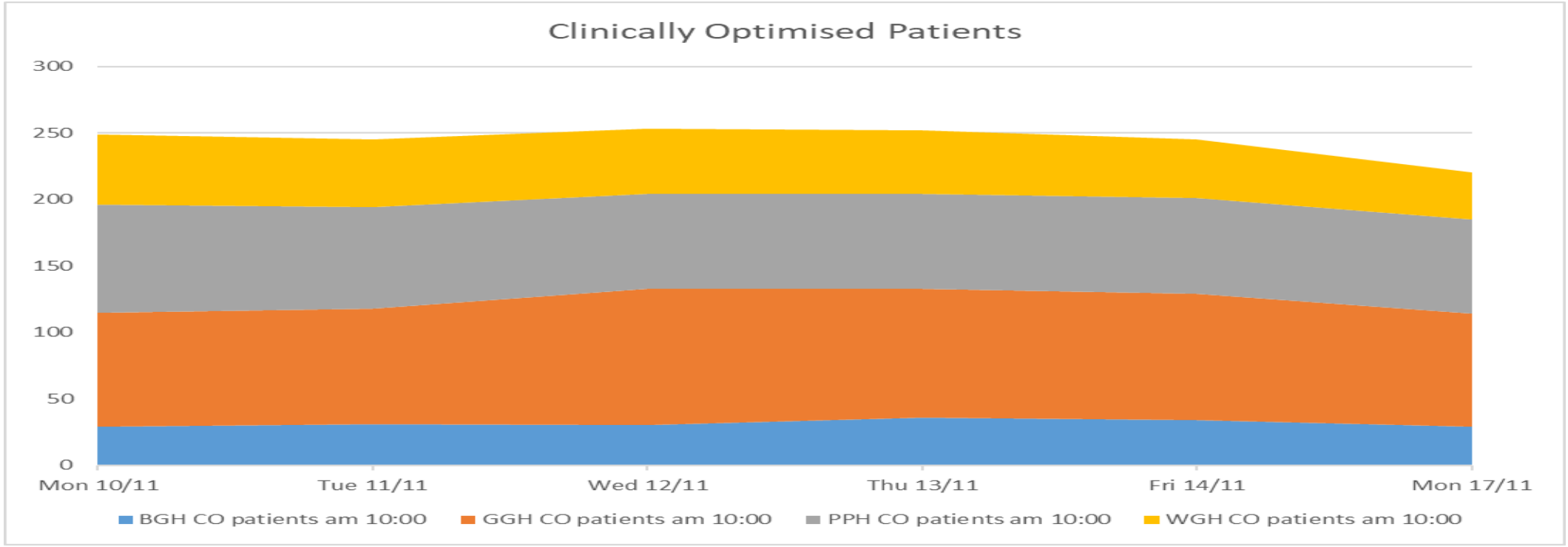
However, this is mainly driven through Community hospital admissions, both Prince Philip Hospital and Withybush Hospital show an increasing trend in this area.

Patients with LoS Over 50 Days
Glangwili Hospital and Prince Philip Hospital have the highest patients staying over 50 days, indicating discharge delays.

Declining LoS Trend at Withybush Hospital
Withybush Hospital shows a decline from 33 to 18 patients over 50 days, suggesting improved discharge processes.

Patients with LoS Over 100 Days
Prince Philip Hospital leads in patients staying over 100 days, highlighting significant long-term hospitalisations.

Clinically-Optimised Patients



Glangwili Hospital consistently has the highest patient counts, morning figures ranging from 86 to 103 and afternoon counts from 89 to 106, indicating a high patient load and potential strain on resources.

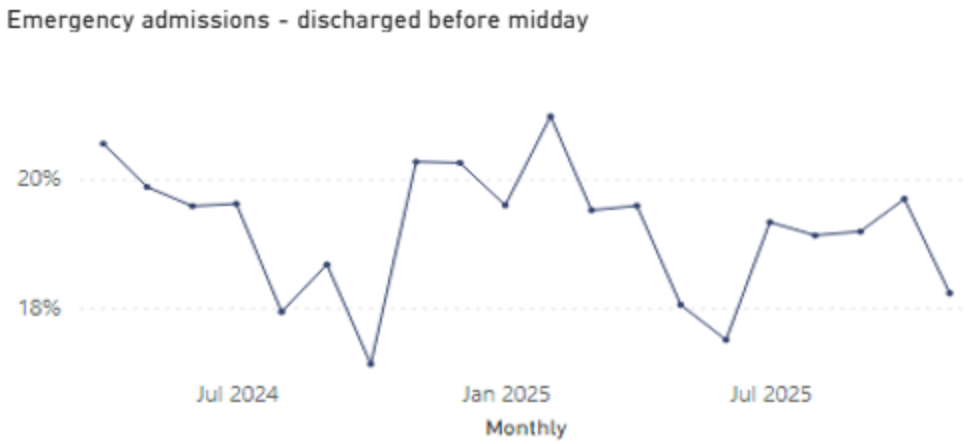
Prince Philip Hospital shows a slight downward trend but remains relatively stable around 70–81.

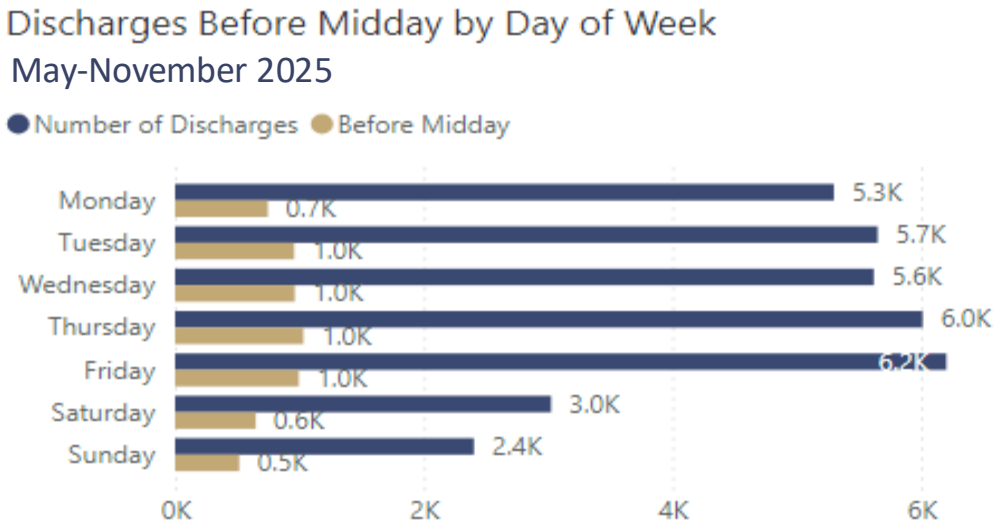
Bronglais Hospital fluctuates between 29–36, with a peak on Thu 13/11.

Withybush Hospital has the lowest counts and a clear decline during the we

35.

Discharges Before Midday





May-November 2025

5859	17.12%	28362	82.88%
Before Midday	Perc Before Midday	After Midday	Perc After Midday

Fragility: Operational and Systemic Strain

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Operational Fragility:

- **Ambulance handover times** are volatile, especially at Withybush Hospital and Bronglais Hospital.
  - Median handover times are 15–30 minutes, but at the 95th percentile, waits can exceed 3 hours at some sites (Bronglais Hospital, Withybush Hospital).

- **Discharge before midday** remains low, limiting bed availability for new admissions.
  - Average rates are 18% (Bronglais Hospital), 29% (Glangwili Hospital), 24% (Prince Philip Hospital), and 15% (Withybush Hospital).
  - **Surge volumes and boarding counts** highlight capacity pressures, especially at Glangwili Hospital and Withybush Hospital.

Systemic Fragility:

- **Pathway of Care Delays** are rising:
  - 258 delays in October (target: 174). This is a key metric showing the system's struggle to move patients through to appropriate care settings.
- **Long lengths of stay:**
  - Glangwili Hospital and Prince Philip Hospital have the highest numbers of patients staying over 50 days (40–45 patients) and over 100 days (10–15 patients). Withybush Hospital has fewer, but still notable, long-stay patients.

- **Site-specific challenges:** Infrastructure works disrupt normal operations.

- **Transport and social care delays** further complicate timely discharge.

Patient Impact:

- **Prolonged waits**, risk of deconditioning, and stress for patients and families.

- **Variability in experience** depending on site and time of attendance.

The Patient Experience

Extended waits and overcrowding can lead to anxiety, discomfort, and poorer outcomes. Patient feedback highlights the importance of clear communication, comfort, and timely care.

Data: The ongoing high percentage of patients waiting >12 hours and the variability in handover times directly affect patient satisfaction and outcomes. These delays increase the risk of harm (e.g., deconditioning, hospital-acquired complications, especially for elderly and frail patients) and harm Health Board reputation.

Initiatives to improve experience: The UEC Environment Programme has progressed the following:

- **Cleanliness and Facilities:** The group has completed a comprehensive scoping exercise for 24/7 domestic and portering staff coverage in EDs. A gap analysis is underway to identify where current provision falls short of the agreed standards. This is a foundational step to ensure consistently high standards of cleanliness and a welcoming environment for patients and families. Environmental audits, including domestics, estates, and nursing, are now regularly conducted, with results reviewed to drive improvements. Early involvement of Infection Prevention and Control is being embedded in all room reconfigurations and upgrades
- **Patient Experience and Communication:** Patient information screens are being installed and maintained across all sites, with a focus on delivering consistent, clear messaging about ED processes, nutrition, hydration, and wayfinding. Content is being developed with Comms and Engagement to ensure all patients and relatives are kept informed during their visit.
- Refurbishments have been made to key areas, such as relatives' viewing rooms and paediatric waiting rooms (including sensory rooms) to improve comfort, privacy, and dignity for patients and their families. These changes are designed to reduce anxiety and create a more compassionate environment.
- **Digital and Service Innovations:** The group is exploring digital solutions to improve patient flow and experience, such as self-registration and e-triage systems. A report has been submitted for digital check-in and e-triage, implementation updates are pending. A pilot for a wayfinding robot and the procurement of sensory equipment for patients with learning disabilities or dementia are underway, supported by charitable funds.
- **Staff Support and Training**. A baseline audit of patient experience has been completed and signed off, providing a benchmark for future improvements. Declutter focus weeks and the presence of PALS (Patient Advice and Liaison Service) team members in reception areas are being organised to further enhance the patient and staff environment.

Responding to Challenges, Immediate Actions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Operational Interventions:

- Front and Back Door Reset Weeks have driven recent improvements in handover times and discharge processes.
- “Call before Convey” and direct lines to Clinical Streaming Hubs for Care Homes
- Recruitment of Optimal Flow Practitioners from pilot monies in Welsh Government and implementation of new policies (Boarding, Home of Choice, Reluctant Discharge).
- Launch of Operational Delivery Unit (ODU) for ongoing monitoring and rapid response.
- Enhanced waiting room safety and oversight, staff allocation, and regular observations.
- Development of staff training and awareness videos to support patient flow and discharge planning. Additionally, the roll out of an online discharge toolkit for staff, with discharge resources and training materials.

Collaborative Actions:

- Daily Multi-Disciplinary Team board rounds and huddles, Red2Green updates, and senior leadership presence.
- Care Home Falls Training and Falls Equipment being rolled out across the Health Board in December 2025, with the aim to improve falls responses in care homes, reduce harm, and lower conveyance rates from Care Homes to EDs.
- Launch of an integrated Strengths Based Collaborative Communication training programme to support discharge planning
- Transport service to support Clinical Streaming services being launched across Health Board in December, to support effective Hospital@home services and reduce ED attendances. This is in collaboration with the third sector organisations Delta and St Johns.
- Winter Plan developed with Local Authorities to ensure coordinated delivery of urgent and emergency care services over the Winter period.

Early evidence from Reset Week shows some improvement in discharge before midday and ambulance handover times, but these gains are fragile and require sustained effort to become embedded practice. The interventions are beginning to “bend the curve” but the system remains vulnerable to surges in demand or external shocks (e.g., social care delays, staffing shortages).

Building for the Future: Systemic Solutions

- **Seven-Day Clinical Streaming, Hospital@Home and SDEC Business Case:**
  - Business case currently being developed, work undertaken by value team and clinicians indicate significant benefits for both patients and Health Board. Business Case will initially be submitted for scrutiny at the Finance and Performance Committee in December 2025 and then to Public Board in January 2026 for decision.

- **Optimal Hospital Flow Programme:**
  - Site-based Quality Improvement teams, monthly flow meetings, and a new framework blueprint.
  - Board rounds, huddles, and Red2Green dashboard to identify and address delays.

- **Criteria-Led Discharge (CLD)** and Discharge Toolkit developed to streamline and standardise discharge processes. Currently being rolled out across Hywel Dda

- **Discharge Lounge optimisation:** Improved data collection, Standard Operating Procedures, and proactive patient "pull" from wards are among the initiatives being rolled out.

- **Collaborative and preventative approaches:**
  - Partnership with local authorities to address social care delays.
  - Staff training on strengths-based communication and deconditioning prevention.
  - Participation in national improvement programmes and supporting the utilisation and planning for Local Authority grant monies to support discharge practices and admission prevention.

Sustained improvement in metrics like POCD and long-stay patients will be key indicators of success for these systemic changes.

The focus is shifting from firefighting to building resilience and reliability into the system, but progress will be measured by how quickly and consistently these metrics improve.

Summary

- Recent improvements in ambulance handover times and discharge before midday at some sites.
- Ongoing challenges with long-stay patients and pathway delays.
- Continuous feedback, audits, and pilot initiatives to refine processes and improve patient experience.
- Triangulation of information indicates that there is inconsistency in experience and performance across pathways, hospital sites and days of the week
- Monitoring trends in handover times, discharge rates, and POCD will guide ongoing improvement and resource allocation
- The system is moving in the right direction, but the data shows that fragility remains, with a requirement to improve 7-day coverage, with sustained focus and cross-system collaboration being essential to achieve lasting change.

3.2

10:20 AM, 20 Mins

3.2 - R1 OPHTHALMOLOGY PERFORMANCE

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

For assurance

Attachments

R1 Ophthalmology Performance FPC 16 December 2025.pdf

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	R1 Ophthalmology Performance
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Executive Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Victoria Coppack, Ophthalmology Service Delivery Manager

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

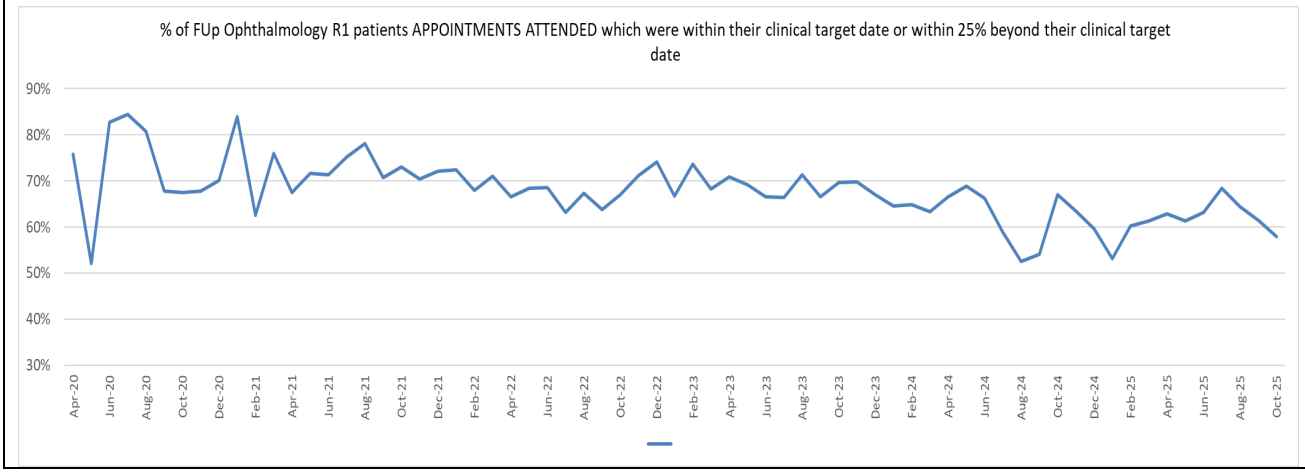
Sefyllfa / Situation

This situation report has been produced to detail the fragility of the delivery of Eye Care Measures (R1 patients) within the Hywel Dda University Health Board (HDdUHB) and the restrictions to delivery that have impacted the recovery of timely delivery of care or treatment.

The Eye Care Measures monitors the delivery of timely treatment for R1 (eyesight-affecting conditions). The target set by the Welsh Government (WG) for delivery of timely treatment for R1 patients is that 95% of patients are waiting within their clinical target date or within 25% excess of their clinical target date for their care or treatment.

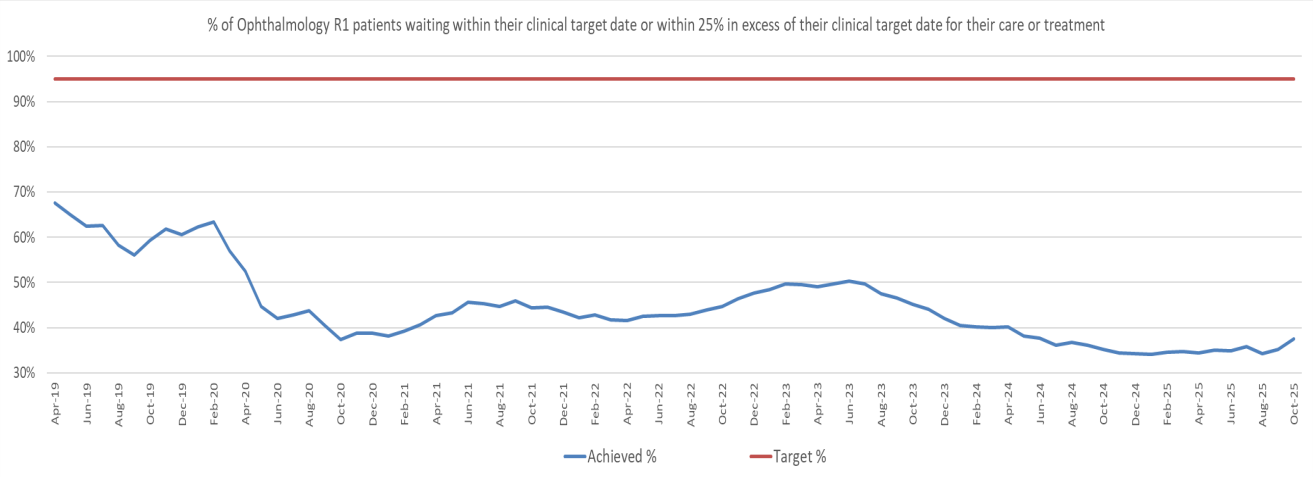
The Health Board is measured against two targets.

The first is the percentage of Ophthalmology R1 patients' appointments attended which were within their clinical target date or within 25% of their clinical target date. For HDdUHB the current delivery for this target is at 58% (as outlined in the table below) therefore, if 100 R1 patients were attending clinic, 58 of these patients will be booked on time or within 25% of their target date, but 42 of these patients booked into clinic are breaching their target date or 25% of their of their target date.



The second measure is the percentage of Ophthalmology R1 patients waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatment.

For HDdUHB the current delivery for this target is at 38% (as outlined in the table below). The Ophthalmology combined waiting list for new and follow up is 24,941, of which 17,998 are R1, so this measure would take the R1 cohort of 17,998 patients and measure the proportion of these patients waiting on the waiting list for clinic or treatment, that are on time or within 25% of their target date, this would be 6,839 patients (38%), however the proportion of these patients waiting who have breached their target date or are 25% beyond their target date for clinic or treatment would be 11,159 patients (62%).



In order to improve the second measure, the first measure cannot be adhered to. This means that instead of using the clinic capacity to treat the patients within their target date, the clinic capacity has to be dedicated to patients who have already breached their target date. This will then increase the waiting list target, but for a period will decrease the appointments attended target until sufficient capacity is grown to have seen the breaching patients. By seeing the breaching patients as a priority, the risk is reduced for the R1 cohort as the longest waiting patients are seen first.

Cefndir / Background

A report was presented to Board on 27 March 2025 detailing the gap in delivery for two sub-specialties in Ophthalmology that have a high proportion of R1 patients. The two subspecialties were the Wet Age-Related Macular Degeneration (AMD) Service (specifically the delivery of intravitreal (IVT) injections) and the Glaucoma Service.

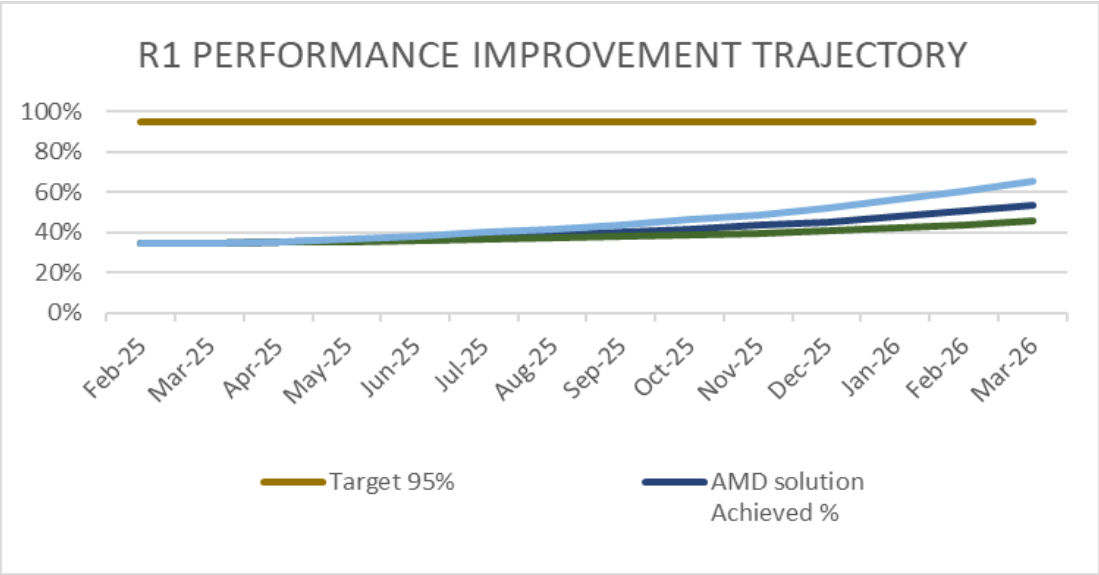
The report detailed a gap of 22.2 clinics per week to meet current demand for Stage 1 and a gap of 273 injections per week to meet the current demand on the intravitreal service. The paper detailed the solutions needed to progress the recovery of the R1 position. This was the investment in the Wet AMD service to deliver 183 injections or virtual reviews per week increasing delivery to 471 injections or virtual reviews per week, leaving a gap of 90 patients per week (1-week breach position), improving the overall R1 position from 38% to 53% in a 12-month period.

The report also detailed a solution for the Stage 1 cohort of patients, which was a cost-neutral solution, recruiting into the Ophthalmology vacancies, gaining the service eight additional clinics:

- Four of these additional clinics was proposed would be provided through the regional consultant posts;
- Three of these clinics would be provided by the Speciality and Associate Specialist (SAS) doctor posts and;
- One of these clinics would be provided by a change of job plan to the current Regional Glaucoma Consultant.

These clinics could then be dedicated to the sub-specialties providing R1 delivery, providing an additional 80 patients per week, totalling 4,160 patients in a 52-week period. The increase of eight additional clinics per week would improve the overall R1 position from 38% to 46% over a 12-month period.

The combined solutions outlined a recovery of the overall R1 position to 65%. The below chart demonstrates the recovery of each solution separately and the combined solution.



The Board decision was to support the report through the 2025/26 annual planning cycle and the costs outlined for the recovery of the R1 position to 65% was agreed.

Cost of increasing the Intravitreal Injections

Staffing: £413,037.85
Drugs: £2,948,015.29 (£1,600,000 was in the current budget for 2025/2026 as underspend)
Total: £3,361,053.14

Asesiad / Assessment

Since the funding was approved the Ophthalmology Team has been working towards the delivery of the additional clinic delivery within the Health Board both for Glaucoma and IVT Injections.

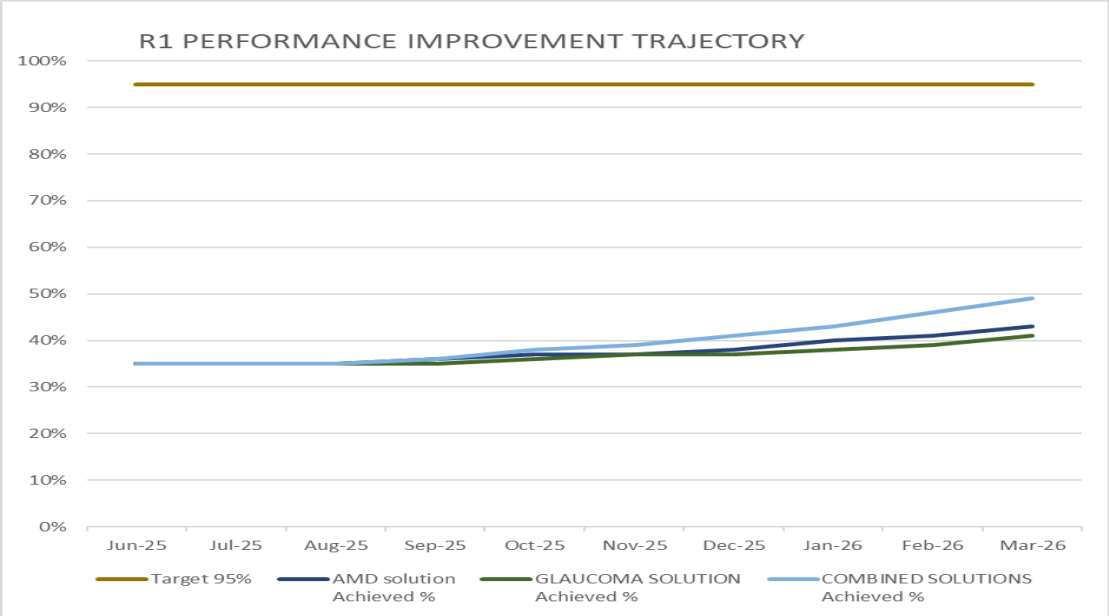
To date, all the staff required to deliver the IVT Injection Clinics have been recruited. The non-medical injectors have been training to undertake injections and of the 3 non-medical injectors recruited, one is now competent to inject, one is expected to be signed off by the end of November 2025 and the third is still training expected to be signed off by January 2025. Of the three SAS doctors recruited, two have been signed off as competent to inject and are currently being trained to review patients and the third has just commenced in post and is in their induction period. The two regional consultant posts are expected to be out to advert by the end of November 2025 with a 6-month period to recruit and onboard.

In addition to the workforce being recruited and trained (or in training). The additional accommodation needed to deliver the extra clinics has been secured on three of the four Injection sites with the exception being at Amman Valley Hospital.

- Withybush Hospital (WGH) will increase to 5 full days per week imminently;
- Cardigan Integrated Care Centre will increase by another full day as soon as the nursing staff to support the service have completed their competencies (end of November 2025); and
- North Road Eye Clinic in Aberystwyth will increase to six clinics weekly as soon as the new SAS doctors has completed her competencies (January 2026)

Amman Valley Hospital continues to pose a problem due to the IVT suite being utilised for other clinics on a Thursday and Friday, preventing the increase of IVT injections being undertaken. The solution to this issue is outside of the control of the Ophthalmology Service and a report has been submitted to the Clinical Care Group for information, with an accommodation meeting to be held to work through possible solutions.

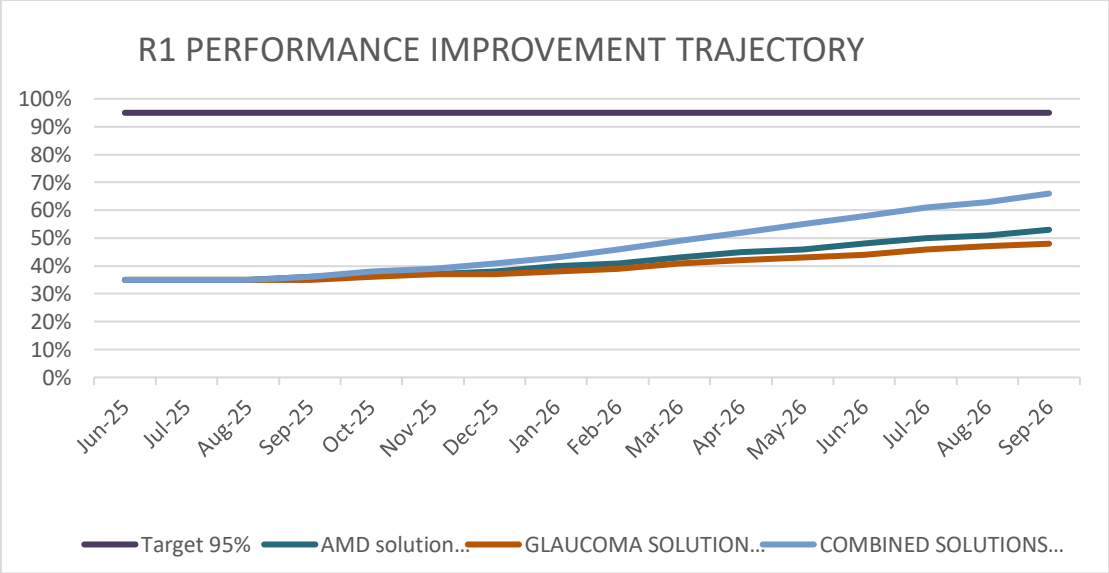
The above issues in the delayed R1 delivery were presented in an updated R1 report in August 2025, which identified a new trajectory for delivery as outlined in the below graph, this showed an improvement trajectory to 49% by March 2026.



The below table demonstrates the target for each month until March 2026. Highlighted in yellow is the predicted delivery for October 2025, which is at 38%, demonstrating that the new trajectory is being maintained to date. The introduction of clinics will continue until September 2026 increasing delivery incrementally. Validation clerks are also being recruited to validate the 17,998 patients on the R1 waiting list, to ensure all duplicates and non-R1 patients are removed.

	Target 95%	AMD solution Achieved %	GLAUCOMA SOLUTION Achieved %	COMBINED SOLUTIONS Achieved %
Jun-25	95%	35%	35%	35%
Jul-25	95%	35%	35%	35%
Aug-25	95%	35%	35%	35%
Sep-25	95%	36%	35%	36%
Oct-25	95%	37%	36%	38%
Nov-25	95%	37%	37%	39%
Dec-25	95%	38%	37%	41%
Jan-26	95%	40%	38%	43%
Feb-26	95%	41%	39%	46%
Mar-26	95%	43%	41%	49%

The timeline to meet the 65% of Ophthalmology R1 patients waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatment has been outlined below, provided the Ophthalmology posts are filled within the given timelines.



Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **TAKE 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.

The additional clinic resources will focus mainly on the delivery of Glaucoma patients and that the recurrent funding for IVT delivery will be utilised fully in 2026/2027 as the service continues to expand to meet its goal of delivering timely care to this high-risk group.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risk 1664 ('Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit'). Risk Score: 16.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective 4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 2. Working together to be the best we can be 3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 4 Planned care, diagnostics and cancer Recovery 10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	https://www.rcophth.ac.uk/resources-listing/intravitreal-injection-therapy/ https://www.nice.org.uk/guidance/ng82/chapter/recommendations https://www.gov.wales/eye-care-measures-nhs-outpatients https://www.gov.uk/guidance/moving-healthcare-closer-to-home
Rhestr Termau: Glossary of Terms:	AVH - Amman Valley Hospital HDUHB - Hywel Dda University Health Board IVT - Intravitreal injections R1 - Risk factor 1 TI - Targeted Intervention
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Clinical Care Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Already agreed through annual plan.
Risg / Cyfreithiol: Risk / Legal:	Failure as a Health Board and public service provider to look after the health and welfare of our citizens in line with required standards.
Ansawdd / Gofal Claf: Quality / Patient Care:	Provide timely care to all patients classified as HFR code R1 within 25% of their target date.
Gweithlu: Workforce:	To develop services in line with additional infrastructure through capital investment and further investment in workforce to close the gap of 14.2 clinics per week.
Risg: Risk:	Risk outlined in Risk 1664 (‘Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit’).

Cyfreithiol: **Legal:**	Failure as a Health Board and public service provider to look after the health and welfare of our citizens in line with required standards.
Enw Da: **Reputational:**	Failure as a Health Board and public service provider to look after the health and welfare of our citizens in line with required standards.
Gyfrinachedd: **Privacy:**	No risk to privacy identified.
Cydraddoldeb: **Equality:**	No risk to equality identified.

3.3

10:40 AM, 20 Mins

3.3 - PARTNERSHIP WORKING - COMMISSIONING ARRANGEMENTS

Shaun Ayres (Hywel Dda UHB - Director of Delivery)

For assurance

Attachments

Partnership Working - Commissioning Arrangements FPC 16 December 2025.pdf



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Partnership Working - Commissioning Arrangements

Finance and Performance Committee – 16 December 2025

Introduction

External commissioning and contracting arrangements form a significant and established part of Hywel Dda University Health Board's (HDdUHB) expenditure. They secure access to specialist services that are not delivered in-house; but also create exposure to financial and operational risk if tariffs, activity and service models are not aligned. A sustained programme of work has been in place to monitor, test and, where necessary, challenge these arrangements. This paper provides an update on that work across several material contracts and pathways, and sets out the current position, areas of agreement and disagreement with providers, and the proposed next steps.
The scope of the paper covers:

- The Swansea Bay University Health Board (SBUHB) Long Term Agreement (LTA), with a focus on emergency coding and tariff application, the elective orthopaedics block and neurology arrangements.
- The Termination of Pregnancy (ToP) contract and associated shift in activity to HDdUHB.
- The South-West Wales arrangements via the NHS Wales Joint Commissioning Committee (NWJCC), in particular cardiac pathways including Transcatheter Aortic Valve Implantation (TAVI) and the drivers of the current overspend.
- Cardiff and Vale University Health Board (CVUHB)-hosted paediatric scoliosis surgery and the introduction of 3D printed surgical guides.
- The developing position in relation to severe acute pancreatitis, as an example of a low-volume, high-cost specialist pathway where there is dispute about commissioning scope and price.

The main body of the report deliberately focuses on the key issues and the principles we are proposing to apply, rather than reproducing all of the underlying analysis. The detailed contractual, activity and financial information that underpins each section is set out in the appendices. This includes the coding reviews, tariff comparisons, block and SLA breakdowns, trend data and worked-through options. The appendices are provided both to support ongoing negotiations with SBUHB, NWJCC and CVUHB, and to give the Committee further assurance and a deeper level of detail on the issues summarised in the report, should members

SBUHB Emergency Admissions and Coding

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contract: £44.4m Budget | Month 6 Position

Uncoded Activity – Contract Breach

Coding remains critically low at Month 6. Many patients discharged as early as April remain uncoded:

83%	82%	25%
Emergency uncoded	Elective uncoded	Daycase uncoded

Contract requires 95% coded within one-month post-episode. Default tariffs create significant financial exposure (e.g. emergency ortho defaults £10,024 vs potential coded £3,918). Potential risk of NWJCC misallocation.

SDEC Coding Errors – Acknowledged

HDdUHB analysis identified patients incorrectly coded to SDEC-type pathways, inflating activity and costs. SBUHB acknowledged and applied provisional adjustment:

£367k full-year adjustment at M6

Resolution timelines remain unclear whilst SBUHB works with informatics to correct recording process.

Proposal

No payment for uncoded activity breaching 95% requirement. Apply 23/24 emergency activity levels until SDEC issue resolved.

Zero-Day LoS – Full Tariff for Short Stays

Analysis of zero-day emergency cases found:

764	44%	59%
Zero-day cases	of emergency activity	discharged under 4hrs

Admissions as low as 8 minutes. Charges for 0 LoS range from £1,153–£10,024. Total cost: £1.2m–£1.7m. Key specialties: Oral/Maxillofacial (141), Midwifery (99), General Surgery Uncoded (91), Vascular (79), Obstetrics (77).

Short-Stay Tariff Proposal

Option 1 – Banded tariff (0 LoS, 764 cases):

Under 4hrs	4–8hrs	Over 8hrs
£450	£900	£1,400

Total = £538k vs current £1.2m–£1.7m

Option 2 – 20% of full tariff (0–1 LoS, 1,063 cases: Total = £345k–£494k (similar to English approach)

Potential saving: £0.9m–£1.4m annually

SBUHB Orthopaedics, Neurology and High Cost Drugs

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Elective Orthopaedics

LTA £2.68m + Regional £21.7m

The Issue

SBUHB received £18m regional orthopaedic funding yet underperforms against LTA which was not uplifted for regional activity:

Daycase: **70 below plan**

Elective IP: **23 below plan**

New OP: **260 below plan** (not part of regional funding inc for completeness)

Follow-up OP: **609 below plan** (not part of regional funding inc for completeness)

Activity not materially above 2018/19 levels. HDdUHB also outsourcing orthopaedic cases at premium cost. OP underperformance only reimbursed at 70% marginal rate, with the £1.58m blocked.

Progress & Proposal

£1.1m credit secured for 24/25 and 25/26. Continue to pursue full £2.68m removal (additional £1.58m) OR extend full tariff adjustments to all elective activity (additional circa £900k mitigation).

Neurology – Double Charging and Tariff

Significant LTA cost driver

A. Locally Provided Services

Activity charged through both LTA and SLA – consultant time via SLA, patient activity via LTA. All work takes place on HD sites by SBU consultants. Historical arrangement (10+ years) lacking transparency.

Infrastructure costs also included which HD considers inappropriate relating to patients going to SBUHB for HCD administration.

B. Daycase vs RDA Tariff

Since 19/20, daycase admissions increased by circa 160% whilst RDAs decreased. Many patients regularly attending for treatment (e.g. immunoglobulins – 8 patients had 105 daycase episodes) should meet RDA definition.

Daycase tariff: **£942**

RDA tariff: **£381**

DC YTD: **518 above plan** (175 total in 18/19)

RDA YTD: **157 below plan** (zero activity)

Proposal

Cease locally provided services component of LTA; implement robust SLA for all HD site work. Apply RDA tariff for patients with multiple attendances for same tre

High-Cost Drugs (NICE/HCD)

Growing cost pressure across LTAs

Context

High-Cost Drugs and NICE-mandated treatments represent a significant and growing element of LTA costs. These are largely non-discretionary expenditures driven by clinical need and national guidance yet create material financial pressure on commissioning budgets.

Link to Activity Growth

The increase in Neurology daycase activity is partly driven by patients requiring regular high-cost drug infusions (e.g. immunoglobulins). This creates a compound effect – tariff inflation from daycase classification plus drug costs.

Financial Impact

NICE/HCD costs are increasing across multiple specialties within the SBUHB contract. Detailed analysis of HCD impact is included in appendix.

Monitoring Action

Continue to review HCD trends and ensure appropriate pass-through arrangements are in place. Challenge any HCD charges where clinical pathway does not support usage.

Wider Commissioning: NWJCC, CVUHB and SAP Pathway

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

NWJCC – Month 7 Position

£4.4m	£7.7m	£627k
M7 overspend	Forecast	HD share

Key Drivers for HDdUHB

PICU and NICU at UH Bristol. TAVI and Specialised Cardiology at SBUHB – 149 cases to date vs 125 plan (60 HD residents, up from 48 same period 24/25).

IMTP Concerns Raised

Draft plan focuses on risks and additionality, not efficiencies or resource reallocation required under flat cash. Limited time for decisions – substantial proposals requiring QIAs may not align with planning timelines.

Action

Continue engagement. Cardiac review underway to rebase activity and tighten TAVI referral criteria. Monitor that criteria being applied.

C&VUHB – Paediatric Scoliosis

C&V contract: £6.8m | 15 scoliosis cases/year

The Issue

Following Spinal Network meeting (16 Sept), C&VUHB confirmed consultant team will not undertake scoliosis surgery without 3D-printed surgical guides, citing patient safety and quality. Successfully tested to reduce screw malposition rates.

Financial Exposure

Costs from 1 January 2026. Average £5k per guide, ranging up to £10k.

Contract: 15 cases/year (14 in 24/25)
Potential exposure: **up to £150k annually**
Not factored into current contract

Proposed Mitigation

Reallocate from orthopaedic underperformance (140 below plan YTD, only 100 cases to date). Note: overall contract already overperforming, limiting flexibility as this would reduce areas of underperformance.

Severe Acute Pancreatitis Pathway

Regional commissioning gap

Background

HDdUHB holds £173k LTA with SBUHB for pancreatic surgical services (baseline 32 cases). SBUHB has clarified their HPB service is commissioned for pancreatic cancer surgery only.

The Gap

SAP support was provided historically on "goodwill basis" pending a Service Delivery Network programme that no longer exists. SBUHB states they lack infrastructure (24/7 IR, interventional EUS, dedicated MDT) for sustainable delivery. Activity data: 3 cases of pancreatic other vs 16 planned; consistent underspend.

Proposed Solution

Rebase SBUHB contract explicitly to cancer-only, reflecting actual scope. Establish direct SAP pathway with CVUHB (who have offered interim prior approval support) within existing £173k envelope contained within the Swansea Bay contract.

Potential funding required but this approach mitigate the full financial risk.

Successes and Systemic Issues

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Oncology/Neurology Challenge – SBUHB agree

HDdUHB analysis identified Oncology and Neurology outpatient activity being charged via the LTA despite being carried out on HDdUHB sites by HDdUHB staff. SBUHB has acknowledged this was inappropriate and agreed to exclude from Month 7 monitoring onwards. This demonstrates the value of detailed contract scrutiny.

ToP Contract – Terminated

Post-COVID, SBUHB lost ward access and ToP activity ceased, yet funding was never repatriated. HDdUHB has developed in-house provision up to 20 weeks gestation. Six-month notice served (ends January 2026) with funding to transfer back to support continued service development and address quality/safety for time-sensitive cases.

Orthopaedic Credit – £1.1m Secured

Successfully negotiated credit within SBUHB LTA for 24/25 and 25/26, recognising the overlap between LTA funding and regional orthopaedic investment. Negotiations continue for full removal of £2.68m LTA element or extension of full tariff adjustments to all elective activity (additional circa £900k mitigation as we would only pay on actual instead of the current block).

Systemic Pattern – Provider Behaviour Under Financial Pressure

The Health Board is experiencing an increasing pattern of providers issuing formal notices to cease or restrict services, citing insufficient funding or lack of formal commissioning arrangements. Three recent examples illustrate this concerning trend:

1. HPB/SAP – SBUHB clarifying service is cancer-only after several years of assumed coverage
2. Orthoplastic referrals – SBUHB expecting prior approval for revisions/infections
3. 3D surgical guides – CVUHB mandating funding for research project without commissioning engagement

The Marginal Rate Problem

Current arrangements mean providers retain 30% of underperformance whilst demanding full funding for new requirements. However, the commissioner does benefit from marginal rate where there are material areas of over-performance. ITU Bed Days £1400 per day marginal rate vs £2000 at Full Cost.

Balanced View Between Commissioner and Provider

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Where you sit determines what you see – all parties face the same financial pressures

Issue	HDdUHB Position	Provider Counter-Position
SBUHB Emergency Tariff & Coding	Short-stay admissions (59% under 4hrs) should not attract full tariff. 83% uncoded breaches contract. 20% approach saves £0.9m–£1.4m.	If full HRG basis applied, SBUHB would pursue English tariff adjustments for complexity and comorbidities – potentially increasing charges overall.
SBUHB Neurology	Daycase tariff (£942) includes infrastructure; RDA (£381) appropriate for regular attenders. Double-charging via LTA + SLA for HD-site work.	MS infrastructure costs require additional funding beyond tariff. Complex patient cohort justifies daycase classification and current arrangements.
SBUHB Orthopaedics	£18m regional funding overlaps with £2.68m LTA. Activity not above 2018/19 levels. Never exceeded LTA baseline – this is double charging.	Regional funding was for additional capacity, not replacement of existing LTA. Costs have increased; baseline should be maintained separately.
NWJCC / TAVI	TAVI cases rising (149 vs 125 plan). Patient criteria should govern access – unclear whether protocol being followed. Costs escalating unchecked.	Clinical need drives referrals. Patient criteria met on case-by-case basis. Questioning clinical decisions risks patient access to evidence-based treatment.
C&VUHB Scoliosis	3D guides introduced via research without commissioning engagement. £150k unfunded cost being imposed unilaterally on commissioners.	Patient safety and quality mandate 3D guides – reduces screw malposition. Cost differential reflects genuine service improvement.
SAP Pathway	£173k LTA should cover SAP or be rebased. Provision exists within contract; discussing cost differential, not entirely new funding.	HPB service commissioned for cancer only. SAP requires 24/7 IR, interventional EUS, dedicated MDT – infrastructure not funded.

Key Insight: Each party's position is internally consistent and defensible. The fundamental tension is that all Welsh health boards face the same financial pressures – every pound saved by one commissioner is a pound lost by another provider. Resolution requires either agreed methodology and a commissioning framework or escalation to all-Wales arbitration.

Wider Considerations and Looking Ahead

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Commissioning Environment

Whilst HDdUHB has achieved several positive outcomes this year, we recognise these negotiations are becoming increasingly difficult. Every Welsh health board faces the same financial constraints- our gains often become provider losses (and vice versa). This creates an adversarial dynamic contrary to collaborative principles.

2025/26 and Beyond

Financial pressures will intensify. Flat cash, rising costs, and workforce challenges mean contract negotiations will become harder. Providers will challenge commissioner positions with equal force, and service withdrawal notices may become more common.

Risk of Perception

HDdUHB's robust approach to contract challenge could be perceived as adversarial or non-collaborative by partner organisations. We must balance legitimate financial protection with maintaining collaborative relationships essential for patient care across boundaries.

Implications for Committee

The positions in this report represent HDdUHB's legitimate interests. However:

1. Provider counter-arguments have merit within their own frames
2. Resolution may require compromise rather than outright wins
3. Some disputes may need escalation to all-Wales forums
4. The cost of protracted disputes may exceed the sums at stake and risk wider progress

Suggested Approach

Pursue with conviction: Emergency tariff reform and coding enforcement – clear contractual matters with quantifiable impact.

Seek agreed methodology: Orthopaedics, Neurology – jointly-agreed costing models rather than unilateral positions.

Escalate appropriately: NWJCC/TAVI criteria adherence – through formal governance with evidence.

Negotiate pragmatically: SAP pathway, 3D guides – focus on cost differentials and realistic envelopes.

Recommendations

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Committee is asked to:

NOTE

The LTA financial position at M6, including HDdUHB's identified challenges and the counter-positions held by provider organisations operating under the same financial pressures.

DISCUSS

The balance between robust contract enforcement and maintaining collaborative relationships with partner Health Board, recognising that resolution may require compromise on some issues.

SUPPORT

With conviction: Emergency tariff reform and coding enforcement as clear contractual matters. **Through negotiation:** Orthopaedic and Neurology arrangements via jointly-agreed methodology where possible.

RECEIVE ASSURANCE

That the approach to commissioning challenges are robust - pursuing legitimate interests whilst recognising provider perspectives and the wider context of NHS Wales financial sustainability.

ACKNOWLEDGE

That these negotiations will become harder in 2026/27 and beyond, and that escalation to all-Wales forums may be required where bilateral resolution proves impossible.

Prioritised Actions

PURSUE WITH CONVICTION

- Short-stay emergency tariff (April 2026)
- 95% coding enforcement

SEEK AGREED METHODOLOGY

- Orthopaedic LTA / regional funding overlap
- Neurology SLA structure and tariff basis

ESCALATE APPROPRIATELY

- TAVI criteria adherence via NWJCC governance
- IMTP efficiency focus through formal channels

NEGOTIATE PRAGMATICALLY

- SAP pathway - cost differential within £173k
- 3D guides - realistic envelope discussions

Appendix (Slides 9–25): Full LTA tables, detailed analysis, and supporting data

Detailed Appendices and Information

These appendices are provided not for line-by-line review at the meeting, but to give the Committee further assurance that the proposed approach is grounded in robust evidence, and to offer additional detail on trends, assumptions and options should members wish to explore any of the issues in more depth or refer back to them as negotiations progress.

i. Uncoded activity

High proportion of uncoded episodes (based on HRG - Emergency 83%,Elective 82%,Daycase 25%). Financial exposure due to default tariffs in certain specialties and risk of misallocation between contracts ie NWJCC activity.

Action – Enforce contract requirement: 95% coding within one month post episode. **Proposal** - no payment for uncoded activity that breaches this requirement.

ii. Emergency Admissions – A. Coding & B. Tariff

A. Incorrect coding (SDEC- type pathways) inflates activity and costs. B. Zero-day and 1 day LoS admissions attract full tariff despite very short stays.

Action – Continue to data review and challenge (financial crude FY adj of £367K applied by SBUHB for incorrect coding). **Proposal** – A. apply payments based on previous years emergency activity until resolved. B. Move to short-stay tariff (banded or 20% of full tariff) to reduce future cost implications.

iii. Elective Orthopaedics – Regional Monies (£18m) Vs LTA (£2.68m)

Underperformance against LTA plan, whilst also in receipt of regional monies (£18m). HDdUHB received £1.1m credit for 24/25 and 25/26.

Action – Continue to negotiate removal or adjustment of LTA elective/daycase amount. **Proposal** – Remove full LTA amount *or* Continue with £1.1m credit and apply full tariff adjustments for elective activity.

iv. Neurology – A. Locally provided services Double Charging & B. Tariff Misalignment

a. Activity and Consultant time undertaken in HD charged under both a LTA (Locally provided services) and SLA arrangement. B. Daycase Vs Regular Day Admission/Attender inflates costs (Daycase £942 vs RDA £381). Reduces transparency and financial control.

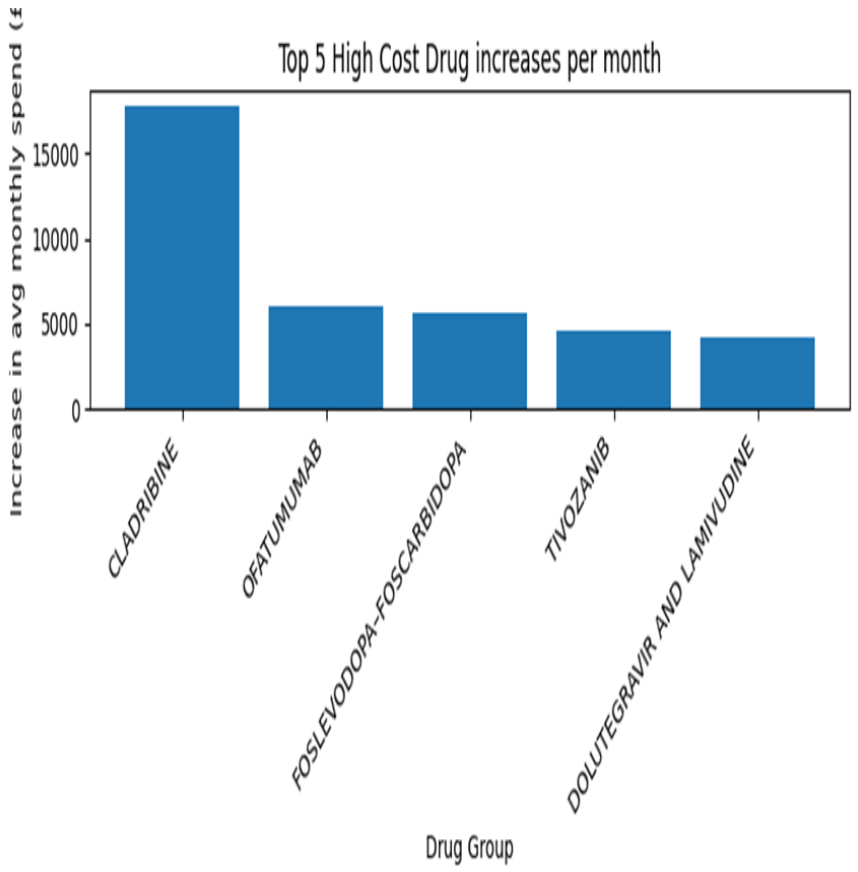
Action - Continue to negotiate the removal of LTA. **Proposal** – A. Cease current local arrangement; implement robust SLA for all HD site work. B. Move to RDA tariff for multiple attendances.

V. Termination of Pregnancy

Activity at Swansea ceased post-COVID, but funding not repatriated to HDdUHB, internal cost pressures and quality risks for time-sensitives cases. Outsourcing to private provide at a premium.

Action – 6-month notice served to terminate contract – due to end Jan 2026.

VI. High Cost Drugs (NICE/HCD)



Interpretation and correlation with activity

Neurology and MS drugs: The largest increases in high-cost drug spend are driven by multiple sclerosis and other neurological therapies (Cladribine, Ofatumumab, Ublituximab, Foslevodopa-Foscarbidopa). This aligns closely with the growth in day-case neurology activity (+7.4 spells per month) and suggests that the higher neurology spend is due in part to more patients receiving biologic therapies or new formulations.

Oncology: Tivozanib and Trastuzumab show increases consistent with the rise in emergency oncology spells (+6.3 per month). However, overall oncology spend is partly offset by reductions in drugs such as Olaparib, Dabrafenib, Niraparib and Osimertinib. This mixed pattern suggests that while some tumour types are driving higher cost, others are stabilising or declining.

HIV and other conditions: Antiretroviral spend is shifting (increase in Dolutegravir + Lamivudine), indicating a change in regimens rather than an increase in patient numbers. Tocilizumab and Upadacitinib point to growth in severe inflammatory diseases.

Clarification on HIV spend: Reductions in spend on some HIV drugs reflect switching to newer regimens rather than a net fall in HIV-related costs; overall spend in this category is broadly flat

Aggregate effect: Despite significant increases in specific drugs, the overall high-cost drugs position is largely flat. Using the total expenditure after adjustments line, spending in Month 6 is about £30 k per month lower than last year, and the full-year forecast indicates only a £59 k reduction for 2025/26. The benefit is therefore modest and could disappear if prescribing of newer drugs (e.g. MS biologics) accelerates. The cost pressure arises from targeted high-growth drugs, particularly MS therapies, rather than a broad reduction.

NWJCC Financial Position – £627k forecast overspend.

Overspend of £4.4m at month 7; forecast £7.7m. HDdUHB share £627k. Main areas of overperformance for HDdUHB is PICU and NICU at UH Bristol Hospital, TAVI and Specialised Cardiology at SBUHB.

Draft IMTP shared with NWJCC subgroups, HDdUHB has raised the issue that the plan seems to focus on risks and additionality, not on efficiencies or resource reallocation, which will be essential under a flat cash allocation. Furthermore, a concern is that there is limited time to make decisions for next year, increasing risk of reactive choices.

Actions/Proposal - Continue to engage in discussions on mitigating actions re plan. Continue to monitor activity and ensure that the TAVI criteria is being applied and met.

Paediatric Scoliosis 3D-printed surgical guides at CVUHB – additional cost exposure £150k

Consultant team will not undertake scoliosis surgery without the use of 3d printed surgical guides, citing patient safety and quality of care. Consequently, following a Spinal Network meeting (16 Sept), CVUHB will recover costs for the introduction of these guides from 1 January 2026.

HDdUHB current contract for paediatric scoliosis is 15 cases per year (14 carried out in 24/25) and the average cost for each guide is £5k, however do range up to £10k. Therefore, the potential additional cost exposure is £150k annually if all 15 cases require the most expensive. This additional cost pressure is not currently factored into the contract.

Actions/Proposal – Reallocate resources from the underperformance seen in the orthopaedic element of the contract. However, please note as the contract overall is already overperforming, such reallocation would heighten pressure across the broader contract.

Successful Challenge – Oncology and Neurology Outpatient activity at SBUHB

Analysis undertaken illustrated that an element of the Oncology and Neurology LTA outpatient activity, was being carried out within a HDdUHB setting by HDdUHB staff, therefore appeared to be inappropriate/incorrect charging. SBU agree with this position and have inserted a step into the monitoring process to ensure that this excluded going forward, will be reflected in the month 7 monitoring report.

Uncoded Activity at Swansea as of Month 6

Uncoded Activity

Uncoded activity remains high: Based on Healthcare Resource Group – Emergency 83%, Elective 82%, Daycase 25%, RDA 12%. Many patients discharged as early as April.

Impact

Difficult to understand patient pathways. Financial exposure due to default tariffs (e.g. emergency orthopaedic defaults £10,024 vs potential coding of £3,918). Risk of misallocation between contracts i.e some coded cases will subsequently transfer across to NWJCC.

SBUHB advise that they have a plan, overseen by their Audit Committee, to increase coding completeness through service modernisation and use of AI, which is underway. HDdUHB acknowledge the challenges within coding, however as per the contract "*95% of episodes clinically coded within one month post episode end date*." Therefore, it is important that coding strictly adheres to these contract rules.

Proposal

No payment to be made for any uncoded activity that does not comply with contract obligations (95%).

Unscheduled care continues to generate the largest cost pressures. Table below summarises the average monthly spells and cost for the key categories in 2024/25 and 2025/26 and shows the annual consequence if the current trends persist. All figures are adjusted for the 1.77 % uplift.

Category	Avg spells FY 24/25	Avg spells 25/26 (M6)	Change in spells per month	Avg cost FY 24/25 (£)	Avg cost 25/26 (£)	Annual cost increase after uplift (£)	Interpretation
Emergency General Surgery - Uncoded	22.2	34.2	+12.0	£53,102	£83,973	+£359,172	New classification with high tariffs; spells doubled; reflects coding step change rather than organic growth; this category alone adds £360 k per year above inflation.
Emergency Orthopaedics - Uncoded	8.4	9.8	+1.4	£56,880	£67,826	+£119,281	Another new line with modest volume growth but high cost per spell; should be challenged as likely short-stay admissions.
Emergency General Surgery - Vascular other	27.4	33.3	+5.9	£46,857	£61,677	+£167,887	Genuine growth in vascular emergencies (?); further analysis needed on case mix and capacity.

SBUHB – Emergency Admissions (Incorrect Coding) as of Month 6

Emergency Admissions (Incorrect Coding)

Analysis by the HDdUHB team identified that a number of patients were incorrectly coded to an SDEC-type pathway, impacting activity and financial reporting. SBUHB has acknowledged the issue and, as of Month 6, applied a provisional full-year financial adjustment of £367k.

However, the matter remains unresolved while SBUHB works with informatics colleagues to correct the recording process and ensure these cases are excluded from contracting data going forward. Resolution timelines remain unclear.

Impact

Creates difficulty in understanding true patient pathways and actual demand, inflates both activity and financial reporting.

Proposal

Until issue is resolved, payments to reflect 2023/24 emergency activity levels. The HDdUHB Commissioning and Contracting Teamwill continue to review data and challenge any further coding or charging discrepancies

SBUHB Emergency Admissions (Tariff) - Zero LoS as of Month 6

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Specialty	CAT2	<4hrs	4-8 hrs	>8hr	Grand Total
Cardiology	Other	2	1	2	5
	Pacing			1	1
Clinical Oncology	(blank)	11	15	6	32
Medical Oncology	(blank)	7	9	4	20
ENT	(blank)	18	8	5	31
Gastroenterology	(blank)	4	2		6
General Medicine	(blank)	19	9	7	35
General Surgery	Other	1	2	1	4
	Other Major			1	1
	Uncoded	47	28	16	91
	Vasc Other	38	28	13	79
Gynaecology	Other	6	2	4	12
Haematology	(blank)	1	1		2
Medicine For The Elderly	(blank)	2			2
Midwifery	(blank)	84	12	3	99
Obstetrics	(blank)	62	10	5	77
Ophthalmology	Ophth	1	1		2
Oral/Maxillo Facial Surgery	(blank)	83	38	20	141
Paediatrics	(blank)	33	17	5	55
Trauma & Orthopaedic	NP	1			1
	Orthopaedic other	4	2		6
	Spinal Other	1		1	2
	Trauma Other	3	7		10
	Trauma Very Major		2		2
	Uncoded	4	4	8	16
Urology	(blank)	17	13	2	32
Grand Total		**449**	**211**	**104**	

As part of the review, HDdUHB examined zero-day LoS emergency cases and associated tariffs. The analysis found that:-

Activity

- 44% of zero-day cases accounted for the total emergency activity in Month 6 (764/1750).
- 58.8% were admitted and discharged in < 4hrs.
- A number of admissions were as low as 8 minutes.
- 83% lacked HRG coding

Costs

- Charges ranged from £1,153 to £10,024 per case.
- Between £1.7m (full cost) and £1.2m (marginal)

Note an element will relate to incorrect coding/charging of SDEC activity, which SBU have acknowledged.

SBUHB Emergency Admissions (Tariff) - Zero to 1 Day LoS as of Month 6

Impact

Current tariff structure results in highly inflated costs for very short stays, this approach diverts funding from areas where it could deliver greater clinical benefit and improved patient outcomes.

Proposal

To move to a short stay tariff (0 LoS or 0-1 Los) and either to a banded tariff or a 20% of full extant tariff (similar to English approach). Both methods would significantly reduce the financial impact.

i. Short-Stay Emergency Tariff, 0 LoS Banded Tariff

Based on Month 6 data, 764 counts of activity:

- **<4 hrs**: £450 = £202k
- **4–8 hrs**: £900 = £190k
- **>8 hrs**: £1,400 = £146k

Total = £538k vs current costs of £1.2m–£1.7m.

ii. Short-Stay Emergency Tariff 0–1 LoS 20% of full unit tariff

Based on Month 6 data, 1063 counts of activity (Includes 1 day LoS also):

Total = £345k- £494k vs current costs of £1.2m - £1.7m

Elective Orthopaedics at SBUHB – Regional Monies vs LTA Monies (circa 2.68m)

Orthopaedic Regional Monies (£18m) vs LTA (£2.68m)

Orthopaedic elective inpatient and daycase activity is set as block funding within the LTA, supported by the regional arrangements outside the LTA (SBUHB £18.0m and HDdUHB £3.6m per annum).

Month 6 activity performance against the LTA YTD plan *(Note - LTA has not been uplifted for regional activity)* is:

- 70 below plan for daycases
- 23 below plan for elective in-patient
- Activity in recent years has not been materially above that undertaken by SBUHB in financial year 2018/19.

£1.1m credit exists in the LTA, but this is insufficient to offset underperformance in elective inpatient and daycase activity and achieve planned access to regional funding. To note HDdUHB are also outsourcing a number of orthopaedic cases at a premium cost.

Whilst not within the block funding, orthopaedic new outpatient appointments are 260 under plan, outpatient follow ups 609 under plan and outpatient procedures 6 above plan – note HDdUHB only receives 70% marginal rate reimbursement for under performance.

HDdUHB has continuously stressed the need for the whole £2.68m (LTA Elective and Daycase value), a further £1.57m to be removed from the contract, in line with the recognition of the recurrent recovery funding which has been provided on a regional basis. SBU, do not share the same view and therefore to date only the £1.1m credit has been enacted.

Impact

Persistent underperformance against planned activity and reliance on credit adjustment. This approach restricts access to regional recovery funding, creates financial strain through premium outsourcing, and prevents reinvestment into pathways that could improve patient flow and reduce waiting times

Proposal

i. **Remove the full LTA (elective and daycase) amount** - circa £2.68m. Remove the full LTA amount (residual £1.57m) for elective and daycase activity until activity levels exceed planned.

OR

ii. **Credit of £1.1m within the LTA to be continued, with full tariff rate financial adjustments for all elective activity**

In addition to the 1.1m credit, application of full tariff rate financial adjustments for all elective activity (inpatient, daycase and extending to outpatients). This would mitigate financial risk by a further circa £900m (full year) and allow HDdUHB to explore other opportunities to recover Orthopaedic waiting times for our population.

Neurology – Potential Double-Charging / Lack of Clarity

Neurology Costs with the System at SBUHB

Neurology activity and costs under the LTA are significant, mainly driven by daycase admissions and outpatient follow-ups. Furthermore, there are a number of Neurology agreements, where HDdUHB consider double charging is being applied, such as locally provided services and infrastructure costs.

Locally Provided Services

A review of Neurology services under the LTA and SLA with SBUHB, identified that the activity for locally provided services is being charged through both the LTA and SLA arrangement. The Consultant time is charged for under the SLA and patient activity seen by these Consultants via the LTA - note all activity takes place on HD sites. This is a historical arrangement (> 10 years) that has led to confused payment mechanisms and lacks transparency and financial control.

Furthermore, there are a number of infrastructure costs relating to Neurology that are included within the LTA, which the HD Commissioning & Contracting team consider are inappropriate, although this view is not necessarily shared with SBU.

Impact

There is a lack of clarity regarding the allocation of costs and the scope of services these charges encompass. From a Hywel Dda perspective, there is concern that certain areas may be subject to duplicate charging, which could result in significant and avoidable financial expenditure. Additionally, the time and resources required to investigate and reconcile these discrepancies detract from strategic priorities and operational efficiency.

Proposal

Cease the current locally provided services arrangement and instead retain a formal Service Level Arrangement (SLA) for all work undertaken by SBUHB consultants on a HDdUHB site. The SLA must be robust, fit for purpose and accurately reflect current practice and service provision. This approach will ensure clear and distinct contractual arrangements, improve accountability, and enhance transparency in service delivery and cost management.

Neurology Daycase vs Regular Day Admissions Tariff

Since 19/20 whilst the number of patients bed days (Inpatient elective/emergency) and Regular Day Attenders/Admissions (RDA) has decreased, the number of daycase admissions has significantly increased (circa +160%). Note: daycase tariff (£942) significantly higher than RDA tariff (£381).

However, many of these patients will be regularly attending for a course of treatment and therefore would potentially meet the definition of an RDA

NHS data dictionary definition of a Regular Day Admission

> Patients admitted electively, during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve an overnight stay, such an admission should be classed as an ordinary (inpatient) admission. The series of regular admissions ends when the patient no longer requires frequent admissions.
>
> Intermittent dialysis cases and patients on regular chemotherapy/radiotherapy are examples of regular day admissions.

Month 6 activity performance against the LTA YTD plan

518 above plan for daycases – note total of 175 daycase activity in 18/19

157 below plan for RDA - note – no RDA activity to date and a total of 368 RDAs in 18/19.

8 patients had a total of 105 counts of daycase activity, typically to receive immunoglobulins

Impact

Potential misalignment in coding and classification inflates expenditure and reduces the availability of funding for services that could deliver greater clinical benefit and improved patient outcomes.

Proposal

Work with SBUHB to look at the coding and tariff of these patients, who would meet the RDA definition. Or

Only pay RDA tariff for those patients who have a certain number of attendances for the same treatment within a month (TBA)

Termination of Pregnancy (ToP) at SBUHB

Prior to COVID, HDdUHB would regularly refer ToP patients to SBUHB, and the activity would flow through the LTA contract. However, since the pandemic, the flow has significantly declined, and there is now no recorded ToPs activity for HDdUHB residents. This is due to a number of reasons, particularly:

- SBUHB lost access to their Pregnancy Advisory Service (PAS) ward and the access has continued to be restricted, which has naturally impacted upon the number that SBUHB can accommodate.
- New guidance introduced to allow patients under 10 weeks' gestation to access early medical abortion at home.
- HDdUHB has developed their service immeasurably, including service provision for patients up to 20 weeks gestation.

However, whilst the activity at SBUHB has been absent for a considerable period of time as it has been absorbed locally, the funding hasn't followed. This is causing significant service and cost pressures internally that HDdUHB cannot continue to sustain. Importantly, there are quality and safety issues for these women, as they are naturally time sensitive cases.

Consequently, HDdUHB has served 6 months notice (due to cease In January 2026) on the contract and expects the funding to transfer back (amount to be determined) to HDdHB in order to be repurposed.

It is acknowledged that, whilst the Health Board does not believe a six-month notice period is strictly required given the lack of delivery, the practical requirement to implement an alternative in-house solution necessitates a transitional period.

NHS Wales Joint Commissiong Committee (NWJCC) – Month 7

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The NWJCC financial position for 2025-26 reported as of Month 7 was an overspend of £4.4m with a forecast overspend of £7.7m against the Integrated Commissioning Plan financial plan. The HDdUHB share of this forecast overspend is £627k.

HDUHB Commissioner Contribution to JCC

Budgeted Income £'000	EOYF £'000	Total £'000
£148,181	£627	£148,808

EOYF Variance as a % of Budgeted Income	*0.42%*

Breakdown of EOYF Variance by Area:

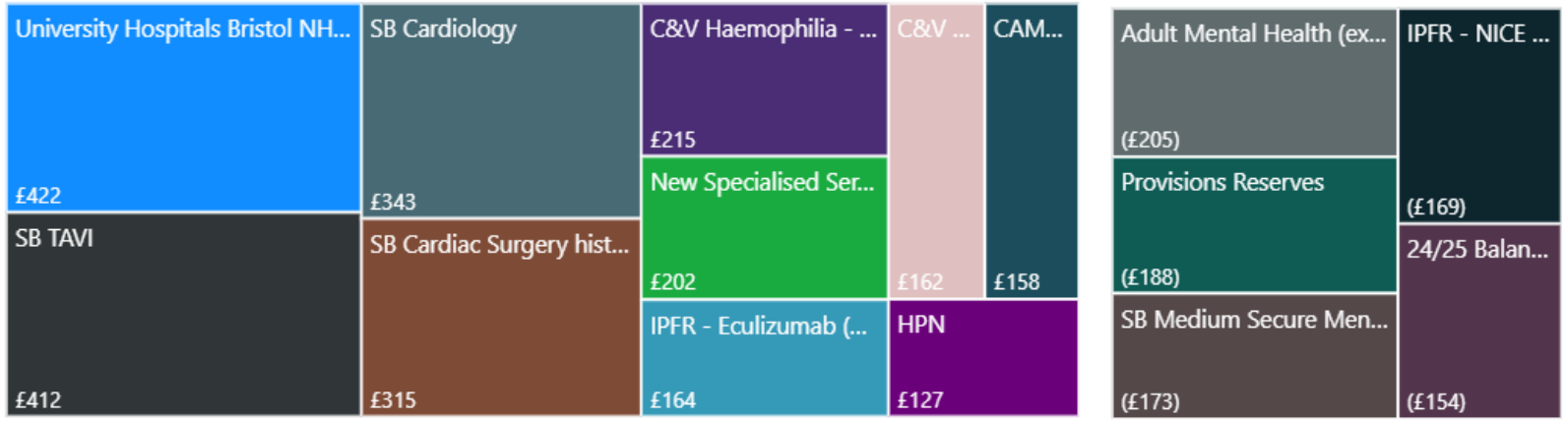
NHS Wales	IPFR	Non Welsh SLA	Savings	Renal	Direct Running Costs	Mental Health	Releases	CIAG & Prior Year Commitments	Total
£973	£512	£451	£31	£0	-	(£119)	(£154)	(£1,066)	**£627**

NHS Wales Breakdown

	YTD Variance £'000	EOYF Variance £'000
Aneurin Bevan	£16	£27
Betsi Cadwaladr	£27	£46
Cardiff & Vale	£14	£163
Cwm Taf Morgannwg	-	-
Hywel Dda	-	-
Swansea Bay	£571	£735
Velindre	£3	£1
WAST	-	-
Total	**£630**	**£973**

Top 15 Services by EOYF Variance £'000 - top 10 overspends and top 5 underspends

All



Comments/Notes:

Hywel Dda residents services come primarily from Cardiff & Vale UHB, Swansea Bay UHB, NHS England and private providers in relation to Mental Health individual placements.

The current year-end forecast variance of £627k overspent includes the following main components:

- University Hospitals Bristol - £422k of overactivity, primarily NICU and PICU
- Swansea Bay - TAVI overactivity of £412k
- HPN homecare drugs - overspend of £127k related to the newly procured contract

Transcatheter Aortic Valve Implantation (TAVI)

Within NWJCC, TAVI continues to present a financial challenge for HDdUHB, with activity exceeding the plan (total of 149 cases to date vs plan of 125), resulting in an overspend. Out of the 149 cases, it would appear that 60 cases relate to HDdUHB residents, which would align to HDdUHB current risk share of 40.25%. To note however, this is an increase in activity compared to the same period in 24/25 of 48 patients.

TAVI delivers clear cost and clinical benefits, e.g reduced hospital and ICU stays, lower complication rates, which help to offset the higher initial costs of TAVI (compared to the alternative), particularly for the providers and patients. Commissioners, however, do not typically experience the financial gains associated with these improvements.

The NWJCC Cardiac review will help to reduce the current TAVI related financial pressure by re-baselining cardiac activity so future contract values better match actual demand. Updated service specifications will tighten referral criteria. The review will also address regional service configuration to ensure activity aligns with population need.

Plan

HDdUHB continues to work with NWJCC around their plan. The draft IMTP appears to focus on risks and additionality, with limited emphasis on efficiencies or resource reallocation required under a flat cash allocation. There is concern about the short timeframe for decision-making, particularly for substantial proposals requiring QIAs, and whether these will be ready for when decisions need to made and how they align to the planning timelines.

Paediatric Scoliosis 3D-printed surgical guides at CVUHB

In response to the growing risks associated with screw malposition, CVUHB has successfully tested the use of 3D-printed surgical guides for all paediatric scoliosis cases, which has significantly reduced screw malposition rates, improved patient safety, and enhanced surgical precision.

Consequently, CVUHB Consultant Team will no longer undertake scoliosis surgery without 3D-printed guides being available. Therefore, the Health Board will need to cover the additional cost of 3D-printed guides. Where this is not agreed, CVUHB will not proceed with scoliosis surgery for out-of-area referrals, including those already on the waiting list.

HDdUHB current contract for paediatric scoliosis is 15 cases per year (14 carried out in 24/25) and the average cost for each guide is £5k, however do range up to £10k. Therefore, the potential additional cost exposure is £150k annually if all 15 cases require the most expensive. This additional cost pressure is not currently factored into the contract.

Month 6 activity performance against the LTA YTD plan

Paediatric scoliosis – 6 below plan, 2 undertaken to date

Total Orthopaedics element – 140 below plan, 100 counts of activity undertaken to date.

Actions/Proposal – Reallocate resources from the underperformance seen in the orthopaedic element of the contract. However, please note as the contract overall is already overperforming, such reallocation would heighten pressure across the broader contract.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3.4

11:00 AM, 20 Mins

3.4 - CLINICAL CARE GROUP FINANCIAL SAVINGS ACTION PLANS

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

For assurance

Attachments

CCG Financial Savings Action Plans FCP 16 December 2025.pdf

Appendix 1 Blue and Red Savings Schemes.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Clinical Care Group Financial Savings
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Keith Jones, Director of Operational Planning and Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is requested to consider the progress achieved by Clinical Care Groups (CCGs) in respect of confirmed savings plans as at Month 7 2025/26 and to note the additional opportunities being explored by CCGs to further improve this position.

Cefndir / Background

Hywel Dda University Health Board (HDdUHB) approved an Annual Plan on 27 March 2025 which represented a planned deficit of £31.5m. This includes provision for investments totalling £11.9m, expected recurrent savings of £19.0m, plus a non-recurrent benefit of underspends and non-recurrent savings of £25.4m. Subsequently in July 2025, the Board has approved a revision to the Annual Plan and a restated recurrent 2025/26 saving requirement of £46.4m.

The anticipated savings delivery was spread across the Health Board on the basis of all budget areas delivering a combination of 5% savings in 2024/25 plus a further 1.5% in 2025/26. Recognising that recurrent saving delivery was achieved to some extent through 2024/25, the remaining balance of 5% was carried forward for each budget area. As a result, the savings delivery required for the Chief Operating Officer portfolio is £39.0m. These figures remain unchanged by the revision to the Annual Plan and increased savings requirement.

Following Month 7 2025/26 reporting, the Health Board revised its forecast to match the outturn position of 2024/25 of £24.1m, aligning to Welsh Government (WG) expectations. At the same time the implication of the additional pressure from the Welsh Risk Pool risk share has been factored into the forecast, raising the end-of-year forecast to £28.3m. This continues to pose a delivery challenge for the Health Board CCGs, recognising the value (circa £3.0m) of potential amber saving schemes not transacted plus the further requirement for additional mitigating actions to a value of £3.3m which need to be identified and delivered across the Health Board.

As part of the planning cycle for 2026/26, CCGs have been requested to identify recurrent solutions for delivery in the next financial year. It is anticipated that this will require budget

holders to close the recurrent 2025/26 savings gap and address a further saving challenge for 2026/27.

Asesiad / Assessment

Savings Delivery to Month 7

In the October 2025 CCG Financial Savings Report to Finance and Performance Committee, the Committee was advised of further actions being pursued by CCGs to review additional opportunities, beyond the current schedule of blue and red savings schemes, including consideration of run rate contributions to the in-year savings target along with non-cash releasing opportunities.

Latest Position:

The table below shows the updated position as of Month 7:

Delegated Officer (£'000)	Annual Savings	In Year Identified Cash Releasing Plans (Recurrent and Non-Recurrent)					Variance From Target
		Blue	Red	Amber	Green	Total	
Chief Operating Officer	**39,048**	**481**	**3,195**		**25,583**	**29,259**	**9,789**
Chief Operating Officer Management	762				639	639	123
Community and Integrated Medicine	10,482	150	1,448		6,278	7,876	2,606
Mental Health and Learning Disabilities	5,851	300	144		5,143	5,587	264
Operational Allied Health and Health Sciences	3,785		26		459	485	3,300
Planned and Specialist Care	11,639	31	1,167		8,437	9,634	2,005
Primary Care, Community Strategy and Long Term Care	6,529		410		4,627	5,037	1,492

Against the target of £39.0m, in year plans have further improved to £29.3m factoring in blue, red, amber and green (BRAG), recurrent and non-recurrent schemes. This represents a further £2.0m improvement over the reported position at the last Finance and Performance Committee meeting in October 2025.

Despite significant operational pressures experienced by CCGs, confirmed in year delivery in respect of amber and green schemes has also increased by a further £2.5m to a current total of £25.6m compared to the position reported at the last Finance and Performance Committee meeting in October 2025.

This progress has been achieved despite:

- Pressures on surge capacity across Pembrokeshire and Carmarthenshire
- Deteriorating medical staffing workforce availability
- Increased referral-to-treatment (RTT) delivery costs including actions to mitigate the operational impact of theatre cancellations due to significant theatre staffing workforce challenges and non-pay costs associated with increased activity levels

Recurrent Schemes

The table below shows the latest position as at Month 7 in relation to recurrent schemes:

Delegated Officer (£'000)	Annual Savings Target	In Year Identified Cash Releasing Plans (Recurrent)					Full Year Plan	Full Year Variance From Target
		Blue	Red	Amber	Green	Total		
Chief Operating Officer	**39,048**	**181**	**3,051**		**10,941**	**14,173**	**22,004**	**£17,044**
Chief Operating Officer Management	762							£762
Community and Integrated Medicine	10,482	150	1,448		2,842	4,441	8,316	£2,166
Mental Health and Learning Disabilities	5,851				1,375	1,375	1,375	£4,476
Operational Allied Health and Health Sciences	3,785		26		459	485	760	£3,025
Planned and Specialist Care	11,639	31	1,167		3,799	4,996	8,661	£2,978
Primary Care, Community Strategy and Long Term Care	6,529		410		2,466	2,876	2,892	£3,637

The full year estimate of recurrent schemes totals £22.0m across all BRAG categories.

Green and Amber Schemes

Alongside the priority focus on closing the current gap to the total savings target for services within the Chief Operating Officer's service portfolio, individual CCG's have also continued to focus on expenditure controls within operating budgets. Within the total green savings schemes, a portion of this value has been realised through the approved principle to routinely transact pay related underspends through the monthly cycle, totalling £5.1m between April 2025 and October 2025. This reflects the increased grip and control applied by CCGs in managing their operating budgets.

The summary table below presents the scale of savings generated through this process:

Delegated Officer (£'000)	M07 YTD Total	Average
Chief Operating Officer	**5,133**	**733**
Chief Operating Officer Management	639	91
Community and Integrated Medicine	689	98
Mental Health and Learning Disabilities	658	94
Planned and Specialist Care	985	141
Primary Care, Community Strategy and Long Term Care	2,161	309

Current Blue and Red Schemes

The current list of red and blue schemes identified by CCGs are included within **Appendix 1** to this report. These represent a potential £4.9m opportunity in year.

Progress updates are provided through CCG '*Executive Improving Together'* (EITs) meetings and Recovery meetings, with progress achieved in converting blue and red schemes to amber and green reflected in the improved position reported above.

In recognition of the workforce and related capacity challenges across its service areas, the Operational Allied Health and Health Sciences CCG has been encouraged via Executive Recovery reviews to focus its efforts on actions to maximise a forecast year end budget underspend given the extent to which the CCG budget reflects pay costs.

Additional Expenditure Reduction Actions

In addition to the progress described above, all CCGs continue to review opportunities to further reduce rates of variable pay expenditure not currently reflected in CCG forecasts. The outcome of these reviews will be incrementally added to non-recurrent schemes as opportunities are confirmed.

During October savings were confirmed totalling £0.5m towards the further improvement required. These relate to Neurodevelopment outsourcing and negotiation with local authorities in respect of shared costs.
Argymhelliad / Recommendation The Finance and Performance Committee is requested to **NOTE** 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.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	4. Efficient
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**

Ar sail tystiolaeth: Evidence Base:	Contained within the body of the report.
Rhestr Termau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Clinical Care Groups

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Contained within the body of the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable

Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Health Board financial stewardship.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

APPENDIX 1: BLUE AND RED SAVING SCHEMES

					Values £'000	
CCG	CSG	Scheme Name	Recurrent	RAG	In Year Plan	Full Year Plan
Community and Integrated Medicine	Carmarthenshire Integrated System	Relocation of stroke services to PPH to align to CSP.	Recurrent	Red	526	2,105
Community and Integrated Medicine	Carmarthenshire Integrated System	Reduction in variable pay for Doctors from changing the front door model GGH	Recurrent	Red	90	120
Community and Integrated Medicine	Carmarthenshire Integrated System	Impact of Emergency General Surgery (Scheduled Care Scheme on GGH)	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	MIU Future Model PPH	Recurrent	Red	84	504
Community and Integrated Medicine	Carmarthenshire Integrated System	Biosimilar switches for USC	Recurrent	Red	19	25
Community and Integrated Medicine	Carmarthenshire Integrated System	LOS reduction and associated bed efficiencies - Bed closure GGH (2 year plan)	Recurrent	Blue	100	400
Community and Integrated Medicine	Carmarthenshire Integrated System	Close Preseli ward (15 bed surgical ward GGH) - med and surical outliers	Recurrent	Red	350	1,400
Community and Integrated Medicine	Carmarthenshire Integrated System	WARD 6 PPH (orthopaedic) reduce from 21 beds to 14	Recurrent	Red	40	80
Community and Integrated Medicine	Carmarthenshire Integrated System	LOS reduction and associated bed efficiencies - bed closure PPH (2 year plan)	Recurrent	Blue	50	200
Community and Integrated Medicine	Carmarthenshire Integrated System	Review the bereavement service GGH	Recurrent	Red	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Evaluation of opportunity to provide alternative care provision for LCH	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review SLA of Ty Bryngwyn and responsible owner	Recurrent	Blue	0	0
Community and Integrated Medicine	Carmarthenshire Integrated System	Review operating model of community hospitals	Recurrent	Blue	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Deep dive of medical rotas	Recurrent	Red	85	85
Community and Integrated Medicine	Pembrokeshire Integrated System	Risk - Emergency General Surgery being removed from WGH	Recurrent	Blue	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Development of the Ambulatory Trauma Pathway from GGH to Withybush	Recurrent	Blue	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Community Nursing OCP	Recurrent	Red	0	0
Community and Integrated Medicine	Pembrokeshire Integrated System	Contract review of Community inpatient beds	Recurrent	Red	212	425
Community and Integrated Medicine	Pembrokeshire Integrated System	Optimise utilisation of Community Estate	Recurrent	Red	29	35
Community and Integrated Medicine	Pembrokeshire Integrated System	Optimise utilisation of Community Estate	Recurrent	Red	13	15
Community and Integrated Medicine Total					**1,598**	**5,394**

CCG	CSG	Scheme Name	Recurrent	RAG	Values £'000 In Year Plan	Full Year Plan
Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	Ref 159 continued - MHLD non-recurrent pay savings (Oct-Mar)	Non Recurrent	Red	392	0
Mental Health and Learning Disabilities	Mental Health and Learning Disabilities	MHLD non-recurrent pay savings (Oct-Mar)	Non Recurrent	Blue	300	0
Mental Health and Learning Disabilities Total					**692**	**0**
Operational Allied Health and Health Sciences	Pathology	Reduction to Agency Locum	Recurrent	Red	0	90
Operational Allied Health and Health Sciences	Pathology	Haem Drug Biosimilar	Recurrent	Red	26	105
Operational Allied Health and Health Sciences	Pathology	OOH Service	Recurrent	Red	0	56
Operational Allied Health and Health Sciences	Pathology	Outsourced Income	Recurrent	Red	0	50
Operational Allied Health and Health Sciences Total					**26**	**301**
Planned and Specialist Care	Cancer and Scheduled Care	Outpatient Transformation	Recurrent	Red	292	500
Planned and Specialist Care	Cancer and Scheduled Care	Nursing variable pay opportunity	Recurrent	Red	0	360
Planned and Specialist Care	Cancer and Scheduled Care	Medical Stabilisation: Opportunity £7m across clinical group.	Recurrent	Red	875	3,500
Planned and Specialist Care	Cancer and Scheduled Care	Enhanced Critical Care model PPH, in line with National Guidelines	Recurrent	Red	0	200
Planned and Specialist Care	Cancer and Scheduled Care	Theatres: Review and reconfigure of DSU South theatre and patient flow ward areas to support formal closure and decommissioning DSU Amman Valley theatre and ward areas.	Recurrent	Blue	31	122
Planned and Specialist Care	Children, Women and Family Health	Ceasing tripartite agreement with Garreglwyd for CCC provision (Rec/Cash Releasing)	Recurrent	Red	238	238
Planned and Specialist Care	Children, Women and Family Health	Medical Workforce Review	Recurrent	Red	0	145
Planned and Specialist Care Total					**1,435**	**5,065**
Primary Care, Community Strategy and Long Term Care	Pharmacy and Medicines Management	Bulk purchase of chemotherapy	Recurrent	Red	188	188
Primary Care, Community Strategy and Long Term Care	Pharmacy and Medicines Management	Bosutinib	Recurrent	Red	113	113
Primary Care, Community Strategy and Long Term Care	Pharmacy and Medicines Management	Dimethyl fumarate	Recurrent	Red	110	110
Primary Care, Community Strategy and Long Term Care Total					**410**	**410**

3.5

11:20 AM, 20 Mins

3.5 - MEDICAL STABLISATION PROGRAMME UPDATE

Mark Henwood (Hywel Dda UHB - Executive Medical Director)

For assurance

Attachments

Medical Stabalisation Programme Update FPC 16 December 2025.pdf

Medical Stabalisation Programme Action Plan FPC 16 December 2025.pdf



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Medical Stabalisation Programme Update

Finance and Performance Committee, 16 December 2025

Medical Stabilisation Programme Update

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

OVERVIEW

Workforce Challenges

The programme addresses vacancies, high agency costs, and inconsistent rostering and job planning practices across the Health Board.

Stabilisation Initiatives

Implementing a pan-Health Board rostering system and standardising rate cards to streamline workforce management and reduce locum reliance.

Recruitment and Sustainability

Enhancing national/international recruitment to build a sustainable workforce and improve service continuity across clinical areas.

Stakeholder Collaboration

Incorporating feedback from Local Negotiating Committee (LNC) and British Medical Association (BMA) ensures alignment with national priorities and workforce needs.

Allocate System Roll-out and Compliance

System Launch and Modules

Allocate system launched in January 2025 with Bank Staff+, Medics On Duty, and Activity Manager modules enhancing staffing control. The roll-out of the system is currently underway with engagement from operational teams. Phases 1 and 2 are complete and phase 3 commenced during November. The accelerated roll out is on track to be completed by the ***end of March 2026***.

Job Planning Compliance

Allocate is consistently used for job planning across the organisation. Job planning compliance rate were at 81% in November 2025. Once the accelerated roll out of the rota system is complete work will commence on integrating job plans with the rota during ***Q1 2026/27***.

Doctor Management and Sign-offs

Allocate system manages 487 doctors, with 400 signing off job plans within the 15-month compliance period.

Ongoing Support and Reporting

Monthly compliance reports on job planning compliance are issued to operational teams and escalation meetings held with Executive Medical Director to maintain and improve compliance. These will continue through 2026.

Monthly variable pay reports are shared with Clinical Care Group (CCG) Directors to support discussions on rates of pay and we now have reduced the maximum rate being paid per hour for additional duty hours. Work will continue to develop dashboards to manage a reduction in variable pay during ***Q1 2026/27*** when the system is fully implemented.

Allocate System Roll-out and Integration

Actions	Impact	Trajectory
Launched Allocate system in January 2025	Improved visibility over staffing allocations	Full rollout on track for March 2026
Completed Phases 1 and 2, Phases 3 - 7 commenced in November 2025	Enhanced operational efficiency through integrated modules	Post-rollout focus will be on integration of rota and job planning and dashboard development for variable pay management
Accelerated rollout plan in progress with strong operational engagement	Positive engagement with teams, supporting adoption and compliance	

Medical Rate Card Standardisation

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Proposal Options Overview

Two main options present different rate revisions for Additional Duty Hours (ADH) and medical bank, with varied cost implications and timelines.

Rationale for Change

Changes aim to ensure parity, transparency, and alignment with competitive benchmarks across staff grades and sites.

Strategic Benefits

Implementing revisions promotes staff engagement, reduces agency reliance, and strengthens service resilience.

Recommendations

Recommendation to align the Health Board with a rate card in line with inflation to be launched in ***Q.4 2025/26***

This has been developed and endorsed by Value and Sustainability Group at an additional cost of £390,172.

This has been presented for decision at Formal Executive Team on the ***3rd December 2025***, along with an agreed escalation process.

Medical Rate Card Standardisation

A revised rate card which is based on inflation (Estimated Cost Increase: £390,172)

Resident Grade	In Hours	Out of Hours
Consultant	£100.00	£125.00
Specialist Grade / Associate Specialist	£100.00	£105.00
Speciality Dr	£65.00	£90.00
ST4 - 8	£65.00	£90.00
ST1 - 3	£55.00	£65.00
F2	£40.00	£55.00
F1	£35.00	£45.00
**Non-resident on-call 50% of above rate*		

Medical Rate Card Standardisation

Actions	Impact	Trajectory
Developed two options for revising ADH and medical bank rates each with distinct cost implications	Provides a structured approach to rate revision, ensuring transparency and parity across staff grades and sites	Decision will guide implementation of revised rates in Q4 2025/26 ensuring consistency across the Health Board
Agreed preferred option at Value and Sustainability Group	Supports financial planning by outlining cost implications upfront	
Presented options for decision at Formal Executive Team on 3 December 2025, including an agreed escalation process		

Reduction of Agency Spend by 30%

- Progress has been made to ensure 100% of assignments are compliant with the national price cap.
- There are no non-direct engagement bookings within the organisation.
- No shifts exceed £160 per hour.
- There is a high dependency at Consultant level which has the highest associated cost impact and greatest risk in terms of sustainability.
- There have been reduce and replace savings of £9,615.90 which reflects efforts to switch premium agency assignments to lower-cost alternatives.
- Further work during ***Q4 2025/26*** to achieve the 30% reduction will continue including repeating the engagement event outlining the benefits of becoming a substantive member of staff.

Reduction of Agency Spend by 30%

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Actions	Impact	Trajectory
Ensured 100% compliance of all assignments with the national price cap	Achieved full compliance with national pricing standards, reducing financial risk and ensuring transparency	Continued efforts in Q4 2025/26 to achieve the 30% reduction target focussing on:
Eliminated non-direct engagement bookings	Removed high-cost, non-direct engagement bookings, improving governance and cost control	- Repeating engagement events to encourage substantive appointments
Implemented controls so no shifts exceed £160 per hour	Maintained hourly rate caps	- Addressing Consultant level dependency through workforce planning and recruitment strategies
Delivered reduce-and-replace savings by switching premium agency assignments	Realised tangible savings through strategic replacement of premium agency shifts	2026/27 – monitor compliance, savings and sustainability metrics to track progress
Planned further engagement activities in Q4 2025/26 to promote substantive roles	Identified consultant-level dependency as a critical sustainability risk, informing targeted interventions	

International Recruitment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

International Recruitment

The Health Board's July 2025 international recruitment trip secured four confirmed offers, demonstrating effective hiring strategies.

Welsh Government (WG) is keen to explore whether there are any requirements for targeted international medical recruitment for 2026/27 and we are engaged in these discussions. Final requirement to be submitted by ***22 December 2025.***

Planning and Service Engagement

Services are identifying suitable grades and consultant posts for overseas recruitment to address workforce needs strategically.

The Health Board has approached WG regarding challenges in Haematology recruitment. To address this, a clinically led national task and finish group is due to be established, which may result in a specialist recruitment event at a future haematology conference, similar to the successful approach taken in Psychiatry.

Recruitment Challenges

Challenges include confirming vacancies and securing clinical support, requiring early engagement with Clinical Care Groups.

Workforce Gap Solutions

Efforts focus on reducing reliance on temporary staffing by addressing recruitment needs and engaging with Welsh Government ahead of ***22 December 2025***.

Recruitment Improvement Initiatives

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Job Description Optimisation

Refreshing and aligning medical job descriptions with service needs to speed up recruitment.

Maximising Medical Education

Leveraging teaching infrastructure to offer career development and attract medical candidates.

Research and Innovation

Promoting clinical research and academic collaboration to foster innovation and learning.

Value Proposition

Enhancing roles with flexible work, professional development, and wellbeing support.

Raising Health Board Profile

Increasing visibility through conferences, recruitment campaigns, and strategic communications.

International Recruitment

Actions	Impact	Trajectory
Participated in an international recruitment trip securing four confirmed offers, demonstrating effective hiring strategies	Strengthened workforce pipeline through successful overseas recruitment	Submit final recruitment requirements by 22 December 2025
Engaged with Welsh Government to explore further targeted international medical recruitment needs	Positioned the Health Board as proactive in addressing critical staffing gaps	Prepare for potential targeted campaigns in 2026/27 based on agreed priorities
	Built collaborative relationships with Welsh Government for strategic workforce planning	

Medical Workforce Planning

- Scoping of all acute medical wards across the 4 acute sites has commenced to understand the bed base and patient acuity

- Meetings taking place through November and December 2025 with Medical Leads to model the Medical Workforce based on demand, acuity, bed base and Royal College of Physicians guidelines

- A report will be developed to describe the current and required medical staffing model to safely staff the acute medical wards and Emergency Departments, taking into consideration the Multi-Disciplinary Teams, for example, Medical Associate Professionals (MAPs) and Advanced Nurse Practitioners (ANPs) ***during Q4 2025/26***

Medical Workforce Planning

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Actions	Impact	Trajectory
Initiated scoping of all acute medical wards across four sites to understand bed base and patient acuity	Provides a data-driven understanding of current capacity and activity across sites	Complete report in Q4 2025/26 detailing: • Current staffing gaps and risks • Required workforce model for safe and sustainable care • Integration of MDT roles to optimise resources
Meeting through November and December 2025 to model the medical workforce based on demand, acuity, bed base and guidelines	Enables evidence-based workforce modelling, ensuring safe staffing aligned with clinical standards	Use report to inform strategic workforce planning and recruitment priorities for 2026/27, supporting long-term sustainability
Planned development of a report during Q4 2025/26 to outline the current and required medical staffing model	Promotes collaborative planning with medical leads, improving service resilience and patient safety	

Short, Medium & Long Term Goals

Short-Term Focus

Maintain zero off-framework usage and target high-cost shifts by ***Q4 2025/26*** to control expenses.

Medium-Term Goals

Implement standardised rate card fully and increase recruitment through international and local campaigns in 2026.

Long-Term Objectives

Reduce agency spend by 30–50%, embed flexible staffing, and align workforce planning by 2027.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Finance and Performance Committee
16 December 2025

Action	Timescale	Update	Responsible
Implement pan-Health Board rostering & job planning system	End of Q4 2025/26	• Allocate is consistently used for job planning across the organisation. • The roll-out of the Allocate rota system is underway with engagement from operational teams, phases 1 & 2 are complete with phase 3 commencing during November. • Accelerated roll out to be undertake by end of March 2026	CH / Medical Rota Team / Clinical Care Groups
Adopt single rate card	By Q4 2025/26	• A rate card based on inflation has been developed and endorsed by Value & Sustainability. • This will be presented for decision at the next Formal Executive Team Meeting, along with an agreed escalation process.	MH / CH
Reduce agency spend by 30%	By Q4 2025/26	• Progress has been made to ensure 100% of assignments are compliant with the national price cap. • There are no non-direct engagement bookings within the organisation. • No shifts exceed £160 per hour. • There is a high dependency at Consultant level which has the highest associated cost impact and greatest risk in terms of sustainability. • There have been reduce and replace savings of £9,615.90 which reflects efforts to switch premium agency assignments to lower-cost alternatives. • An agency engagement event developed to showcase the benefits of substantive employment successfully achieved 5 conversions from agency to substantive appointments.	Medical Workforce Planning Group / Clinical Care Groups
International recruitment	Ongoing	• The HB participated in the Welsh Government international recruitment drive successfully and	Medical Recruitment / Medical Workforce

		continues to engage operational service to identify vacancy and high spend areas that would benefit from international recruitment.	Planning Group / Clinical Care Groups
Medical Workforce Planning – Acute Medical Wards and Emergency Departments	By Q4 2025/26	• Scoping of all acute medical wards across the 4 sites has commenced to understand the bed base and patient acuity • Meetings taking place through November & December with Medical Leads to model the Medical Workforce based on demand, acuity, bed base and RCP guidelines • An SBAR will be developed to describe the current and required medical staffing model to safely staff the acute medical wards and Emergency Departments, taking into consideration the Multi-disciplinary Team e.g. MAPs, ANPs, etc	CH / EE / Clinical Care Group Senior Medical Leaders
Development of a Clinical Vision for ED services across Hywel Dda	Completed, with ongoing engagement and progression to a planning stage	• Following clinical concerns raised by ED and GIM clinicians across the HB relating to standards of care in ED departments and frailty within the Medical Rotas, together with recommendations raised by HEIW and GIRFT/SEDIT reviews • A programme of works has been completed working with all ED Clinicians to describe a vision for future ED services across the HB.	CIM CCG/ Planning Team/ Medical Directorate

4

11:40 AM, 0 Mins

4 - FINANCE

4.1

11:40 AM, 15 Mins

4.1 - FINANCIAL PERFORMANCE ASSURANCE REPORT

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

For assurance

Attachments

M8 2025-26 Financial Performance Assurance Report FPC 16 December 2025.pdf

Appendix 1 P08 2025-26 Finance Performance Report.pdf

Appendix 2 2025-26 In-Year Financial Position Letter from Hywel Jones 10 December 2025.pdf

Appendix 3 2025-26 Target Control Total Letter from Hywel Jones 10 December 2025.pdf

Appendix 4 2025-26 Strategic Cash Request Letter 5 December 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Performance Assurance Report – Month 8 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Spratt, Deputy Director of Finance Jennifer Thomas, Head of Corporate Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date against the Annual Financial Plan and assesses the key financial projections, risks and opportunities for the financial year, including the implications of in-year recurrent delivery for the forthcoming financial year.

Cefndir / Background

The Board recognises that approving a budget which included a planned deficit was a 'novel and contentious action' and, as such, the Accountable Officer wrote to the Director General Health, Social Care and Early Years Group in Welsh Government (WG) to advise them of this action in line with requirements.

The Board, at its meeting on the 31 July 2025, endorsed and approved a revised annual plan financial deficit of £30.0m, having made decisions to increase the savings target, defer originally planned investments and recognise changing national funding assumptions.

The WG expectation is that the Health Board should plan to deliver, as a minimum, the 2024/25 financial outturn of £24.1m, and ongoing dialogue continues with an expectation that the Health Board further improves its financial forecast beyond the revised annual plan deficit.

An In-Committee Board was held on the 9 September 2025 to review and conclude forward actions to improve the year end forecast. Following this meeting, the year-end forecast improved to £27.8m.

Asesiad / Assessment

Financial Position

- The in-month financial position is a surplus of £4.4m, which is an improvement against the £2.5m in-month deficit plan, with the year-end forecast being £22.1m, aligned to the revised target control total of £22.1m.
- Following confirmation received from Welsh Government on 10 December 2025, the Health Board has recognised funding for the increases to the Welsh Risk Pool risk share agreement (£4.2m) and the Band 2/3 (£2.9m) (**Appendix 2**). With these funding confirmations, the Target Control Total expectation has been revised to £22.1m (**Appendix 3**).
- The in-month savings target of £3.9m has been fully identified and delivered in-month and the core operational variance in-month is an underspend of £6.9m, linked to the recognition of the funding new allocations.
- The financial run rate is on track to achieve the forecast position, with mitigating actions of £2.4m required should the forecast cost increases predicted by services materialise. Any material increases to the current run rate would put at risk the year-end forecast, with internal focus needing to remain resolute.
- The following table summarises the key drivers, with full analysis included within **Appendix 1.**

Key Driver (£'m)	Current month variance to breakeven	Year to Date variance to breakeven	End of Year forecast to breakeven
Planned Deficit	2.5	20.0	30.0
Savings gap / (improvement)	0.0	(4.7)	(2.1)
Under / (Over) delivery of savings schemes	0.0	0.3	0.3
Core operational variation	(6.9)	(3.7)	(3.7)
Gross Forecast	(4.4)	11.9	24.5
Future Mitigating Actions	-	-	(2.4)
Reported Position	(4.4)	11.9	22.1

Note: Due to the timing of the allocation funding communication, and with the finalisation of the position having concluded internally within the Health Board prior to it, the normal detail contained within **Appendix 1** references the reported position in lieu of the funding confirmation, i.e. an end of year forecast of £28.3m, not £22.1m. The only changes between the high-level summary provided, and the detail, is the combination of both funding confirmations for Welsh Risk Pool and Band 2/3 uplift. It is recognised this is unorthodox, but to ensure committee members had sufficient time to review the detail it has been shared in this way given the meeting already had an advanced timetable due to the Christmas period.

Alert (may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

Top Priority Alerts

Included within **Appendix 1** are the top priority alerts with mitigating actions being required to negate the impact, the key themes being:

- Medical Pay – there is continued use of additional medical cover in the form of premium pay across several sites. An urgent update is required for timelines on Medical Stabilisation Programme, which is provided as an update within section 3 of the meeting agenda – Escalation Response.
- Continuing Healthcare – increased packages and purchase of Psychiatric Intensive Care Unit beds from independent sector is continuing to be an increasing trend. Clarity on price, mix and volume breakdowns are being sought.
- Increased expenditure to improve patient waiting lists across Scheduled Care specialties, associated with both insourcing and outsourcing activities. The cost pressures are currently being offset by an underspend within Oncology drugs, of which £3.6m has been transacted as a recurrent saving from April 2026. With no action, the Clinical Care Group will significantly deteriorate at the point the savings are committed, but no later 1 April 2026 given the recurrent saving having been committed to from then. Transparency of the cost pressures gross of the fortuitous Oncology drugs underspend is required urgently, triangulated with core capacity activity verses recovery activity.
- Further non-pay overspend in several service areas including Long Term Agreements, Estates and Facilities and Community & Integrated Medicines require further management understanding and mitigating actions.

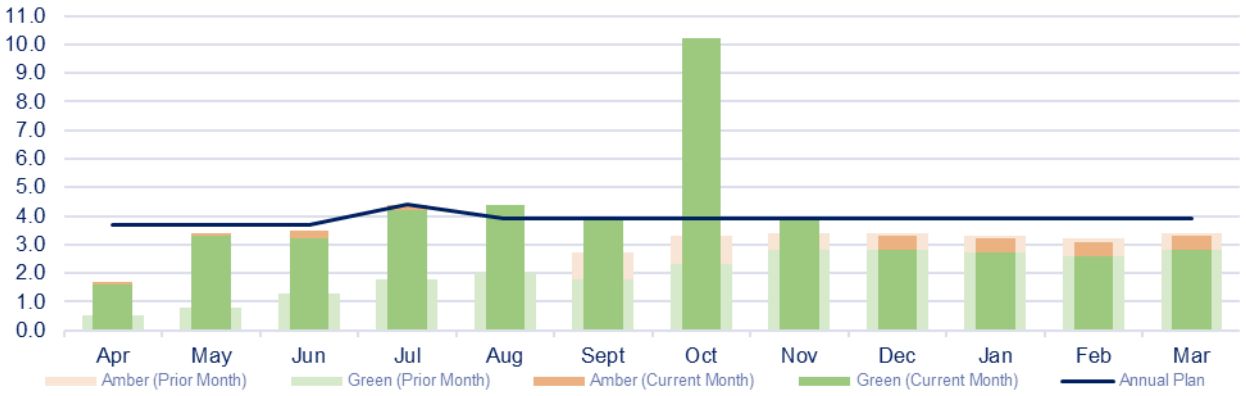
Recurrent savings delivery and impact on underlying deficit and FY27 Planning Cycle

- The underlying deficit as part of the financial planning cycle is £58.5m, which assumes £19.0m of recurrent savings delivery. As at Month 8, due to a large recurrent Oncology drugs savings scheme of £3.6m due to deliver from 1 April 2026, the full year recurrent savings gap has reduced to £0.8m, resulting in an underlying deficit of £59.3m.
- Whilst the in-year savings target has been delivered, the end of year key performance breakdown per Clinical Care Group (CCG) / Executive functions in **Appendix 1** shows the mis-balance across service areas with Executive functions over delivering by £14.8m and CCG's under delivering by £13.0m.
- There is an over-reliance on non-recurrent savings plans, with the in-year recurrent savings gap being £4.7m, and with non-recurrent savings being over-delivered by £6.5m. A key action for the Health Board is to ensure further options are converted from the opportunities framework and translated into robust recurrent savings plans to improve the recurrent underlying deficit.
- Work on the financial plan for 2026-27 has commenced, and a separate update paper is presented to the Finance and Performance Committee.
- A financial roadmap continues to be developed and updated and clearly sets out the actions that are required to ensure a financial break-even position is achieved for the 2027/28 financial year, meeting expectations set out as part of conditional funding arrangements from 2024/25. Comprehensive assessments and scenarios are modelled and included across a three-year horizon to 2028/29.

Advise (to monitor)
There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

Lack of proactive in-year savings commitment where savings are evidenced

- At the start of the financial year, to expedite budget holders to declare savings proactively, a non-recurrent underspend savings principle was agreed by Executives. This principle was to ensure that any pay savings were declared within the month they occurred, at the latest, and were not used to offset unrelated overspends.
- Whilst this principle has worked as expected, a proactive approach to declaring savings has not yet materialised from some budget holders, and there is a significant gap between the month on month saving delivery and that forecast for remaining periods in the year. The following graph shows that each month's actual savings consistently exceeds the prior month's forecast.



- A revised approach was introduced in Month 5 to ensure, as a minimum, a realistic financial position is confirmed as part of the gross forecast, including savings delivery. An amber scheme was created for £6.0m to show run rate reductions forecasted to future months. This was required due to the continued disconnect month on month with in-month delivery of savings and those forecast in future periods.
- Several targeted service review meetings were held between the service and senior finance colleagues and whilst some progress was made in Month 7 following these meetings, the Amber savings scheme remains and causes a credibility query, now £2.0m in Month 8, from £3.0m as reported in Month 7.
- As planning discussions are underway for the FY27 Planning cycle, it is recognised that the organisation must change the savings approach, the reactive underspend conversion approach is not sustainable and must be resolved in the budget setting process for the new financial year. An resolution update will be brought as part of the February 2026 Finance and Performance Committee meeting.

Cash

- The strategic cash request was discussed at the November Board meeting prior to submission to WG, factoring in working capital assumptions such as expected reimbursements for clinical negligence cases and potential impacts from Band 2 to 3 re-banding back pay.
- In line with Welsh Government guidelines (Technical Update 3 dated 7 November 2025), the Health Board submitted its Board approved Accountable Officer letter to request strategic cash assistance on 5 December 2025, a response is not expected until February 2026. Copy attached as **Appendix 4**.

- Should the requested strategic cash not be made available the Health Board will need to instigate its Cash Management Strategy, having previously been development and agreed via the Finance and Performance Committee and its previous titles.

£2.4m Board Improvement Decisions

- An update on the Board decisions made to improve the end of year forecast is included within **Appendix 1**.
- No further progress has been confirmed since the Month 7 update was made to the Board. Executive Directors are expected to progress decisions for their areas and update through the monthly financial cycle.

Ministerial Priorities

Contained within 'Ministerial Enablers: Annex 2' are specific requirements setting out what the Health Board must take further action on, to reduce the amount it spends on variable pay and premium agency, and has set out the following mandate on an adopt or explain basis:

- Deliver a further continued and sustained reduction in agency expenditure, with a target 30% reduction in 2025/26 from 2024/25 outturn, and ensuring no off-contract expenditure;
- Ensure a reduction in agency spend on Healthcare Support Worker, Admin and Clerical, and Estates and Ancillary staff to zero by 30 September 2025;
- Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025;
- Ensure a reduction in sickness absence in 2025/26 in comparison to 2024/25, through maximising adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales Occupational Health minimum service levels.

Continued positive action is evidenced towards achieving a 30% reduction in on-contract agency expenditure with a further reduction in spend in Month 8, with off-contract use now eliminated throughout the Health Board. There remains a national use of agency workers within Mental Health and Learning Disabilities for Healthcare Support Workers, in breach of the ministerial priority, with working continuing to remove the reliance.

Capital

- There is new risk around confirmation of WG funding and overspending against the Capital Resource Limit (CRL) at this stage of the financial year.
- Delivery against the capital programme remains at a medium risk. Whilst all capital schemes are forecast to complete within budget by the end of the financial year, there remains a level of uncertainty with regards to the receipt of end of year capital funding from Welsh Government, linked to the urgent Concrete Cladding Works at Withybush Hospital £(0.85)m. Also, a significant proportion of spend is remaining within the capital programme.
- The risk of underspending is caused by the profile of spend against capital projects, with 50% of the annual spend forecast to be committed in February and March 2026. There is no flexibility for these schemes to delay beyond March 2026, with project management oversight of progress being of upmost focus.

Welsh Risk Pool

- Welsh Government have formally notified the Health Board (**Appendix 2**) of funding being made available to cover a maximum of £49m, reflecting the Month 7 minimum position forecast by NWSSP.
- Clarity will be sought on whether the Health Board will be responsible for managing any further increases beyond the minimum position, and if so, the current worst case scenario would see a potential impact of £1.1m that could worsen the reported forecast.

Assure (to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

In-year savings delivery achievement

- Of the annual savings target of £46.4m, £48.5m has been identified on an in-year basis resulting in a £(2.1)m over-identification, however £48.2m are forecast to deliver, resulting in an overall £(1.8)m over-delivery of the savings target.
- Run rate management of year-to-date savings of £2.0m are now in the savings forecast to deliver in future months, with assurance not yet fully provided by services.
- Given the significant identification gap for robust deliverable savings schemes across some portfolios, further escalation for the Finance domain is likely due to risk associated with delivering the annual plan equitably across services, and the risks associated with the impact for the 2026/27 financial plan.

Grip and control measures

- An internal escalation framework has been revised and implemented, aligned to the Clinical Care Group and Executive Functions. Escalation meetings have been undertaken for all escalated services. These services have received a clear message regarding the need to deliver recurrent financial recovery plans for the November 2025 series of update meetings.
- Grip and control measures covering recruitment, training and procurement, overseen through the Financial Control Sub-Group (FCSG), chaired by the Executive Director of Finance, are providing scrutiny to current vacancies, with a sense of control permeating across the organisation, resulting in improvements to the financial bottom line.
- Additional controls have been communicated with a Workforce led sub-group reviewing all pay affecting change requests, supported with the introduction of an automated solution for recording, tracking and approving requests into NWSSP Payroll, which FCSG will oversee by exception.
- All Procurement approaches to market are approved by FCSG at the initial request and prior to awarding contracts.
- A new, recognised best practice, scheme of delegation within the Oracle requisition system has been implemented for the new Clinical Care Group structures, with aligned values across each of the seven approval levels. Further updates will be made in the coming months for the Executive Functions, and a hierarchical approval method will be introduced, which would require a requisition to be approved at each stage, adding visibility and appropriate oversight for all budget holders.

Reporting Developments

- As part of the internal Finance departments drive for continuous improvement and insightful reporting, the Finance team have been developing reporting suites, namely, Reporting Hwb, to provide a more relevant and appropriate financial output.
- The Month 8 Finance Performance report includes additional outputs focussing on actual trends within key spend categories such as, pay, primary care prescribing, secondary care drugs and continuing healthcare.
- This will provide further insight into key drivers of spend within the Health Board and has been developed with All Wales reporting via Financial Planning & Delivery.
- The developments have been a further improved from work undertaken across NHS Wales, NHS England, and industry best practice.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **RECOGNISE** that the Health Board's forecast deficit has improved to £22.1m, the revised target control total, following funding allocation confirmation from Welsh Government.
- **SCRUTINISE** the top priority alerts for urgent remedial action plans.
- **ACKNOWLEDGE** that the in-year savings delivery target has been over-achieved**.**
- **NOTE** 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.
- **ACKNOWLEDGE** 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.
- **NOTE** the Finance Performance report now includes additional outputs to provide more insightful and relevant reporting to the Committee.
- **NOTE** the strategic cash request has been sent to Welsh Government in December 2025.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers; 3.1.5.2 Performance against the savings requirement;

	3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086 (score 15) Risk of the Health Board not being able to meet the statutory requirement of breaking even in 2025/26 due to significant deficit position.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termau: Glossary of Terms:	BGH – Bronglais General Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili General Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours

	PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush General Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The impact on patient care is assessed within the savings schemes.
Gweithlu: **Workforce:**	The report considers the financial implications of our workforce.
Risg: **Risk:**	Financial risks are detailed in the report.
Cyfreithiol: **Legal:**	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.

Enw Da: **Reputational:**	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Gyfrinachedd: **Privacy:**	Not Applicable.
Cydraddoldeb: **Equality:**	Not Applicable.



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

2025/26 Financial Performance Report
Finance and Performance Committee

Month 8 November 2025/26

Additional Funding Allocation Update

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Key Information

Following confirmation received from Welsh Government on 10 December 2025, the Health Board has recognised funding for the increases to the Welsh Risk Pool risk share agreement (£4.2m) and the Band 2/3 uplift (£2.9m). With these funding confirmations, the Target Control Total expectation has also been revised to £22.1m from £21.1m, improving by the £2.0m Band 2/3 uplift assumption that was contained within the financial plan.

Due to the timing of the communication, with the finalisation of the position having concluded internally within the Health Board prior to it, the normal detail contained within this report references the reported position in lieu of the funding confirmation, i.e. £28.3m. The reported position has improved to £22.1m, and the following table explains the movements at a summary level that have been made since the detailed report was produced.

Key Driver (£'m)	Original End of Year Forecast	Revised End of Year Forecast	Movement	Explanations
Planned Deficit	**30.0**	**30.0**	**-**	**No change from original**
Savings gap / (improvement)	(2.1)	(2.1)	-	No change made from original
Under / (Over) delivery of savings schemes	0.3	0.3	-	No change made from original
Core operational variation	3.4	(3.7)	(7.1)	£4.2 WRP and £2.9m Band 2/3 funding allocations confirmed
Gross Forecast	**31.6**	**24.5**	**(7.1)**	**£4.2 WRP and £2.9m Band 2/3 funding allocations confirmed**
Future Mitigating Actions	(3.3)	(2.4)	(0.9)	£0.9m of funding from Band 2/3 assisted to improve mitigating actions
Reported Net Position	**28.3**	**22.1**	**(6.2)**	**£4.2m WRP and £2.0m Band 2/3 changes. Target Control Total revised to £22.1m**

Contents

Executive Summary
- Position Overview
- Actionable Insights
- Financial Summary

Income and Expenditure Insight
- Pay Insights
- Non-Pay Insights
- Income Insights

Operational and Financial Performance
- Key Drivers and Month on Month Movements
- Performance and Accountability
- Savings Performance
- Core Operational Variation
- Capital Performance

Appendices
- Trend Analysis
- Staffing Establishment Reports
- Revenue vs Plan Variance Matrices
- Savings Detail

Key

Risk Assessment and key performance indicator RAG criteria:

Alert	○	Lack of confidence in current actions to resolve issue; engagement, action or intervention required.
Advise	○	Areas of concern with current actions; assurance taken but close monitoring needed as early warning of potential serious issue.
Assure	○	Confidence that actions are robust and sufficient; routine monitoring only.

Savings BRAG and visual guide:

Current Month	Prior Month	Savings Blue, Red, Amber and Green Schemes (BRAG)
		A potential saving has been identified but is not yet scoped or developed. No detailed plan exists.
		Scheme is under consideration and initial scoping has started, but it is not yet fully developed or approved.
		Scheme has a clear plan, with actions and timelines defined, but delivery is not yet certain (medium risk).
		Implemented or near completion; savings delivery highly confident.



Revenue vs plan variance matrix report RAG indicator criteria:

Matrix Appendices RAG	In-Month Matrix	YTD Matrix	EOY Matrix
Large Positive Variance	>100,000	In-Month range x No. Months	In-Month range annualised
Moderate Positive Variance	50,000 – 99,999	In-Month range x No. Months	In-Month range annualised
Moderate Negative Variance	(99,999) – (50,000)	In-Month range x No. Months	In-Month range annualised
Large Negative Variance	<(100,000)	In-Month range x No. Months	In-Month range annualised

Position Overview – Executive Summary

The Health Board's Annual Planned Deficit is £30.0m with an Annual Savings Target of £46.4m. The reported end of year financial position is £24.1m, plus the anticipated best case Welsh Risk Pool risk share increase of £4.2m; a total deficit of £28.3m, aligned to the target control total. £3.3m of future mitigating actions are to be finalised to deliver this.

Financial Management

The in-month financial position is a deficit of £1.8m, which is an improvement against the £2.5m in-month deficit plan due to a core operational underspend of £(0.7)m. The savings target of £3.9m has been fully identified and delivered in-month. The financial run rate is on track to achieve the forecast position of £28.3m with mitigating actions of £3.3m required.

Key Driver (£'m)	Prior month variance to breakeven	Current month variance to breakeven	Year to Date variance to breakeven	Prior Month End of Year forecast to breakeven	End of Year forecast to breakeven
Planned Deficit	**2.5**	**2.5**	**20.0**	**30.0**	**30.0**
Unidentified / (Identified) savings gap / (improvement)	(6.3)	0.0	(4.7)	(2.0)	(2.1)
Under / (Over) delivery of savings schemes	0.0	0.0	0.3	0.3	0.3
Core operational variation	4.4	(0.7)	2.5	3.3	3.4
Gross Forecast	**0.6**	**1.8**	**18.1**	**31.6**	**31.6**
Future Mitigating Actions	0.0	0.0	0.0	(3.3)	(3.3)
Reported Position	**0.6**	**1.8**	**18.1**	**28.3**	**28.3**

Key Measures

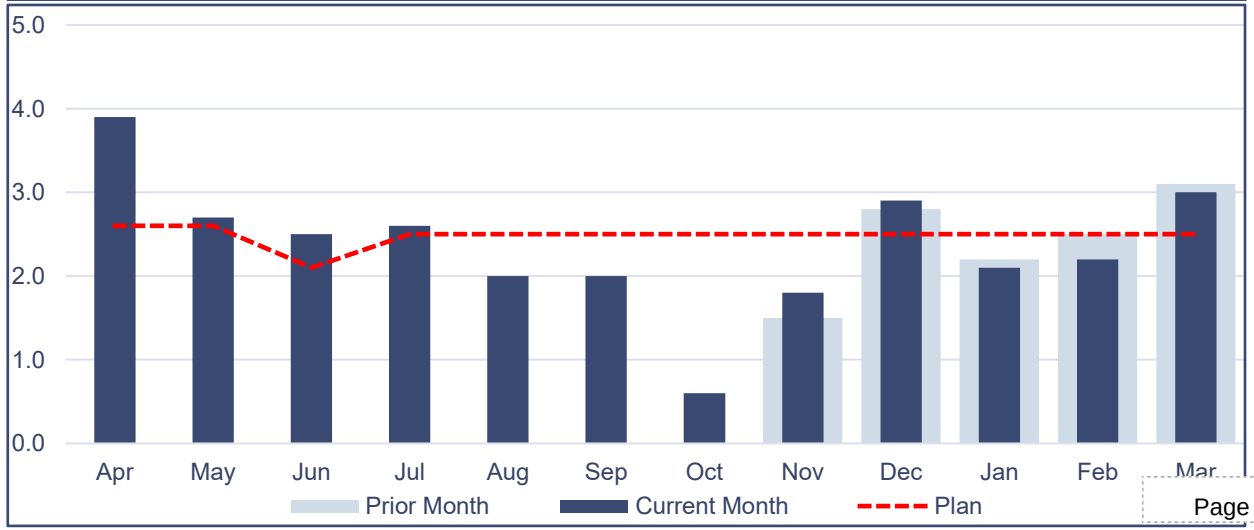
(Risk rating = Impact x Likelihood)

Core Operational Variation	**Risk #2086** 5 x 3 = 15	The in-month core under performance is driven Primary Care prescribing volume reductions from August and vaccination uptake delays within Public Health. Further increase to Medical costs due to absence staffing issues are contributing to the end of year deterioration.
Cash		Welsh Risk Pool risk share agreement increase of £4.2m creates a cash risk that may require a management strategy, due to it causing the Health Board to increase its deficit above the £24.1m expectation of Welsh Government. The strategic cash request was discussed at the November Board meeting prior to submission to WG, factoring in working capital assumptions such as expected reimbursements for clinical negligence cases and potential impacts from Band 2 to 3 re-banding back pay.
Savings		Of the annual savings target of £46.4m, £48.5m has been identified on an in-year basis resulting in a £(2.1)m over-identification, however £48.2m are forecast to deliver, leaving a £(1.8)m savings delivery overachievement. Run rate management of year-to-date savings of £2.0m are now in the savings forecast to deliver in future months, with assurance not yet fully provided by services.
Capital	**Risk #2204** 3 x 4 = 12	Delivery against the capital programme remains at a medium risk. Whilst all capital schemes are forecast to complete within budget by the end of the financial year, there remains a level of uncertainty with regards to the receipt of end of year capital funding from Welsh Government, linked to the urgent Concrete Cladding Works at Withybush Hospital (£0.85m). Also, a significant proportion of spend is remaining within the capital programme.
Underlying Deficit	**Risk #1199** 5 x 5 = 25	£18.2m of recurrent full year effect schemes have been identified and forecast to deliver, which includes a new Oncology drugs saving of £3.6m to deliver from April 2026, resulting in an underlying deficit of £59.3m. However, this does not support the organisations required trajectory to achieve financial breakeven by 2027/28. In addition, there are an increasing number of areas with clinical var[illegible]hich will need to be considered as part of the current planning cycle.

Position Overview – Change from Prior Month

Key Driver (£'m)	Prior Month Reported Position	Current Month Reported Position	Movement
Planned Deficit	**2.5**	**2.5**	**0.0**
Savings gap / (improvement)	(6.3)	0.0	6.3
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	4.4	(0.7)	(5.1)
Gross Forecast	**0.6**	**1.8**	**1.2**
Future Mitigating Actions	0.0	0.0	0.0
Reported Net Position	**0.6**	**1.8**	**1.2**

In-Month Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
Aseptic Unit saving in prior month	6.1
Decrease in Dental savings	0.2
Movement in Unidentified Savings Gap	**6.3**

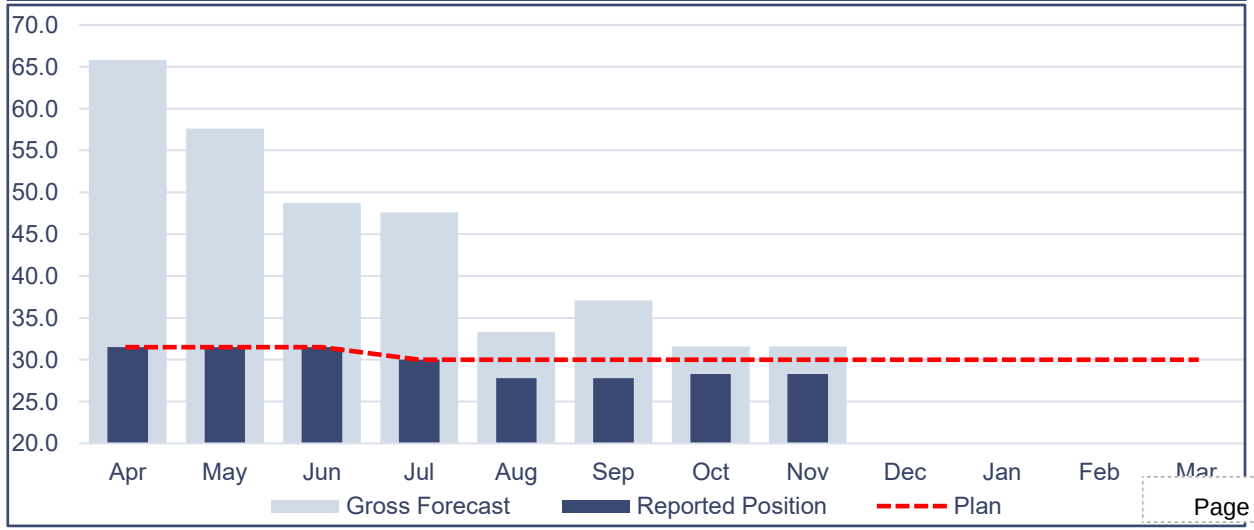
Under / (Over) Delivery of Savings Schemes (£'m)	Change
No change to report	0.0
Movement in Savings Delivery	**0.0**

Core Operational Variation (£'m)	Change
Band 2/3 Additional Healthcare Support Workers Uplift year to date catch up	0.6
Welsh Risk Pool Risk Share agreement in prior month	(4.2)
Public Health Shingles and Covid-19 vaccinations uptake	(0.6)
Primary Care Prescribing price (£0.03p) and volume reduction (4.6%)	(0.5)
Income overachievement for Cost Recovery and Non-Contracted Activity	(0.4)
Movement in Core Operational Variation	**(5.1)**

Position Overview – Change from Prior Forecast

Key Driver (£'m)	Prior Month End of Year Forecast	End of Year Forecast	Movement
Planned Deficit	**30.0**	**30.0**	**0.0**
Savings gap / (improvement)	(2.0)	(2.1)	(0.1)
Under / (Over) delivery of savings schemes	0.3	0.3	0.0
Core Operational Variation	3.3	3.4	0.1
Gross Forecast	**31.6**	**31.6**	**0.0**
Future Mitigating Actions	(3.3)	(3.3)	0.0
Reported Net Position	**28.3**	**28.3**	**0.0**

End of Year Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
In-month pay underspends conversion over and above amber scheme	(0.1)
Movement in Unidentified Savings Gap	**(0.1)**

Under / (Over) Delivery of Savings Schemes (£'m)	Change
No change to report	0.0
Movement in Savings Delivery	**0.0**

Core Operational Variation (£'m)	Change
Band 2/3 Additional Healthcare Support Workers Uplift full year increase	0.9
Planned Care Orthopaedic & Dermatology insourcing and outsourcing	0.8
Medical locum usage to cover sickness, vacancies and surge capacity	0.7
Continuing Healthcare negotiation of uplift costs	(1.5)
Income overachievement for Cost Recovery and Non-Contracted Activity	(0.4)
Health Board Wide NWSSP rebate of distribution costs	(0.4)
…vement in Core Operational Variation	**0.1**

Actionable Insights – Top Priority Alerts

Theme	Description	£'m	Accountability Status
Medical Pay – Additional cover at premium costs	Continued use of additional medical cover, including premium locum and agency within Community and Integrated Medicine (£2.2m), Planned Care (£2.4m), Mental Health (£1.1m) and Primary Care (£1.0m). **Required:** Update required for timelines on Medical Stabilisation Programme	6.6	CCG Directors / Medical / Workforce **Overdue**
Continuing Healthcare	Increased packages and purchase of Psychiatric Intensive Care Unit beds from independent sector. Mental Health and learning Disabilities (£2.9m), Community & Integrated Medicines (0.6m)	3.5	CCG Directors **Overdue**
Planned & Specialist Care	Increased expenditure to improve recovery waiting lists across Planned Care specialties, associated with both insource and outsourcing activities. **Required:** Confirm the plans and performance trajectories, including the impacts on resources and finances, on waiting times/ lists.	2.3	Director of Operational Planning & Performance **Overdue**
LTA 's with other NHS Providers	Continued increases in Swansea Bay Emergency Activity	1.9	Executive Director of Strategy and Planning **January 2026**
Community & Integrated Medicines	Other non pay expenditure for the purchase of incontinence products and insulin pumps above plan levels. **Required:** Full review of non pay spend levels and mitigating actions to reduce spend	1.6	CIM CCG Service Director **December 2025**
Estates & Facilities	Other non pay costs, including Laundry, Energy, Utilities and External Maintenance Contracts, shows increasing trend. **Required:** Full review of non pay spend levels and mitigating actions to reduce spend	1.0	Executive Director of Allied Health **December 2025**
Reactive Savings Planning	Areas continue to forecast materially lower savings when compared to what is being delivered each month. An Amber overlay judgement scheme remains and causes a credibility query, now £2m from £3m last month. **Required:** Savings need to be forecast into future months, in particular for those Service areas delivering monthly pay underspends	2.0	CCG/Function Leads **Overdue**

£2.4m Board Improvement Decisions (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Category 1 Items £k				
Scheme	**Original Opportunity**	**In Position at M08**	**Opportunity Balance**	**Details**
HB wide recruitment freeze for non-patient facing roles	1,127	500	644	Actual Admin and Clerical WTE in July was 2,110wte. In Month 8, this has increased to 2,142wte so no reduction seen. Opportunity balance reduced to reflect only 5 months of the year remaining
Pause procurement of non-essential non-clinical equipment/ consumables to promote recycling	41	0	41	No benefit included in the Month 8 position
Mandate virtual meetings for management staff	33	0	33	No benefit included in the Month 8 position.
MHLD - Neurodevelopmental outsourcing, core funding. Pause on the basis that plan is deferred temporarily and review in Q4.	230	144	0	In Month 7, £144k has been achieved. Any further opportunity will be dependant on the mix of providers.
Strategic Planning budget including consultancy use Split A: Non-CSP work	250	250	0	Savings transacted and the £250k was included in the Month 6 position.
Sub Total	**1,681**	**894**	**718**	

Category 1: Options which present lesser negative impact from a service delivery perspective, though are not without consequence.

£2.4m Board Improvement Decisions (2 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Category 2 Items £k				
Scheme	**Original Opportunity**	**In Position at M08**	**Opportunity Balance**	**Details**
Pause all overtime until the end of March	96	0	54	No progress in Month 8 Opportunity balance reduced to reflect only 4 months of the year remaining
Reduce/eliminate all on contract agency	0	0	0	No progress in Month 8
Local Authority shared costs	450	392	0	Benefit delivered in Month 7, no further benefit expected
Cease Minor Works other than essential	100	0	100	Ceasing minor works other than essential works remains an option but at this stage, this has not been actioned
Non-renewal of contracts and or digital licences	75	75	0	£75k forecast improvement in Month 6 to reflect the action taken
Opportunity linked to commissioning cost control	70	0	70	Further work ongoing but at this stage, this benefit is seen as unlikely
Sub Total	**791**	**467**	**250**	
Total	**2,472**	**1,361**	**968**	**No further improvement has been achieved in Month 8**

Category 2: Options of consequences – options which require more detailed assessment by CCGs/Functions to assess what can be delivered within specific services.

Financial Summary

In-Month Actual
£112.5m
Variance to Plan = £(0.7)m

YTD Actual
£862.7m
Variance to Plan = £(1.9)m

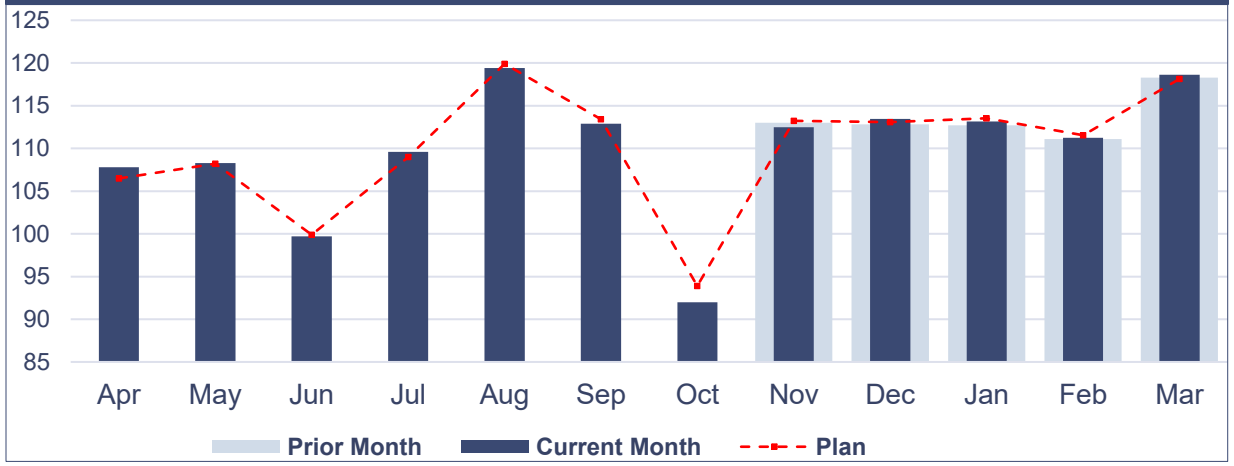
EOY Forecast
£1,319.1m
Variance to Plan = £(1.7)m

3-Year Growth
16.2%
2022-23 Outturn £1,135m*

In-Year Growth
0.2%
2024-25 Outturn £1,317m*

YTD Extrapolation
£1,294m
Risk / (Opp) = £(25.1)m

Net Income and Expenditure



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay	**57.2**	**56.8**	**58.0**	**455.0**	**682.5**	**683.3**		**(0.8)**
Administration and Estates	11.6	11.5	11.7	92.1	138.2	137.8		0.4
Allied Health, Scientists and Other	7.1	7.3	7.2	57.0	85.5	85.8		(0.3)
Medical and Dental	13.5	13.3	13.4	106.3	159.5	160.7		(1.2)
Nursing, Midwifery and Clinical Support	25.0	24.8	25.7	199.5	299.2	299.1		0.2
Non Pay	**62.3**	**41.7**	**61.6**	**457.9**	**686.9**	**713.4**		**(26.5)**
Clinical Services and Supplies	3.8	4.7	4.4	33.7	50.5	51.2		(0.6)
Commissioned Healthcare Services	38.1	36.5	36.9	283.8	425.7	427.4		(1.7)
Drugs and Prescribing	12.1	7.3	11.7	95.5	143.2	147.9		(4.6)
Other Non-Pay	8.4	(6.7)	8.6	45.0	67.5	87.0		(19.5)
Income	**(6.7)**	**(6.6)**	**(7.0)**	**(50.2)**	**(75.4)**	**(77.5)**		**2.2**
Net Income and Expenditure	**112.9**	**91.9**	**112.5**	**862.7**	**1,294.0**	**1,319.1**		**(25.1)**
Allocations	**110.9**	**91.4**	**110.8**	**844.6**	**1,266.9**	**1,290.8**		**24.0**
Reported Position	**2.0**	**0.6**	**1.8**	**18.1**	**27.1**	**28.3**		**(1.2)**

Key Information

Month 3, June, amortisation of capital expenditure reduced circa £8.0m.

Month 5, August, 2025-26 pay award expenditure, including year to date backpay circa £9.0m.

Month 7, October, amortisation of capital expenditure reduced circa £16.2m and drugs expenditure reduced by £6.1m relating to Aseptic Unit System saving.

Month 12, March, includes a £6.0m increase in relation to anticipated Depreciation and Amortisation Impairment increases.

***Outturn adjusted for Notional Pension costs 2024-25 c£40.3m, 2022-23 c£22.0m.**

Financial Summary – Key Drivers

In-Month

Reported Position
£1.8m
Planned Deficit = £2.5m
Prior Month Forecast = £1.5m

Savings Identification Gap
£0.0m
Savings Target = £3.9m
Total Identified = £3.9m

Savings Delivery Gap
£0.0m
Savings Delivery = £3.9m
Prior Month Delivery = £3.9m

Core Operational Variation
£(0.7)m
Prior Month Variation = £4.4m

Year to Date

Reported Position
£18.1m
Planned Deficit = £20.0m

Savings Identification Gap
£(4.7)m
Savings Target = £30.9m
Total Identified = £35.6m

Savings Delivery Gap
£0.3m
Savings Delivery = £35.3m
Prior Month Delivery = £31.5m

Core Operational Variation
£2.5m
Prior Month Variation = £3.2m

End of Year

Reported Position
£28.3m
Annual Plan = £30.0m
Prior Annual Forecast = £28.3m

Savings Identification Gap
£(2.1)m
Savings Target = £46.4m
Total Identified = £48.5m

Savings Delivery Gap
£0.3m
Savings Delivery = £48.2m
Prior Month Delivery = £48.1m

Core Operational Variation
£3.4m
Prior Month Variation = £3.2m

Gross Forecast
£31.6m
Prior Gross Forecast = £31.6m
Mitigating Actions = £(3.3)m

Net Risks / (Opportunities)
£1.6m
Prior Month = £1.8m

Capital Position
£36.7m
Annual Plan = £36.7m
Prior Annual Forecast = £34.5m

Underlying Deficit
£59.3m
Annual Plan = £58.5m

Total Pay Insights

In-Month Actual
£58.0m
Variance to Plan = £0.9m

YTD Actual
£455.0m
Variance to Plan = £0.3m

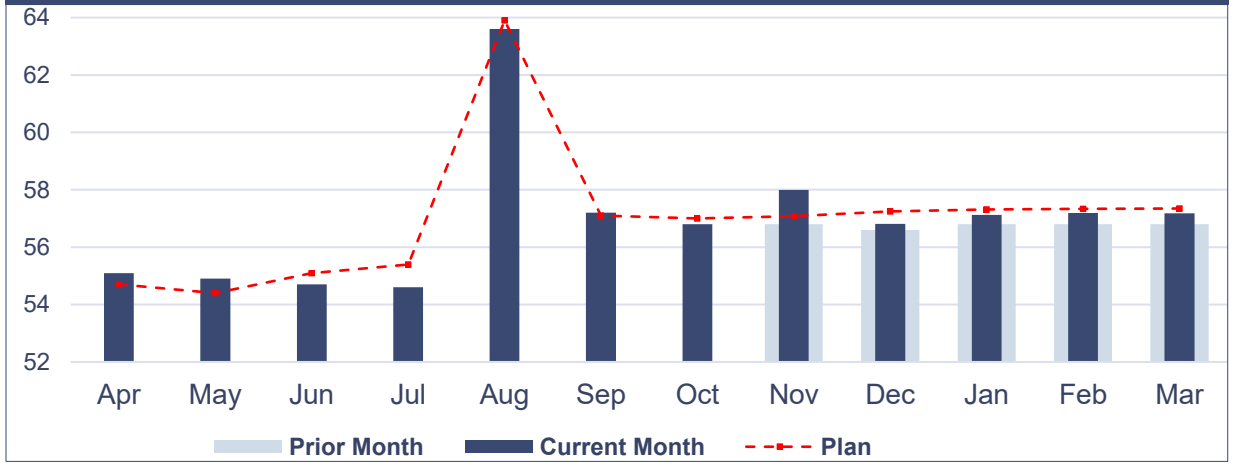
EOY Forecast
£683.3m
Variance to Plan = £(2.7)m

3-Year Growth
25.2%
2022-23 Outturn £545.6m*

In-Year Growth
7.5%
2024-25 Outturn £635.5m*

YTD Extrapolation
£682.5m
Risk / (Opp) = £(0.8)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Substantive	**51.8**	**51.7**	**52.9**	**413.8**	**620.6**	**621.1**		**(0.4)**
Administration and Estates	11.2	11.1	11.3	89.5	134.3	133.8		0.5
Allied Health, Scientists and Other	6.9	7.0	7.0	54.9	82.4	82.7		(0.3)
Medical and Dental	10.9	10.8	10.9	85.8	128.7	129.5		(0.8)
Nursing, Midwifery and Clinical Support	22.9	22.8	23.6	183.6	275.3	275.1		0.2
Variable	**4.5**	**4.2**	**4.3**	**35.0**	**52.5**	**52.6**		**(0.0)**
Administration and Estates	0.4	0.3	0.3	2.6	4.0	4.0		(0.0)
Allied Health, Scientists and Other	0.2	0.2	0.2	1.1	1.7	1.7		(0.0)
Medical and Dental	2.3	2.0	2.1	18.1	27.1	26.8		0.3
Nursing, Midwifery and Clinical Support	1.7	1.7	1.7	13.2	19.7	20.0		(0.3)
Agency (Premium)	**0.8**	**0.9**	**0.8**	**6.2**	**9.3**	**9.6**		**(0.4)**
Administration and Estates	-	-	-	-	-	-		-
Allied Health, Scientists and Other	0.1	0.1	0.1	0.9	1.4	1.3		0.1
Medical and Dental	0.3	0.4	0.4	2.5	3.7	4.4		(0.7)
Nursing, Midwifery and Clinical Support	0.4	0.4	0.4	2.8	4.1	3.9		0.2
Total Expenditure	**57.2**	**56.8**	**58.0**	**455.0**	**682.5**	**683.3**		**(0.8)**
Plan	**57.1**	**57.0**	**57.1**	**454.7**	**682.0**	**686.0**		
Variance to Plan	**0.1**	**(0.2)**	**0.9**	**0.3**	**0.4**	**(2.7)**		

Key Information

Month 5, August, 2025-26 pay award expenditure inclusive of year to date backpay circa £9.0m, with subsequent months consequentially increasing.

Month 8, November, includes year to date recognition of additional band 2 to 3 pay award and rebanding uplift expenditure £0.6m.

***Outturn adjusted for Notional Pension costs 2024-25 c£40.3m, 2022-23 c£22.0m.**

Substantive Insights

In-Month Actual
£52.9m
Variance to Plan = £(2.3)m

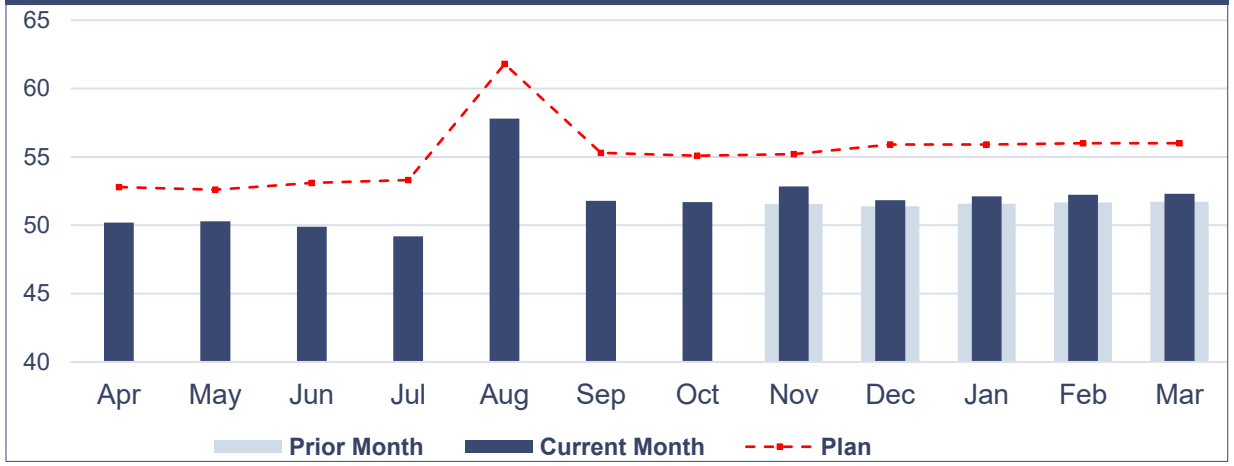
YTD Actual
£413.8m
Variance to Plan=£(25.5)m

EOY Forecast
£621.1m
Variance to Plan=£(41.9)m

In-Year Growth
1.5%
2024-25 Outturn £611.7m

YTD Extrapolation
£658.8m
Risk / (Opp) = £(0.4)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	**51.8**	**51.7**	**52.9**	**413.8**	**620.6**	**621.1**		**(0.4)**
Administration and Estates	11.2	11.1	11.3	89.5	134.3	133.8		0.5
Allied Health, Scientists and Other	6.9	7.0	7.0	54.9	82.4	82.7		(0.3)
Medical and Dental	10.9	10.8	10.9	85.8	128.7	129.5		(0.8)
Nursing, Midwifery and Clinical Support	22.9	22.8	23.6	183.6	275.3	275.1		0.2
Functions	**51.8**	**51.7**	**52.9**	**413.8**	**620.6**	**621.1**		**(0.4)**
Chief Operating Officer Management	0.9	0.9	1.0	7.6	11.5	11.4		0.0
Community and Integrated Medicine	15.7	15.6	15.6	124.8	187.2	187.8		(0.6)
Mental Health and Learning Disabilities	5.7	5.7	5.8	45.5	68.3	69.2		(0.9)
Operational Allied Health and Health Sciences	5.5	5.6	5.5	43.7	65.6	65.9		(0.3)
Planned and Specialist Care	13.1	13.1	13.3	104.4	156.6	157.1		(0.6)
Primary Care, Community Strategy and Long Term Care	2.6	2.6	2.6	21.0	31.5	31.5		0.0
Executive Functions	8.3	8.2	9.0	66.7	100.0	98.2		1.8
Total Expenditure	**51.8**	**51.7**	**52.9**	**413.8**	**620.6**	**621.1**		**(0.4)**
Plan	**55.3**	**55.1**	**55.2**	**439.2**	**658.8**	**662.9**		
Variance to Plan	**(3.5)**	**(3.4)**	**(2.3)**	**(25.5)**	**(38.2)**	**(41.9)**		

Key Information

Month 5, August, includes 2025-26 pay award expenditure, including year to date backpay circa £9.0m.

Month 8, November, Executive Functions increase of £0.8m on prior month as a result of additional band 2 to 3 pay award and rebanding uplift expenditure mainly relating to Healthcare Support Workers within Nursing £0.6m.

Variable Insights

In-Month Actual
£4.3m
Variance to Plan = £2.7m

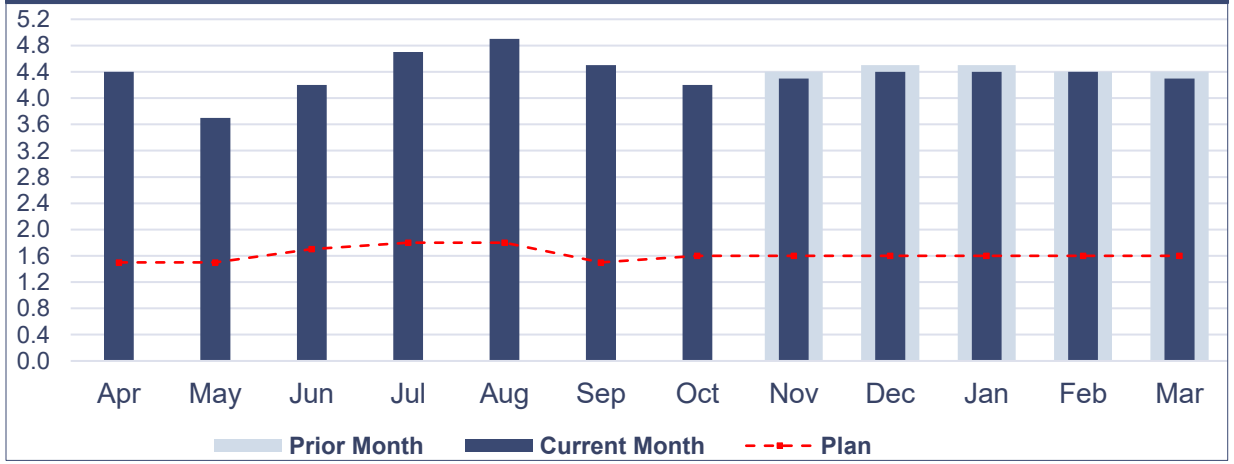
YTD Actual
£35.0m
Variance to Plan = £22.3m

EOY Forecast
£52.6m
Variance to Plan = £33.6m

In-Year Growth
(15.7)%
2024-25 Outturn £62.4m

YTD Extrapolation
£52.5m
Risk / (Opp) = £0.0m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	**4.5**	**4.2**	**4.3**	**35.0**	**52.5**	**52.6**		**(0.0)**
Administration and Estates	0.4	0.3	0.3	2.6	4.0	4.0		(0.0)
Allied Health, Scientists and Other	0.2	0.2	0.2	1.1	1.7	1.7		(0.0)
Medical and Dental	2.3	2.0	2.1	18.1	27.1	26.8		0.3
Nursing, Midwifery and Clinical Support	1.7	1.7	1.7	13.2	19.7	20.0		(0.3)
Functions	**4.5**	**4.2**	**4.3**	**35.0**	**52.5**	**52.6**		**(0.0)**
Chief Operating Officer Management	-	-	-	0.1	0.1	0.1		(0.0)
Community and Integrated Medicine	1.6	1.6	1.7	13.4	20.1	20.0		0.1
Mental Health and Learning Disabilities	0.4	0.3	0.3	2.6	3.9	3.7		0.2
Operational Allied Health and Health Sciences	0.3	0.3	0.3	1.8	2.8	2.9		(0.1)
Planned and Specialist Care	1.5	1.3	1.3	10.6	15.9	16.1		(0.1)
Primary Care, Community Strategy and Long Term Care	0.5	0.4	0.6	4.3	6.4	6.6		(0.2)
Executive Functions	0.3	0.3	0.3	2.2	3.3	3.3		0.0
Total Expenditure	**4.5**	**4.2**	**4.3**	**35.0**	**52.5**	**52.6**		**(0.0)**
Plan	**1.5**	**1.6**	**1.6**	**12.7**	**19.1**	**19.0**		
Variance to Plan	**3.1**	**2.6**	**2.7**	**22.3**	**33.4**	**33.6**		

Key Information

Agency Insights

In-Month Actual
£0.8m
Variance to Plan = £0.5m

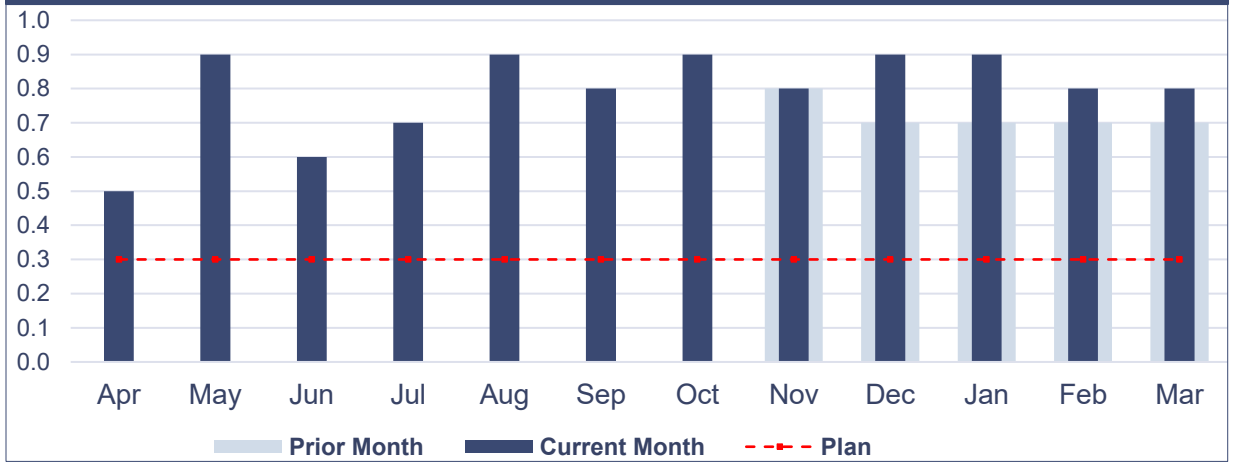
YTD Actual
£6.2m
Variance to Plan = £3.5m

EOY Forecast
£9.6m
Variance to Plan = £5.6m

In-Year Growth
(42.9)%
2024-25 Outturn £16.8m

YTD Extrapolation
£9.3m
Risk / (Opp) = £(0.4)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	**0.8**	**0.9**	**0.8**	**6.2**	**9.3**	**9.6**		**(0.4)**
Administration and Estates	-	-	-	-	-	-		-
Allied Health, Scientists and Other	0.1	0.1	0.1	0.9	1.4	1.3		0.1
Medical and Dental	0.3	0.4	0.4	2.5	3.7	4.4		(0.7)
Nursing, Midwifery and Clinical Support	0.4	0.4	0.4	2.8	4.1	3.9		0.2
Functions	**0.8**	**0.9**	**0.8**	**6.2**	**9.3**	**9.7**		**(0.4)**
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	0.4	0.5	0.4	3.1	4.7	5.1		(0.5)
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.7	1.1	1.1		0.0
Operational Allied Health and Health Sciences	0.2	0.2	0.1	1.4	2.2	2.1		0.1
Planned and Specialist Care	0.1	0.1	0.2	0.9	1.3	1.3		0.0
Primary Care, Community Strategy and Long Term Care	-	-	-	-	-	-		-
Executive Functions	-	-	-	-	-	-		-
Total Expenditure	**0.8**	**0.9**	**0.8**	**6.2**	**9.3**	**9.6**		**(0.4)**
Plan	**0.3**	**0.3**	**0.3**	**2.7**	**4.1**	**4.1**		
Variance to Plan	**0.5**	**0.6**	**0.5**	**3.5**	**5.2**	**5.6**		

Key Information

Community and Integrated Medicine forecast increased premium medical agency costs in Carmarthenshire and Pembrokeshire for surge capacity, vacancies and sickness absence increases.

Clinical Services and Supplies Insights

In-Month Actual
£4.4m
Variance to Plan = £0.2m

YTD Actual
£33.7m
Variance to Plan = £1.2m

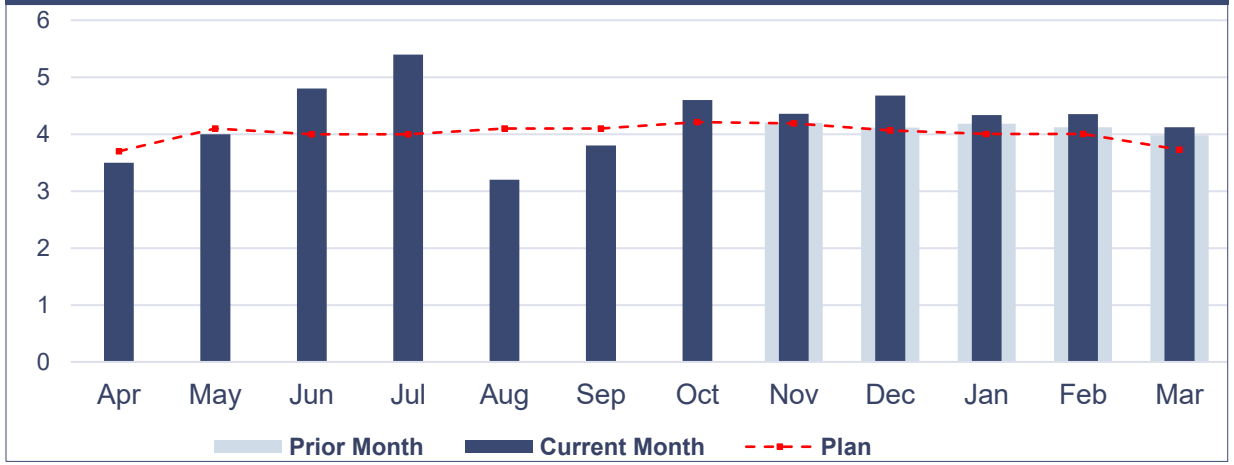
EOY Forecast
£51.2m
Variance to Plan = £2.9m

3-Year Growth
18.7%
2022-23 Outturn £40.6m

In-Year Growth
1.7%
2024-25 Outturn £47.4m

YTD Extrapolation
£50.5m
Risk / (Opp) = £(0.6)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**3.8**	**4.6**	**4.4**	**33.7**	**50.5**	**51.2**		**(0.6)**
Chief Operating Officer Management	-	-	-	0.1	0.2	0.2		-
Community and Integrated Medicine	1.0	1.1	1.2	8.3	12.5	12.6		(0.1)
Mental Health and Learning Disabilities	-	-	-	0.2	0.2	0.2		-
Operational Allied Health and Health Sciences	0.8	1.2	1.1	9.0	13.5	14.1		(0.6)
Planned and Specialist Care	2.0	2.2	1.8	14.7	22.0	22.2		(0.2)
Primary Care, Community Strategy and Long Term Care	0.1	0.3	0.2	1.9	2.8	2.8		-
Executive Functions	(0.1)	(0.1)	-	(0.4)	(0.6)	(0.9)		0.3
Total Expenditure	**3.8**	**4.6**	**4.4**	**33.7**	**50.5**	**51.2**		**(0.6)**
Plan	**4.1**	**4.2**	**4.2**	**32.4**	**48.7**	**48.2**		**0.4**
Variance to Plan	**(0.3)**	**0.4**	**0.2**	**1.2**	**1.9**	**2.9**		**(1.1)**

Key Information

Month 5, August, includes a year to date reclassification of Planned and Specialist Care Theatre outsourcing activity from Clinical Services and Supplies to Commissioned Healthcare Services.

Month 7, October, includes an increase relating to Planned and Specialist Care stock due to flooding replacements and increased stock levels due to new system.

Commissioned Healthcare Services Insights

In-Month Actual
£36.9m
Variance to Plan = £1.9m

YTD Actual
£283.8m
Variance to Plan = £2.7m

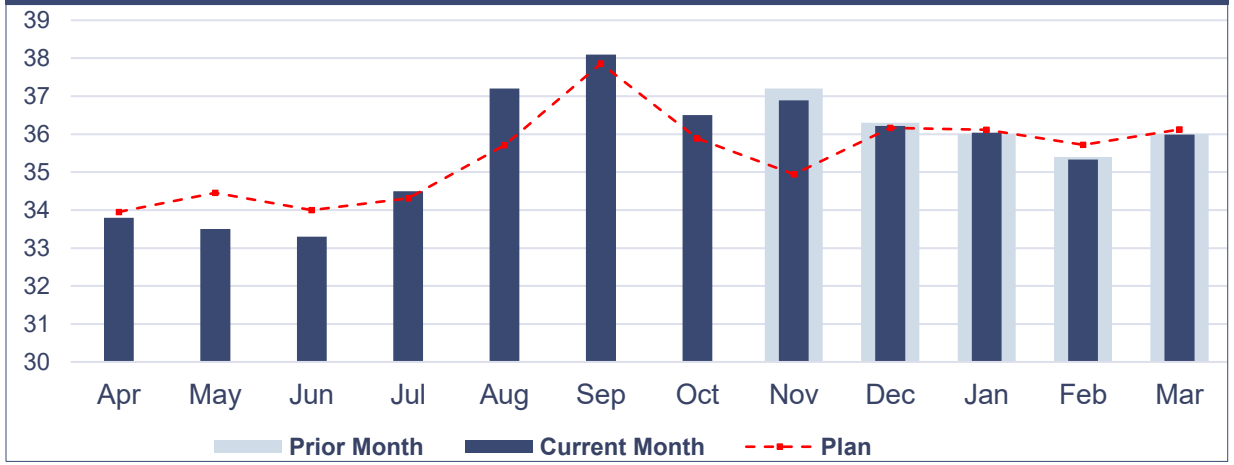
EOY Forecast
£427.4m
Variance to Plan = £3.6m

3-Year Growth
20.8%
2022-23 Outturn £353.8m

In-Year Growth
5.3%
2024-25 Outturn £405.7m

YTD Extrapolation
£425.7m
Risk / (Opp) = £(1.7)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**38.1**	**36.5**	**36.9**	**283.8**	**425.7**	**427.4**		**(1.7)**
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	2.6	2.6	2.6	20.4	30.6	30.6		0.1
Mental Health and Learning Disabilities	3.9	4.1	3.9	29.9	44.8	44.7		0.1
Operational Allied Health and Health Sciences	0.4	0.4	0.4	3.6	5.4	5.4		-
Planned and Specialist Care	0.6	1.0	1.3	6.5	9.8	10.2		(0.4)
Primary Care, Community Strategy and Long Term Care	10.2	10.3	10.4	79.8	119.7	119.9		(0.2)
Executive Functions	20.4	18.0	18.3	143.6	215.3	216.5		(1.2)
Total Expenditure	**38.1**	**36.5**	**36.9**	**283.8**	**425.7**	**427.4**		**(1.7)**
Plan	**37.9**	**35.9**	**34.9**	**281.1**	**421.7**	**423.8**		**(2.1)**
Variance to Plan	**0.3**	**0.6**	**1.9**	**2.7**	**4.0**	**3.6**		**0.4**

Key Information

Month 5, August, includes a year to date reclassification of Planned and Specialist Care Theatre outsourcing activity from Clinical Services and Supplies to Commissioned Healthcare Services, and increase in Continuing Healthcare due to a year to date backdated catch up for anticipated retrospective uplift.

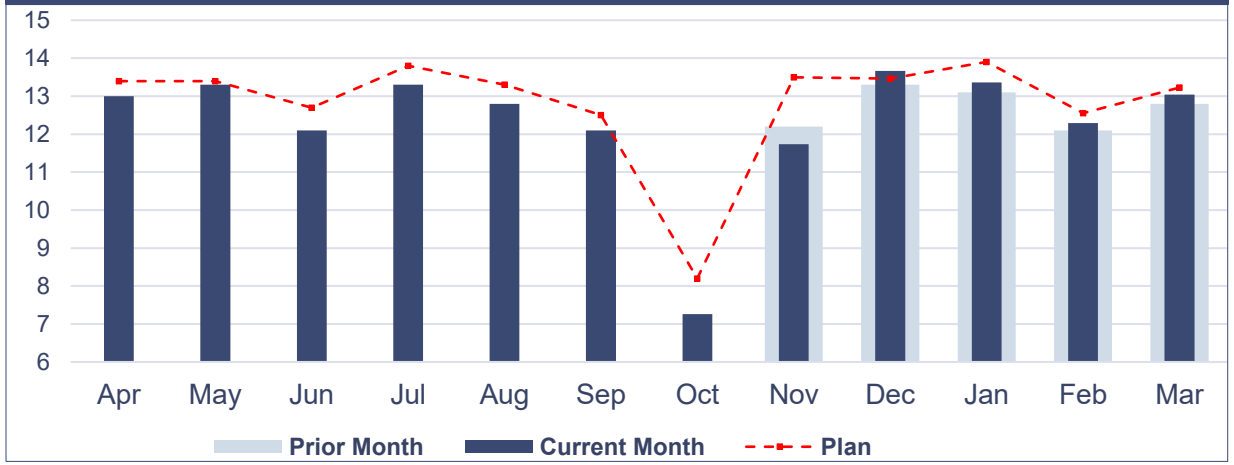
Month 6, September, includes year to date Joint Commissioning Committee expenditure relating to Pay Award, Vertex and Health Education Improvement Wales Doctors Dentist Remuneration Board Pay Matrix, all of which totalling £3.4m, offset by increase in funding.

Month 8, November, includes a year to date recategorisation of Primary Care Dental underspends savings from Other Non Pay.

Drugs & Prescribing Insights

In-Month Actual	YTD Actual	EOY Forecast	3-Year Growth	In-Year Growth	YTD Extrapolation
£11.7m	£95.5m	£147.9m	5.2%	(4.5)%	£143.2m
Variance to Plan = £(1.8)m	Variance to Plan = £(5.2)m	Variance to Plan = £(6.0)m	2022-23 Outturn £140.6m	2024-25 Outturn £154.9m	Risk / (Opp) = £(4.6)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**12.1**	**7.3**	**11.7**	**95.5**	**143.2**	**147.9**		**(4.6)**
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	1.5	1.3	1.4	11.6	17.3	17.5		(0.2)
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.8	1.2	1.3		(0.1)
Operational Allied Health and Health Sciences	0.6	0.5	0.4	4.1	6.1	6.0		0.1
Planned and Specialist Care	2.5	3.0	2.9	24.3	36.5	37.0		(0.5)
Primary Care, Community Strategy and Long Term Care	7.1	7.9	6.7	57.6	86.4	87.8		(1.4)
Executive Functions	0.4	(5.6)	0.1	(2.9)	(4.3)	(1.7)		(2.6)
Total Expenditure	**12.1**	**7.3**	**11.7**	**95.5**	**143.2**	**147.9**		**(4.6)**
Plan	**12.5**	**8.2**	**13.5**	**100.7**	**151.0**	**153.8**		**(2.8)**
Variance to Plan	**(0.5)**	**(0.9)**	**(1.8)**	**(5.2)**	**(7.8)**	**(6.0)**		**(1.8)**

Key Information

Month 7, October, reduction of £6.1m as a year to date recognition of Aseptic Unit System saving alignment.

Month 8, November, reduction in Primary Care prescribing days from 23 days in October to 20 days in November. In month recognition of most recently available Prescribing Audit Report, sighting a reduced price per item of £0.03p and volume reduction 4.6% for August.

Expenditure from December to March increased monthly circa £0.3m, to a total of £1.3m due to the step up in Mounjaro costs as seen in the recent Prescribing Audit Report.

Other Non-Pay Insights

In-Month Actual
£8.6m
Variance to Plan = £1.2m

YTD Actual
£45.0m
Variance to Plan = £21.3m

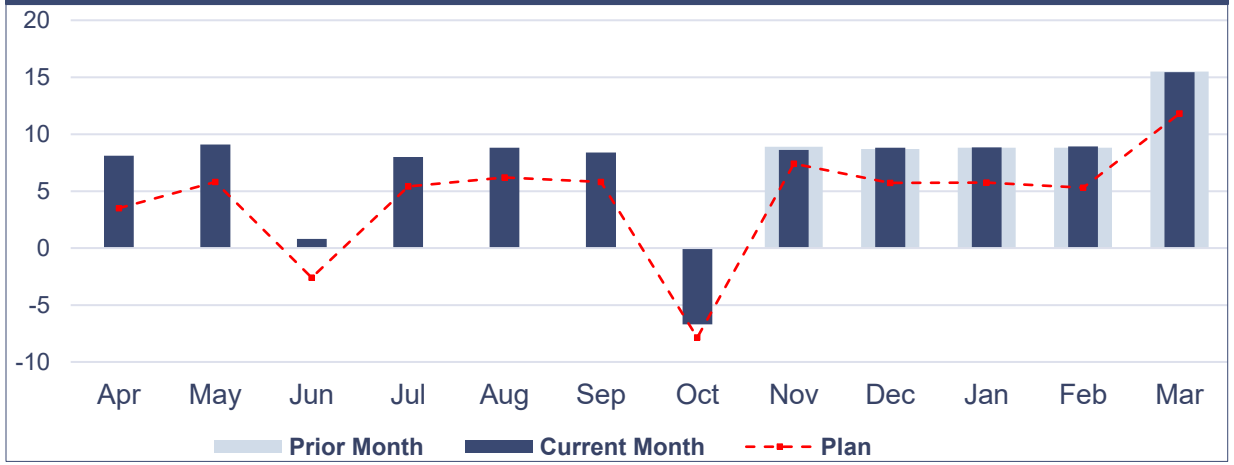
EOY Forecast
£87.0m
Variance to Plan = £35.4m

3-Year Growth
(21.7)%
2022-23 Outturn £111.1m

In-Year Growth
(38.5)%
2024-25 Outturn £141.5m

YTD Extrapolation
£67.5m
Risk / (Opp) = £(19.6)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**8.4**	**(6.7)**	**8.6**	**45.0**	**67.5**	**87.0**		**(19.6)**
Chief Operating Officer Management	0.1	0.2	0.1	1.1	1.6	1.9		(0.3)
Community and Integrated Medicine	0.6	0.7	0.9	6.6	10.0	10.2		(0.2)
Mental Health and Learning Disabilities	0.2	0.3	0.2	1.7	2.6	2.6		-
Operational Allied Health and Health Sciences	0.1	0.1	0.2	1.2	1.8	1.8		-
Planned and Specialist Care	0.3	0.3	0.4	2.7	4.0	4.2		(0.1)
Primary Care, Community Strategy and Long Term Care	0.3	0.3	0.2	2.0	3.0	3.0		-
Executive Functions	6.7	(8.6)	6.7	29.7	44.5	63.5		(19.0)
Total Expenditure	**8.4**	**(6.7)**	**8.6**	**45.0**	**67.5**	**87.0**		**(19.6)**
Plan	**5.8**	**(7.9)**	**7.4**	**23.7**	**35.5**	**51.6**		**(16.1)**
Variance to Plan	**2.6**	**1.1**	**1.2**	**21.3**	**32.0**	**35.4**		**(3.4)**

Key Information

Month 3 and 7, June and October, Amortisation and revaluation and impairment adjustments of Capital Expenditure reduced by circa £8.0m and £16.2m respectively.

Month 12, March, includes a £6.0m increase in relation to anticipated Depreciation and Amortisation Impairment increases.

Income Insights

In-Month Actual
£7.0m
Variance to Plan = £0.7m

YTD Actual
£50.2m
Variance to Plan = £2.2m

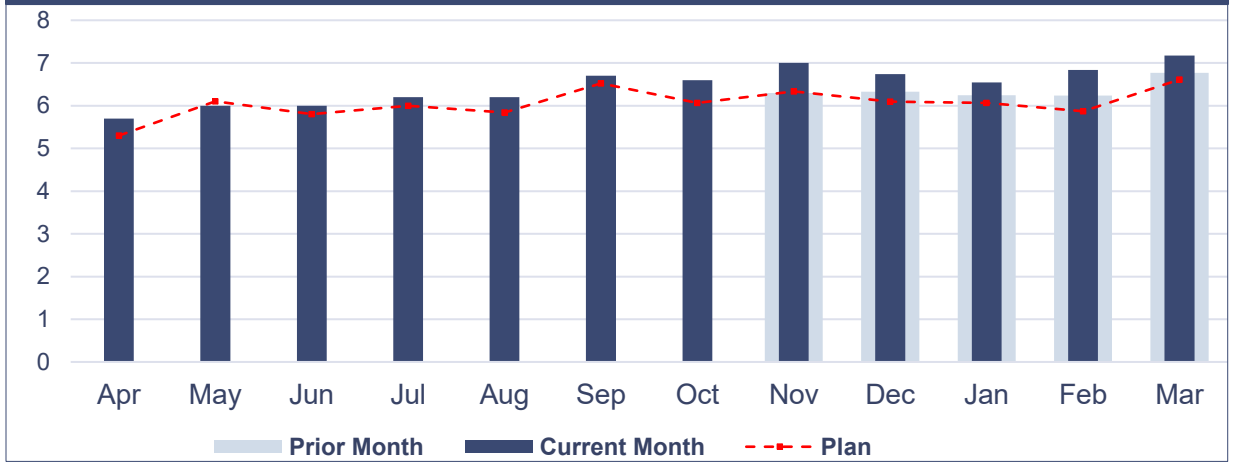
EOY Forecast
£77.5m
Variance to Plan = £4.9m

3-Year Growth
7.2%
2022-23 Outturn £72.3m

In-Year Growth
(1.2)%
2024-25 Outturn £78.4m

YTD Extrapolation
£75.3m
(Risk) / Opp = £(2.2)m

Income Monthly Trend (£'m)

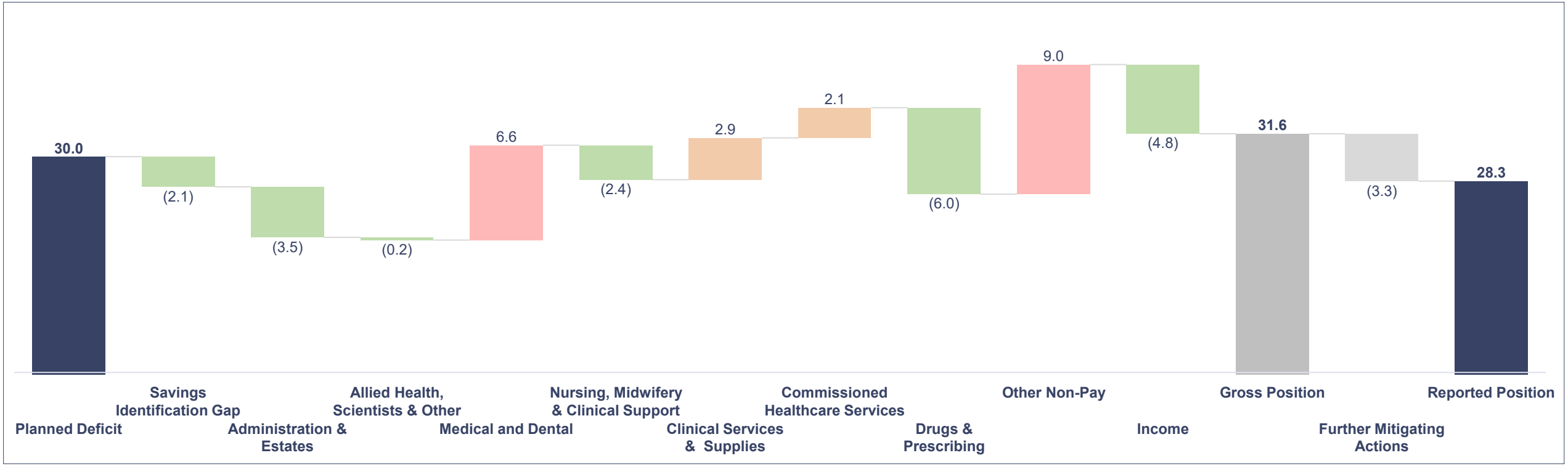


Income Trajectory Analysis (£'m)	P06-26	P07-26	P08-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	**6.7**	**6.6**	**7.0**	**50.2**	**75.4**	**77.5**		**(2.2)**
Chief Operating Officer Management	0.1	-	-	0.4	0.5	0.6		-
Community and Integrated Medicine	0.2	0.2	0.5	2.4	3.6	3.6		-
Mental Health and Learning Disabilities	0.3	0.3	0.3	2.0	3.1	3.0		-
Operational Allied Health and Health Sciences	0.3	0.3	0.3	2.2	3.4	3.2		0.2
Planned and Specialist Care	0.5	0.5	0.4	4.0	6.1	6.0		0.1
Primary Care, Community Strategy and Long Term Care	0.4	0.5	0.5	3.5	5.3	6.5		(1.2)
Executive Functions	4.9	4.7	5.0	35.6	53.4	54.7		(1.3)
Total Income	**6.7**	**6.6**	**7.0**	**50.2**	**75.4**	**77.5**		**(2.2)**
Plan	**6.5**	**6.1**	**6.3**	**48.0**	**72.0**	**72.7**		**(0.6)**
Variance to Plan	**0.1**	**0.5**	**0.7**	**2.2**	**3.3**	**4.9**		**(1.5)**

Key Information

Month 8, November, includes increased income relating to Central Income Cost Recovery Unit for two large cases and Non-Contracted Activity relating to informatics £(0.4)m and Health Board Wide NWSSP rebate of distribution costs £(0.4)m.

End of Year – Key Drivers vs Plan



Key Information

Medical and Dental – Premium locum usage to cover vacancies, sickness and surge capacity within Planned and Specialist Care and Community and Integrated Medicine.

Drugs – Reduction in costs due to lower Oncology drugs prices and lower flu and Covid-19 vaccination uptake, offset by increase in high-cost drugs and Mounjaro uptake.

Other Non-Pay – Welsh Risk Pool Risk Share agreement £4.2m, prior year Patient Flow invoice in Pembrokeshire £1.6m, Estates inflationary contract uplifts for maintenance, premises, energy, and laundry £1.0m, Clinical Negligence losses claims £0.8m and Orthopaedic and Dermatology insourcing costs £0.5m.

Income – Mounjaro income rebate £(1.2)m, continued Bowel and Breast Screening and Wet Age-related Macular Degeneration £(1.0)m and Health Board Wide Cost Recovery Unit of large cases, Non-Contracted Activity, Powys and Betsi high-cost drugs income, and NWSSP income overachievement £(1.0)m.

End of Year – Key Performance vs Plan

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				**30.0**	
Chief Operating Officer Management	0.1	0.0	(0.5)	**(0.4)**	Vacancies held within Medical Records.
Community and Integrated Medicine	4.0	0.0	1.6	**5.6**	Medical locum usage to cover surge capacity, Continuing Healthcare packages, purchase of incontinence products and premises costs.
Mental Health and Learning Disabilities	0.5	0.0	2.4	**2.9**	Net increase of 23 Continuing Healthcare packages, purchase of Psychiatric Intensive Care Unit beds, and Medical Locum usage.
Operational Allied Health & Health Sciences	3.3	0.0	0.0	**3.3**	Over-achievement of income and reduction in drug costs, offset by Physiotherapy and Occupational Therapy agency and variable pay.
Planned and Specialist Care	3.2	0.3	(0.2)	**3.3**	Oncology drugs lower than planned, income overachievement, offset by theatres insourcing and outsourcing and ongoing usage of Medical locums to address Waiting List initiatives.
Primary Care, Community Strategy & Long Term Care	1.6	0.0	(3.0)	**(1.4)**	Underspend relating to Dental contracts, General Medical Services and Community Pharmacy relating to flu services.
Executive Functions	(14.8)	0.0	3.1	**(11.7)**	Welsh Risk Pool risk share £4.2m, increase in Emergency activity within Swansea Bay LTA's £1.9m, offset by vacancies, income and reduction in uptake of vaccinations within Public Health.
Sub Total	**(2.1)**	**0.3**	**3.4**	**1.6**	
Gross Position				**31.6**	
Further Mitigating Actions				(3.3)	
Reported Position				**28.3**	

End of Year – Key Performance vs Prior Month

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target Movement	Savings Delivery vs Plan Movement	Core Operational Variation Movement	Total Movement	Key Information
Prior Month Forecast				**31.6**	
Chief Operating Officer Management	(0.1)	0.0	0.0	**(0.1)**	No material deviation
Community and Integrated Medicine	(0.2)	0.0	0.5	**0.3**	Increased Medical locum and agency costs in Carmarthenshire and Pembrokeshire for surge capacity, vacancies and sickness increase.
Mental Health and Learning Disabilities	(0.2)	0.0	0.3	**0.1**	Increased Continuing Healthcare costs and Psychiatric Intensive Care Unit bed purchases.
Operational Allied Health & Health Sciences	0.0	0.0	(0.1)	**(0.1)**	Reduction in Pathology Managed Service contract costs due to a reduction in activity, and reduction in haematology drugs costs.
Planned and Specialist Care	0.0	0.0	0.3	**0.3**	Increased Orthopaedics and Dermatology Insourcing and outsourcing costs to improve Waiting List initiative performance.
Primary Care, Community Strategy & Long Term Care	(0.3)	0.0	0.4	**0.1**	General Medical Services dispensing fee increase and Dental Savings transacted.
Executive Functions	0.7	0.0	(1.3)	**(0.6)**	Previously assumed Health Board wide amber savings recognised across service areas. Continuing Healthcare negotiation of uplift costs, Cost Recovery, Non-Contracted Activity and NWSSP rebate.
Sub Total	**(0.1)**	**0.0**	**0.1**	**0.0**	
Gross Position				**31.6**	
Further Mitigating Actions				(3.3)	
Reported Position				**28.3**	

End of Year – Saving Delivery Performance

Savings

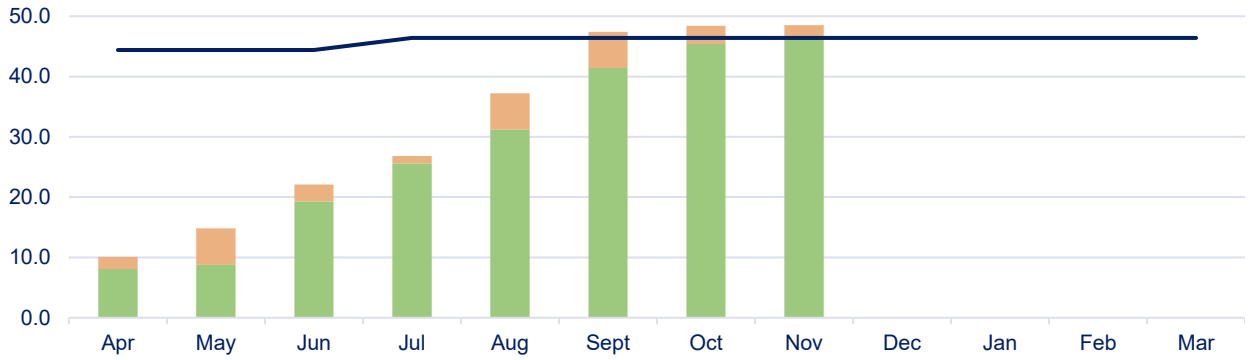
Savings Target
£46.4m
Recurrent = £19.0m
Non-Recurrent = £27.4m

In-Year Recurrent Gap
£4.7m
Target = £19.0m
Delivery = £14.3m

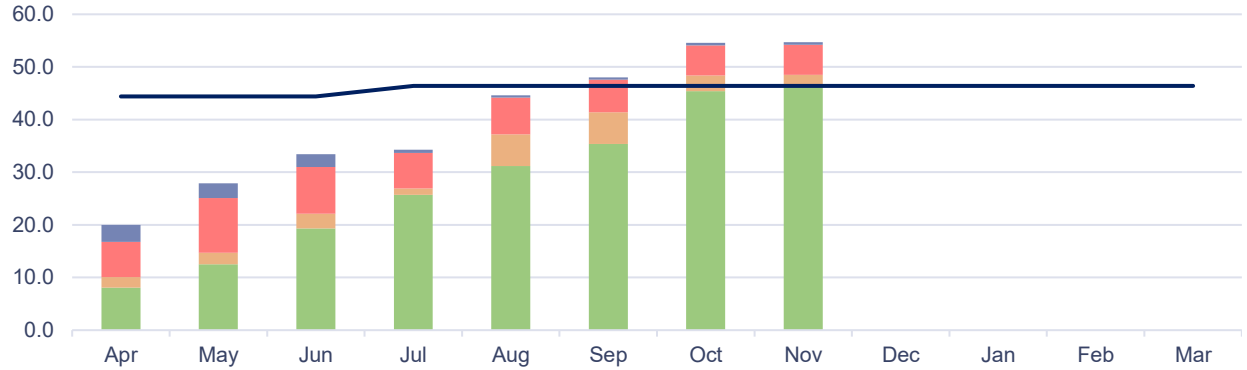
In-Year Non-Recurrent Gap
£(6.5)m
Target = £27.4m
Delivery = £33.9m

Full Year Recurrent Gap
£0.8m
Target = £19.0m
Delivery = £18.2m

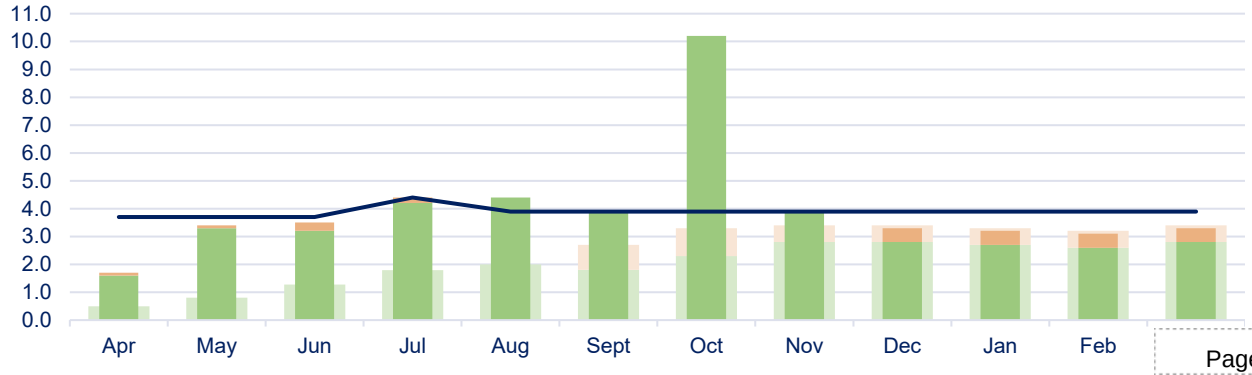
Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



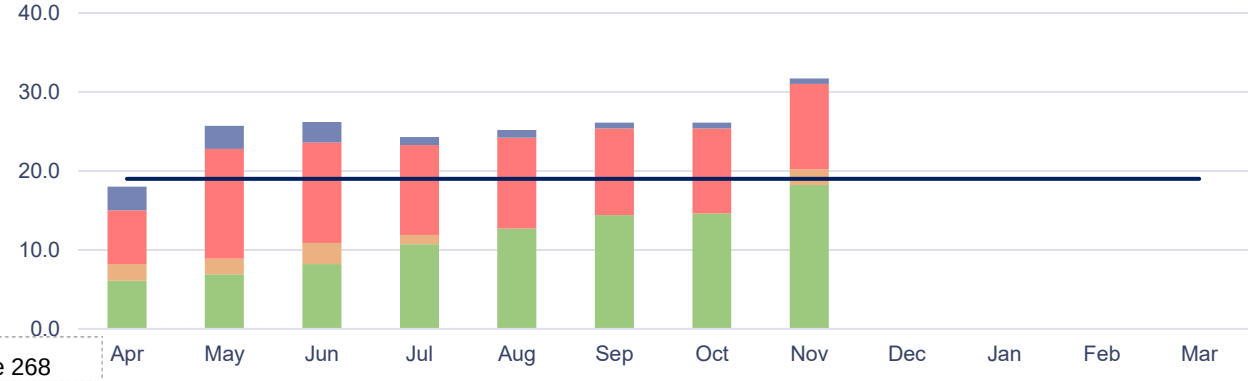
Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)



Monthly Profiled Risk-Assessed Savings Delivery (£'m)

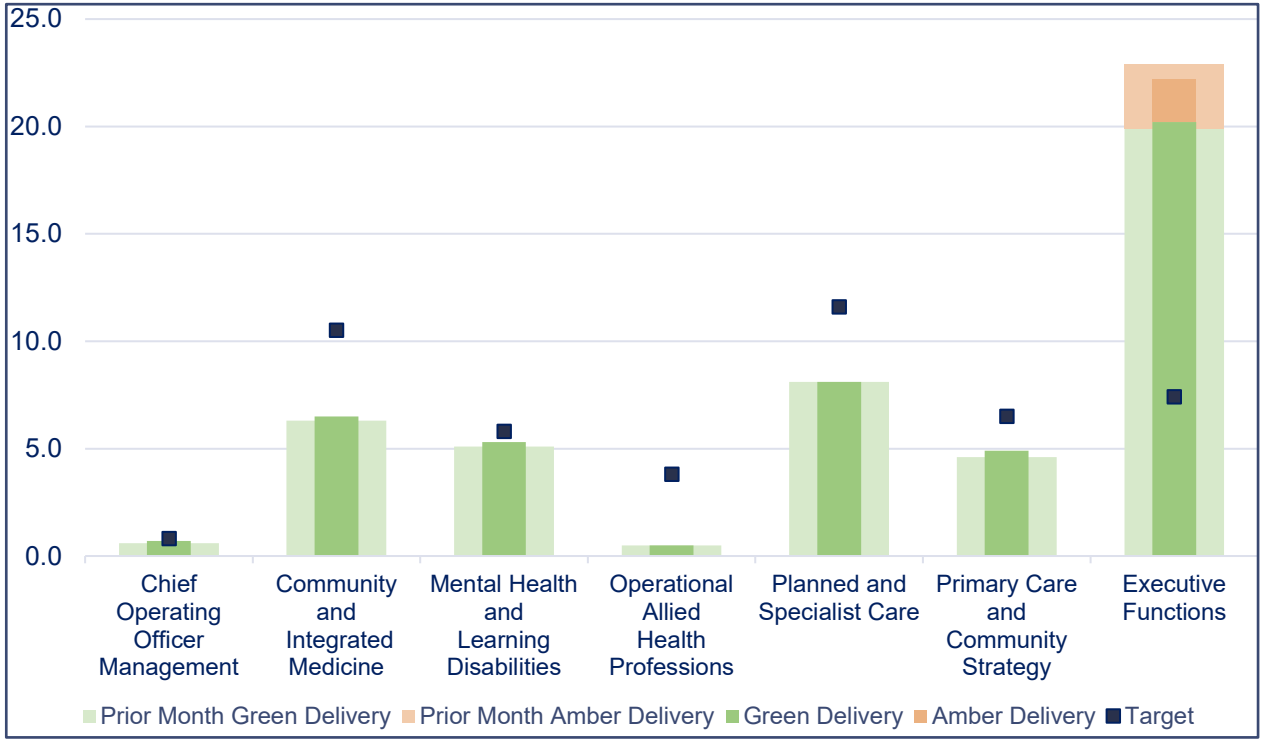


Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)



End of Year – Savings Performance Breakdown

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.8	0.7	0.7	0.1
Community and Integrated Medicine	10.5	6.5	6.5	4.0
Mental Health and Learning Disabilities	5.8	5.3	5.3	0.5
Operational Allied Health and Health Sciences	3.8	0.5	0.5	3.3
Planned and Specialist Care	11.6	8.4	8.1	3.5
Primary Care, Community Strategy and LTC	6.5	4.9	4.9	1.6
Executive Functions	7.4	22.2	22.2	(14.8)
Grand Total	**46.4**	**48.5**	**48.2**	**(1.8)**

Key Information

£1.2m in-month underspend conversion of pay and non-pay savings, no new in-year recurring savings schemes have been identified in Month 8.

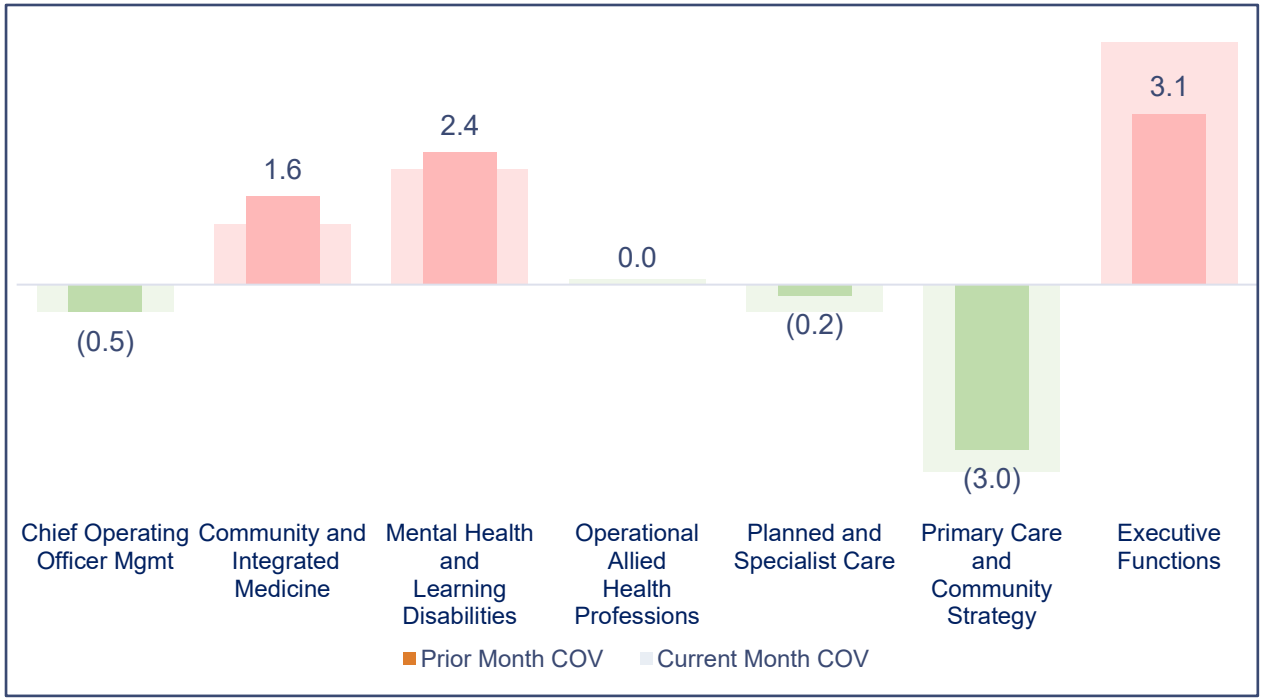
A full-year effect recurrent savings scheme identified in Month 8 of £3.6m for Oncology Drugs within Planned and Specialist Care.

Continuation of run rate management of pay vacancy underspends recognised as an amber saving in future months of £2.0m.

Full year recurrent delivery is £18.2m against an in-year recurrent delivery of £14.[illegible]e to Oncology drugs saving of £3.6m due to deliver from 1 April 2026.

End of Year – Core Operational Variation

Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	(0.5)	0.0	0.0	**(0.5)**
Community and Integrated Medicine	(0.2)	2.4	(0.6)	**1.6**
Mental Health and Learning Disabilities	(0.3)	2.6	0.1	**2.4**
Operational Allied Health and Health Sciences	1.0	(0.2)	(0.8)	**0.0**
Planned and Specialist Care	1.1	(0.4)	(1.0)	**(0.2)**
Primary Care, Community Strategy and LTC	(0.1)	(2.1)	(0.8)	**(3.0)**
Executive Functions	(0.8)	5.8	(1.8)	**3.1**
Total	**0.2**	**8.1**	**(4.9)**	**3.4**

Key Information

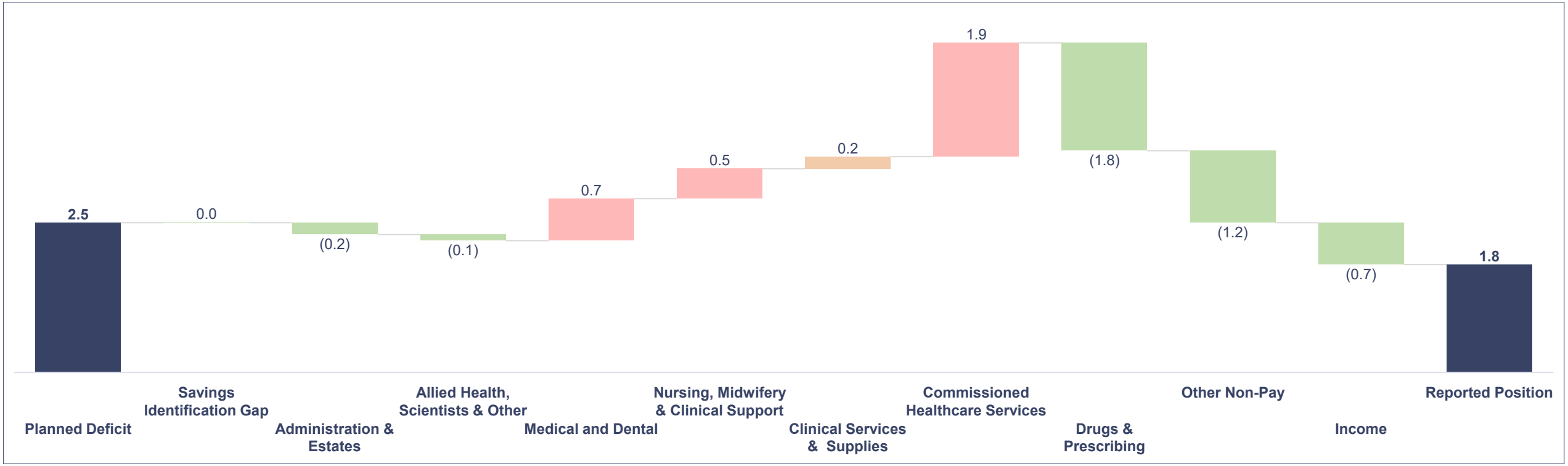
Community and Integrated Medicine Prior year patient flow invoice £0.7m, Continuing Healthcare packages £0.6m, incontinence products and insulin pumps £0.3m. Medical locum pay usage £1.7m due to vacancies and sickness and surge capacity cover, offset by vacancies within Admin and Nursing £(1.9)m.

Mental Health Net increase in Continuing Healthcare packages £1.6m and purchase of independent sector Psychiatric Intensive Care Unit beds £1.2m. Medical pay locum usage due to ongoing vacancies £ increase due to ongoing vacancies.

Primary Care Dental contracts underperformance £(1.6)m, Community Pharmacy and General Medical Services supplementary services £(0.5)m and overachievement of income £(0.8)m.

Executive Functions Increase in Welsh Risk Pool Risk Share agreement £4.2m, Emergency activity relating to Swansea Bay Long Term Agreements £2.1m, Losses claims offset by continued pay vacancies £(0.8)m and income overachievement £(1.8)m.

In-Month – Key Drivers vs Plan



Key Information

Commissioned Healthcare Services within Planned and Specialist Care increased insourced Theatres activity and increased outsourcing of MRI imaging relating to prostate cancer pathway within Urology £0.5m. Continued Continuing Healthcare and purchase of Psychiatric Intensive Care Unit Beds pressures within Mental Health £0.3m. Reference Other Non-Pay below £1.2m

Other Non-Pay year to date re-categorisation of Primary Care Dental savings budgets to Commissioned Healthcare Services £(1.2)m.

Drugs and Prescribing relating to Oncology Drugs prices £(0.8)m within Planned and Specialist Care lower than planned, Public Health Shingles vaccinations and Covid-19 vaccination uptake lower than anticipated £(0.5)m and recognition of Primary Care Drugs August PARS reduction in price and volume £(0.4)m.

Income Central Income for Cost Recovery Unit large cases, Non-Contracted Activity and Powys and Betsi high-cost drugs income has overachieved against plan values.

In-Month – Key Performance vs Plan

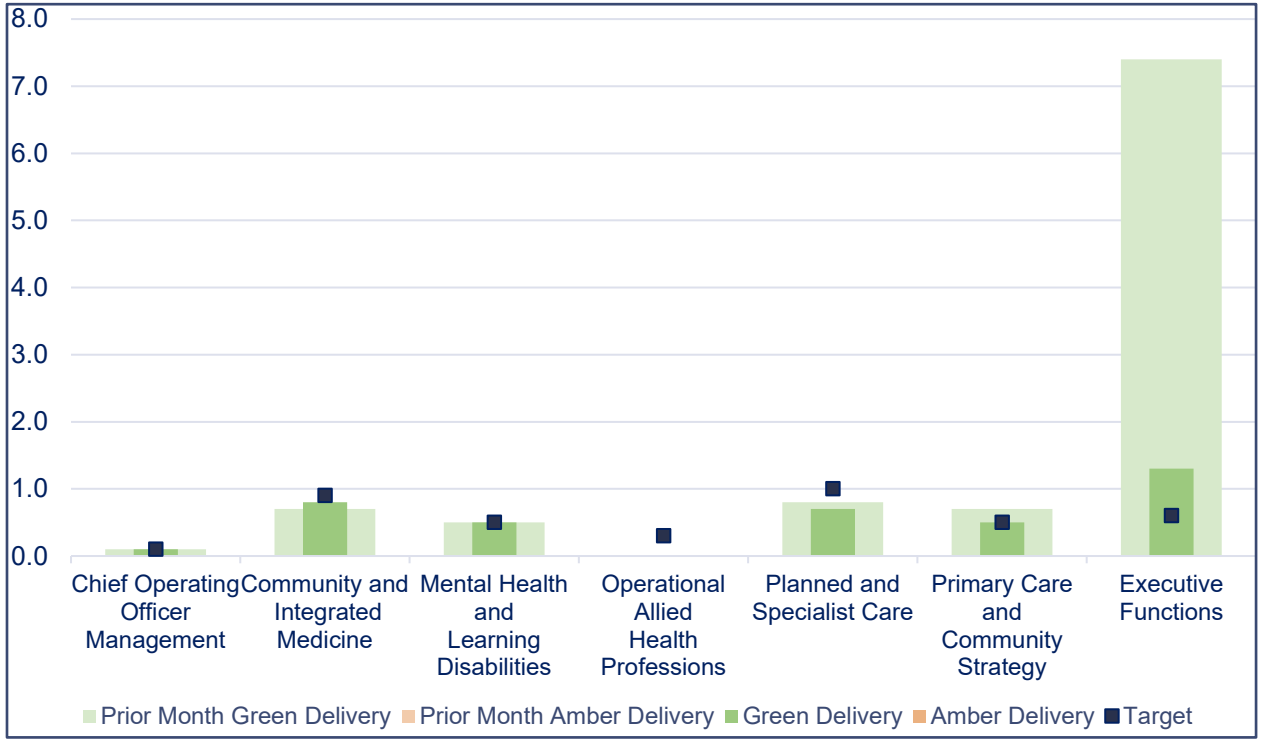
Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				**2.5**	
Chief Operating Officer Management	0.0	0.0	(0.1)	(0.1)	No material deviation to budget.
Community and Integrated Medicine	0.1	0.0	0.3	0.4	Medical and Dental locum usage to cover sickness and vacancies, and purchase of incontinence products and insulin pumps.
Mental Health and Learning Disabilities	0.0	0.0	0.3	0.3	Continuing Healthcare packages and purchase of Psychiatric Intensive Care Unit beds from independent sector.
Operational Allied Health & Health Sciences	0.3	0.0	(0.2)	0.1	Continuing under achievement of savings against target, offset by reduction in Pathology drugs and lab chemicals spend.
Planned and Specialist Care	0.3	0.0	0.3	0.6	Ophthalmology outsourcing and Theatres insourcing activity and Medical and Dental cover offset by Oncology drugs underspend.
Primary Care, Community Strategy & Long Term Care	0.0	0.0	(0.5)	(0.5)	Primary Care Drugs August PARS reduction in price and volume, and General Medical Services supplementary services underspend.
Executive Functions	(0.7)	0.0	(0.8)	(1.5)	Workforce overachievement of savings. Public Health Drugs underspends, Central Income overachievement.
Sub Total	**0.0**	**0.0**	**(0.7)**	**(0.7)**	
Gross Position				**1.8**	

In-Month – Key Performance vs Prior Month

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target Movement	Savings Delivery vs Plan Benefits Movement	Core Operational Variation Movement	Total Movement	Key Information
Planned Deficit				**0.0**	**No change to Planned Deficit of £2.5m**
Chief Operating Officer Management	0.0	0.0	(0.1)	**(0.1)**	Improvement largely relating to Car Pool and Taxi expenditure recharges.
Community and Integrated Medicine	(0.1)	0.0	0.4	**0.3**	Increase in Pembrokeshire Continuing Healthcare packages, and reduced underspend relating to Urgent and Emergency Care.
Mental Health and Learning Disabilities	0.0	0.0	(0.1)	**(0.1)**	Reduction in purchase Psychiatric Intensive Care Unit beds expenditure, due to a reduction of 5 patients and 100 days.
Operational Allied Health & Health Sciences	0.0	0.0	(0.2)	**(0.2)**	Reduction in agency and variable pay expenditure from prior month.
Planned and Specialist Care	0.1	0.0	0.0	**0.1**	Reduction in savings identified compared to prior month.
Primary Care, Community Strategy & Long Term Care	0.2	0.0	0.0	**0.2**	Reduction in savings identified in relation to Dental underspends.
Executive Functions	6.1	0.0	(5.1)	**1.0**	Aseptic drugs savings £6.1m in prior month. Welsh Risk Pool risk share agreement of £4.2m in prior month. Public Health Drugs, Estates laundry reduction and Central Income overachivement.
Sub Total	**6.3**	**0.0**	**(5.1)**	**1.2**	
Gross Position				**1.2**	

In-Month – Savings Performance Breakdown

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.1	0.1	0.1	0.0
Community and Integrated Medicine	0.9	0.8	0.8	0.1
Mental Health and Learning Disabilities	0.5	0.5	0.5	0.0
Operational Allied Health and Health Sciences	0.3	0.0	0.0	0.3
Planned and Specialist Care	1.0	0.7	0.7	0.3
Primary Care, Community Strategy and LTC	0.5	0.5	0.5	0.0
Executive Functions	0.6	1.3	1.3	(0.7)
Grand Total	**3.9**	**3.9**	**3.9**	**0.0**

Key Information

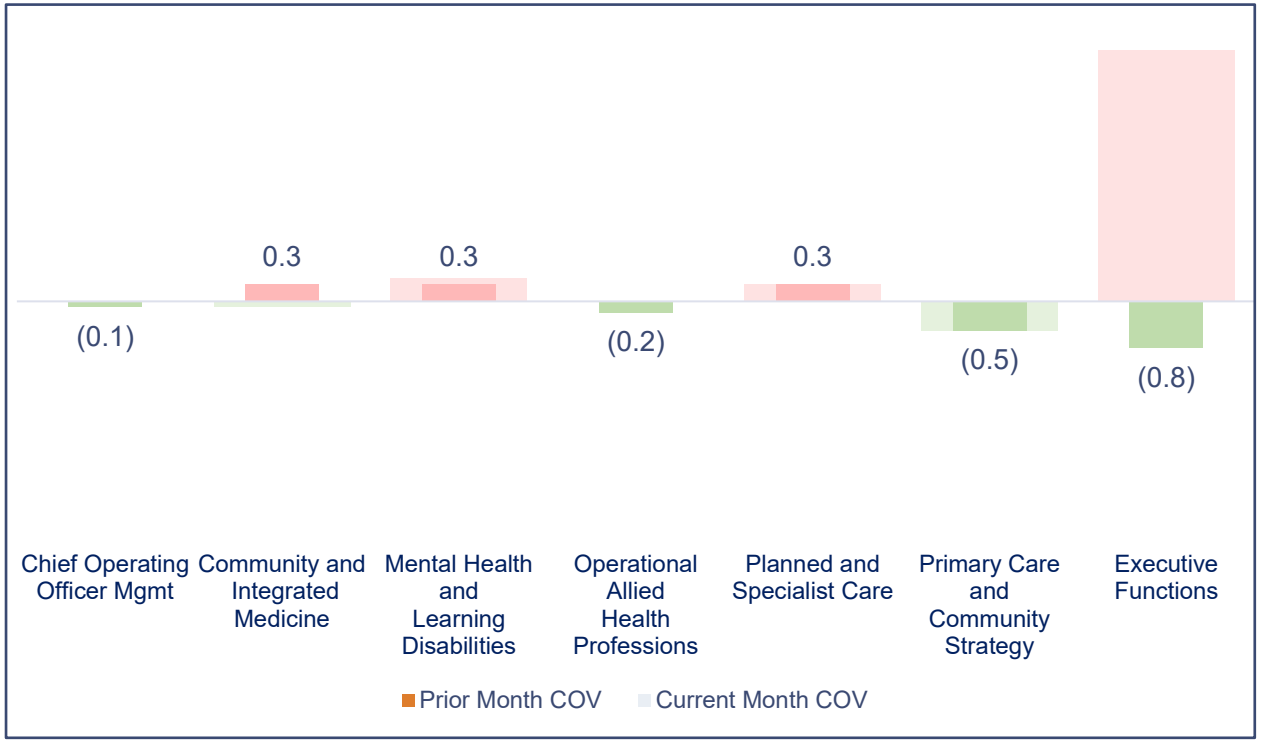
Overall savings delivery of £3.9m has been achieved, with variations across Clinical Care Groups.

No new recurring savings schemes identified in Month 8, all newly identified schemes relate to underspend conversion of £1.2m, compared to £1.1m in Month 7. Underspend conversion schemes in-month relate to £1.0m pay vacancy underspends, and £0.2m non pay efficiencies.

Executive Functions – The prior month delivery is a result of the one-off Aseptic drugs saving of £6.1m.

In-Month – Core Operational Variation

Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.0	(0.1)	0.0	**(0.1)**
Community and Integrated Medicine	0.1	0.4	(0.2)	**0.3**
Mental Health and Learning Disabilities	0.0	0.3	0.0	**0.3**
Operational Allied Health and Health Sciences	0.1	(0.2)	(0.1)	**(0.2)**
Planned and Specialist Care	0.2	0.1	0.0	**0.3**
Primary Care, Community Strategy and LTC	0.0	(0.5)	0.0	**(0.5)**
Executive Functions	0.5	(0.9)	(0.4)	**(0.8)**
Total	**0.9**	**(0.9)**	**(0.7)**	**(0.7)**

Key Information

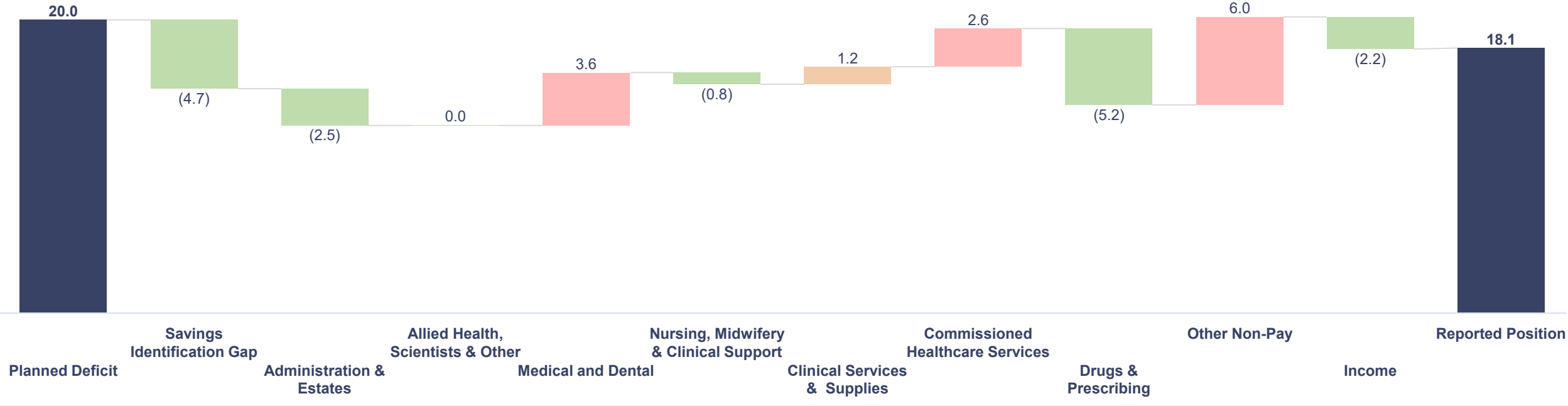
Community and Integrated Medicine Purchase of incontinence products and insulin pumps and increase in Pembrokeshire Continuing Healthcare packages, offset by Urgent and Emergency Care income overachievement.

Mental Health High cost Continuing Healthcare packages, and purchase of independent sector Psychiatric Intensive Care Unit beds.

Primary Care Drugs and Prescribing August PARS reduction in price and volume, and General Medical Services supplementary services underspend.

Executive Functions underspends relating to Public Health drugs and Central Income overachievement relating to Cost Recovery Unit and Non-Contracted Activity, offset by year to date recognition of additional band 2 to 3 pay award and rebanding uplift expenditure relating to Healthcare Support Workers.

Year to Date – Key Drivers vs Plan



Key Information

Medical & Dental – Premium costs to cover vacancies and sickness across the Health Board. Planned and Specialist Care also see continued use of the premium rate card and increased Waiting List Initiative Payments.

Drugs & Prescribing – Oncology drugs underspend due to price increases being lower than planned, and NICE treatments increases expected later in the year. Public Health Shingles vaccinations underspend and lower Covid-19 vaccination uptake. Primary Care Drugs and Prescribing August PARS reduction in price and volume in Month 8.

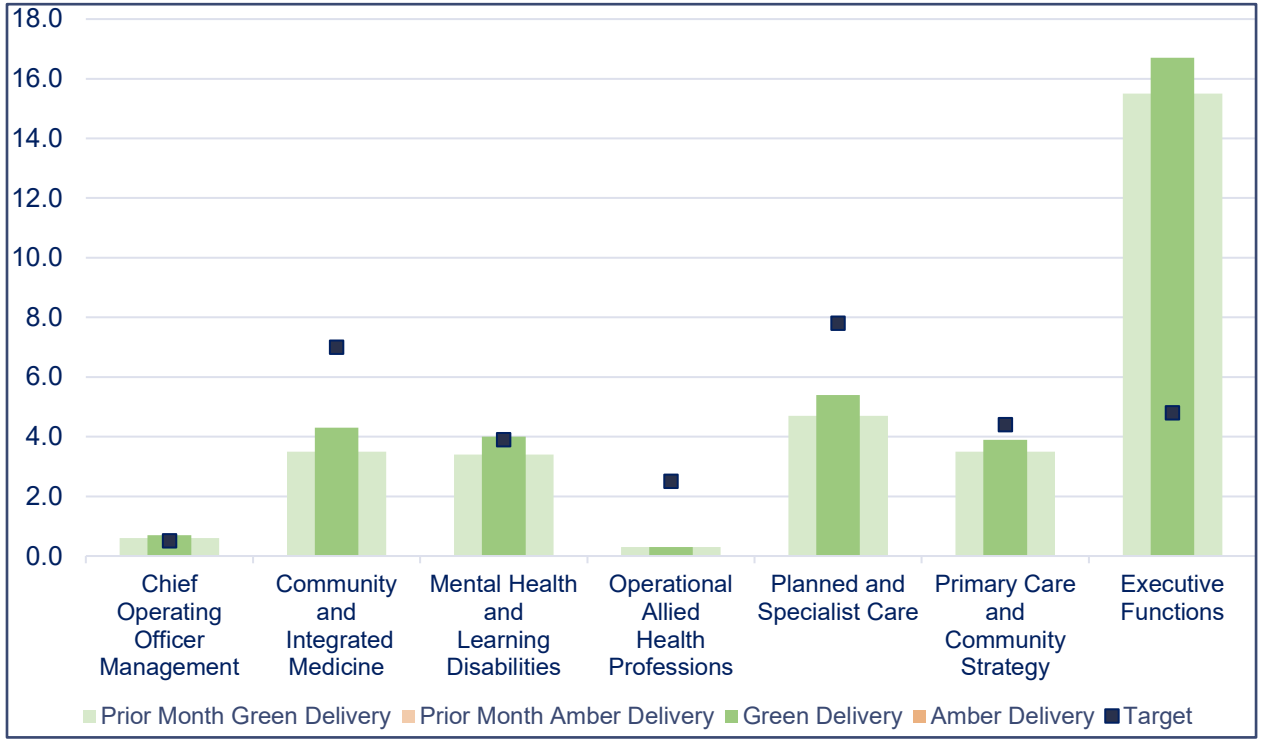
Other Non-Pay – Welsh Risk Pool Risk Share agreement increase, increase in losses claims and increased contract pressures relating to Digital, maintenance, premises, energy, and laundry. Payment of prior year Patient Flow invoice relating to Pembrokeshire County, and increased Nursing Legal Services costs.

Year to Date – Key Performance vs Plan

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				**20.0**	
Chief Operating Officer Management	(0.2)	0.0	(0.3)	**(0.5)**	Vacancies held within Medical Records.
Community and Integrated Medicine	2.7	0.0	0.4	**3.1**	Continuing Healthcare packages and prior year patient flow invoice offset by pay vacancies.
Mental Health and Learning Disabilities	(0.1)	0.0	1.8	**1.7**	Continuing Healthcare packages, purchase of Psychiatric Intensive Care Unit beds and premium Medical costs to cover vacancies
Operational Allied Health & Health Sciences	2.2	0.0	(0.4)	**1.8**	Over-achievement of income, reduction in Pathology drugs and lab chemicals offset by agency and variable pay.
Planned and Specialist Care	2.1	0.3	(1.2)	**1.2**	Oncology drugs underspend, income overachievement, offset by theatres pressures and ongoing usage of Medical locums.
Primary Care, Community Strategy & Long Term Care	0.5	0.0	(2.0)	**(1.5)**	Underspend relating to Dental contracts, General Medical Services supplementary services and Primary Care drugs and prescribing.
Executive Functions	(11.9)	0.0	4.2	**(7.7)**	Overspends largely relating to Welsh Risk Pool Risk Share increase and Swansea Bay Long Term Agreement Emergency Activity.
Sub Total	**(4.7)**	**0.3**	**2.5**	**(1.9)**	
Gross Position				**18.1**	

Year to Date – Savings Performance Breakdown

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.5	0.7	0.7	(0.2)
Community and Integrated Medicine	7.0	4.3	4.3	2.7
Mental Health and Learning Disabilities	3.9	4.0	4.0	(0.1)
Operational Allied Health and Health Sciences	2.5	0.3	0.3	2.2
Planned and Specialist Care	7.8	5.7	5.4	2.4
Primary Care, Community Strategy and LTC	4.4	3.9	3.9	0.5
Executive Functions	4.8	16.7	16.7	(11.9)
Grand Total	**30.9**	**35.6**	**35.3**	**(4.4)**

Key Information

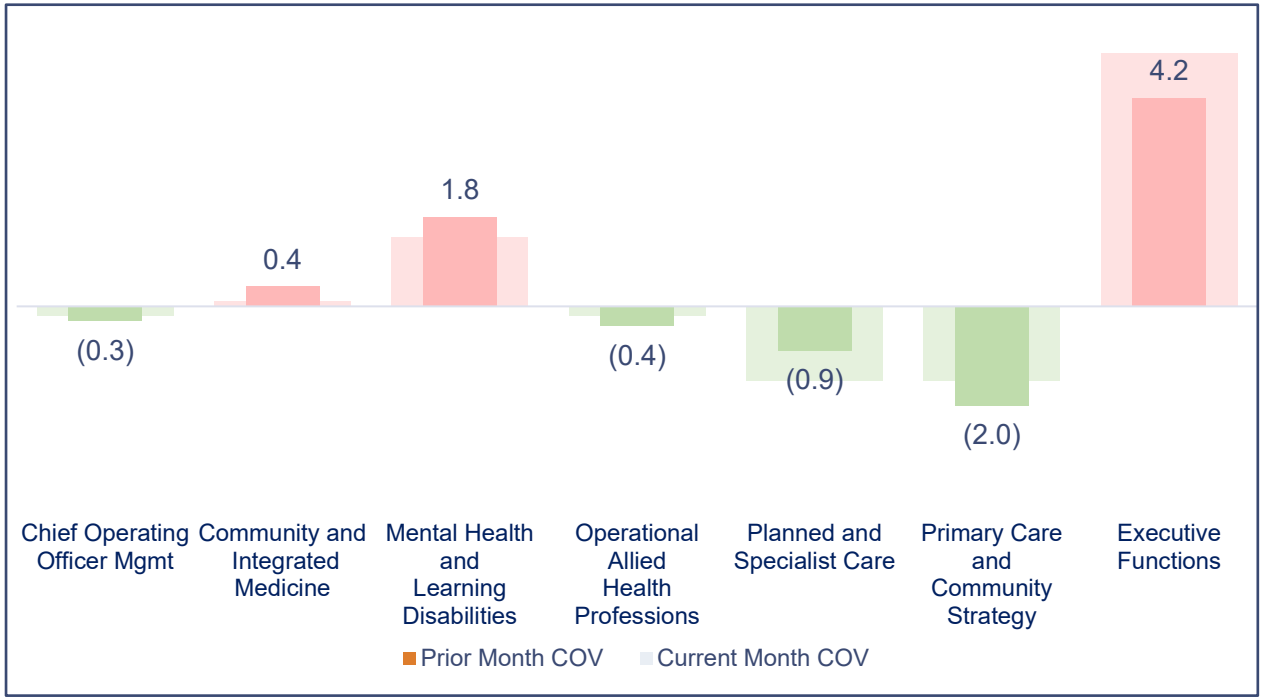
Savings delivery year to date is £35.3m, which is a £4.4m over delivery against the £30.9m target.

This over delivery largely relates to Executive functions, due to pay vacancy underspends and a one-off Aseptic drugs saving of £6.1m.

The over delivery of savings within Executive functions is offset by under delivering Operational functions largely relating to Community and Integrated Medicine, Operational Allied Health and Planned and Specialist Care.

Year to Date – Core Operational Variation

Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	(0.2)	(0.2)	0.1	**(0.3)**
Community and Integrated Medicine	(0.5)	1.3	(0.4)	**0.4**
Mental Health and Learning Disabilities	(0.1)	1.8	0.1	**1.8**
Operational Allied Health and Health Sciences	0.7	(0.6)	(0.5)	**(0.4)**
Planned and Specialist Care	0.6	(0.8)	(0.7)	**(0.9)**
Primary Care, Community Strategy and LTC	0.1	(2.4)	0.3	**(2.0)**
Executive Functions	(0.3)	5.6	(1.1)	**4.2**
Total	**0.3**	**4.7**	**(2.2)**	**2.8**

Key Information

Mental Health High cost Continuing Healthcare packages and purchase of independent sector Psychiatric Intensive Care Unit beds.

Planned and Specialist Care Oncology & Ophthalmology drugs underspend due to growth increases lower than planned, with increases due later in the year. Overachievement of income in relation to Flying Start and Bowel and Breast Screening.

Primary Care Continued Dental underspends due to contracts handed back to the Health Board, General Medical Services supplementary services and Primary Care drugs and prescribing underspend relating to reduced price and volume, offset by under-delivery of patient income.

Executive Functions relating to the recognition of the increase in the Welsh Risk Pool Risk Share agreement, increase in Emergency activity relating to Swansea Bay Long Term Agreements, additional losses claims, Nursing legal fees, Digital contracts and licens laundry and utilities costs, offset by income overachievement and pay vacancies.

Capital Performance

Capital

Total Capital Performance

£36.7m

Annual Plan = £36.7m

All Wales Capital

£28.7m

Annual Plan = £28.7m

Discretionary Capital

£6.9m

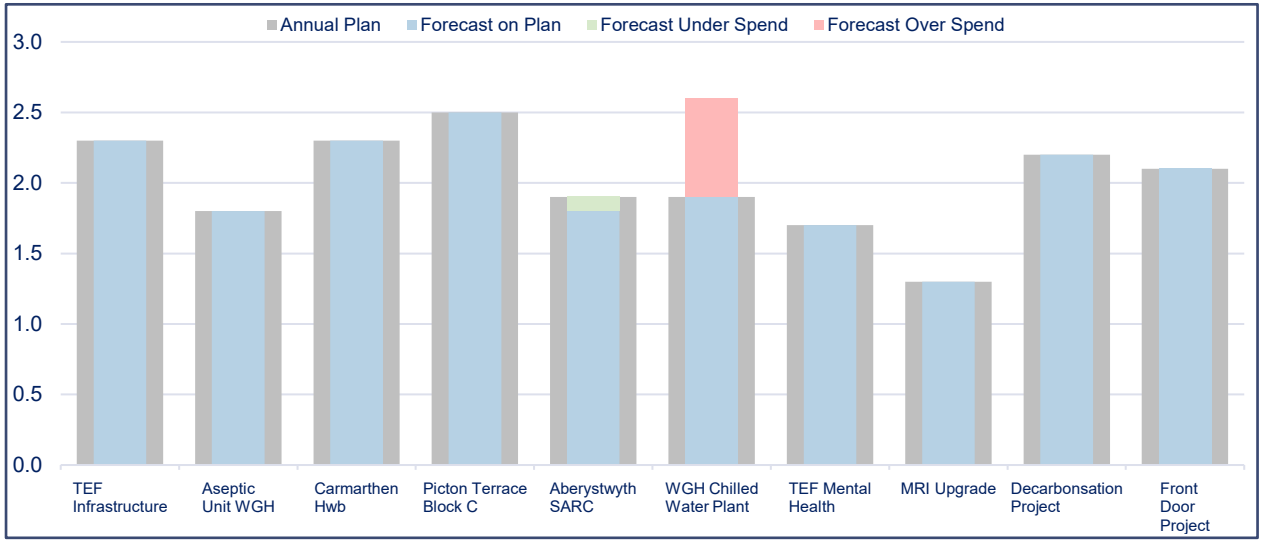
Annual Plan = £6.9m

IFRS 16

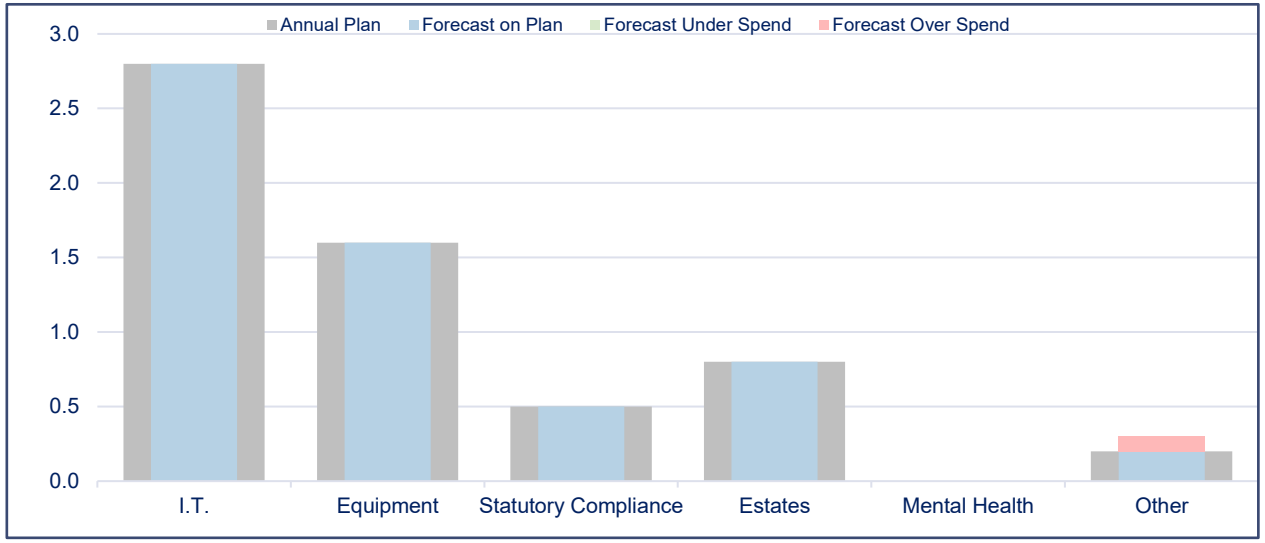
£1.1m

Capital Resource Limit = £1.1m

All Wales Capital Programme Top 10 Schemes (£'m)



Discretionary Capital Programme Category Summary (£'m)

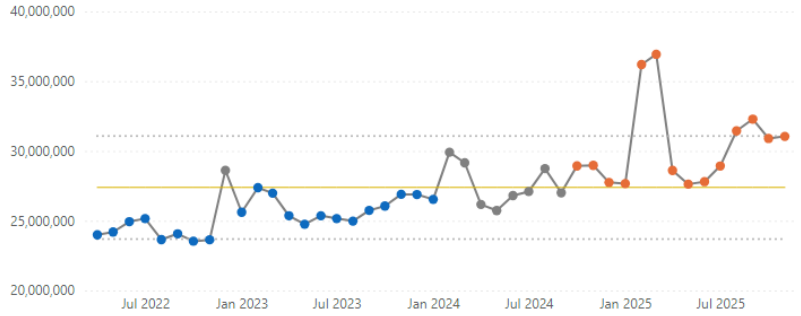


49% (£18.0m of the £36.7m) of capital programme expenditure is forecast to be spent in February and March 2026. Therefore, the risk to delivering the capital programme in full signals **a medium status** and ongoing monitoring will be required due to late expenditure profile with no option to extend beyond March 2026.

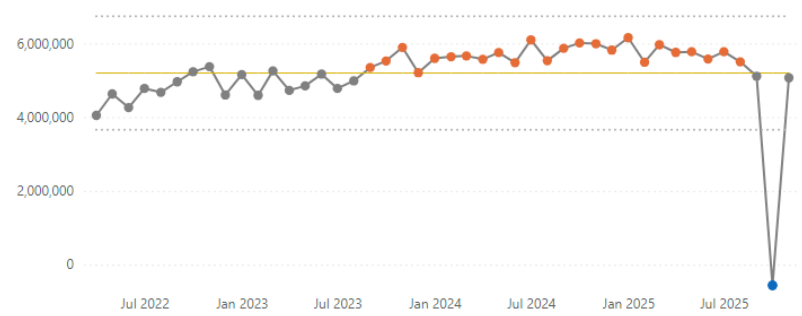
Whilst all capital schemes are forecast to complete within budget by the end of the financial year, there remains a level of uncertainty with regards to the receipt of End of Year capital funding from Welsh Government, linked to the urgent Concrete Cladding Works at Withybush Hospital (£0.85m). Also, a significant proportion of spend is remaining within the capital programme.

Trend Analysis – Non-Pay and Income

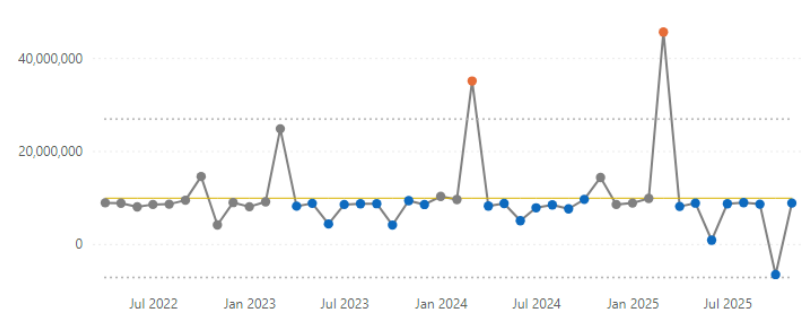
Commissioned Healthcare Services (£)



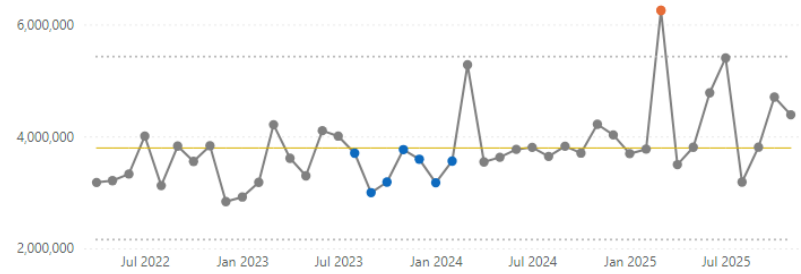
Secondary Care Drugs (£)



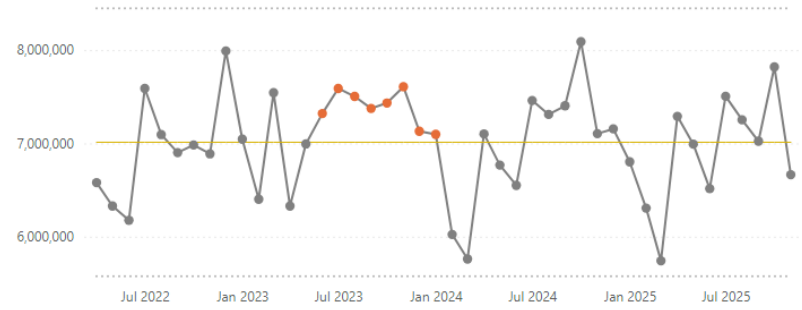
Other Non-Pay (£)



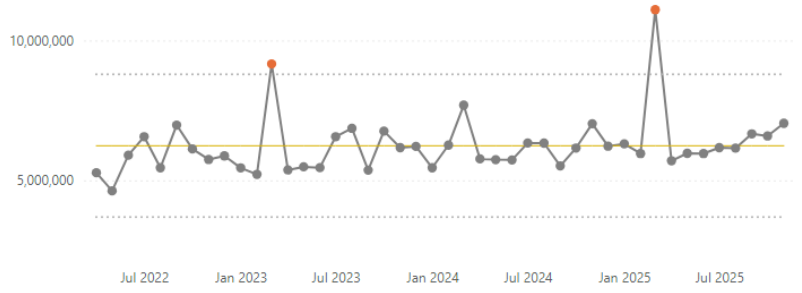
Clinical Services and Supplies (£)



Primary Care Prescribing (£)



Income (£)



Key Information

Secondary Care Drugs – Aseptic Unit System drugs saving in prior month, returning to typical levels in-month.

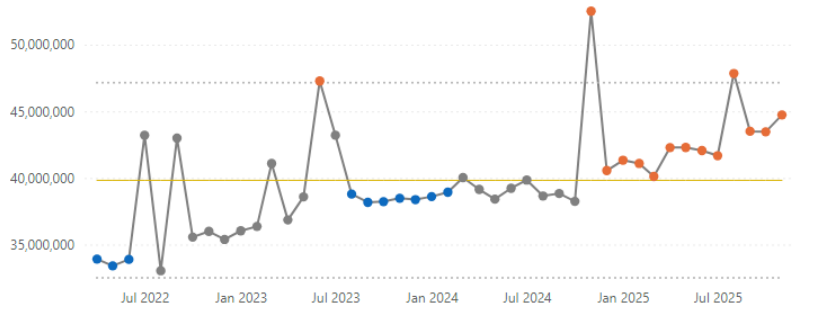
Other Non-Pay – Reduction to Annually Managed Expenditure (AME) depreciation and impairments in prior month due to indexation rate revision for buildings, returning to typical levels in-month.

Clinical Services & Supplies – Increased theatres stock in prior month due to flood and new stock system, offset by increase in purchase of incontinence products and insulin pumps in-month.

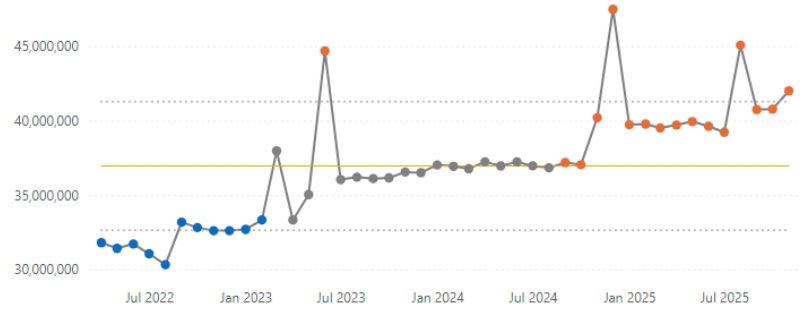
Primary Care Prescribing – In-month reduction in expenditure due to August Prescribing A[illegible]e (£0.03p) and volume reduction (4.6%).

Trend Analysis – Pay Agenda for Change

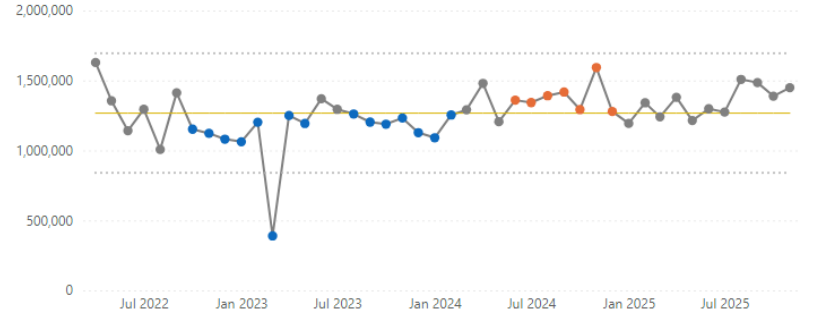
Total (£)



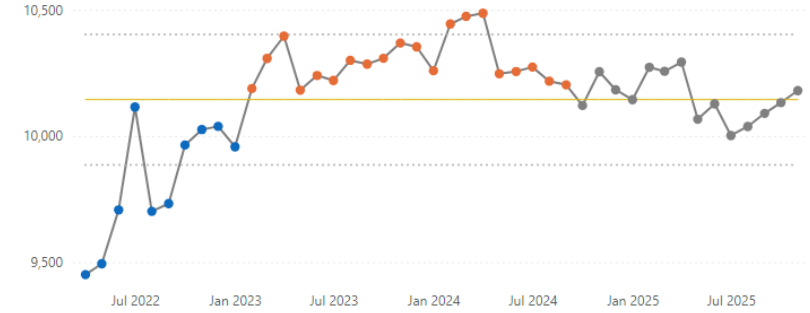
Substantive (£)



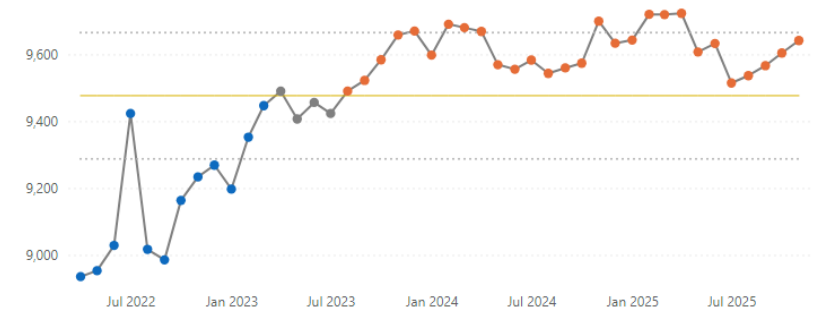
Bank (£)



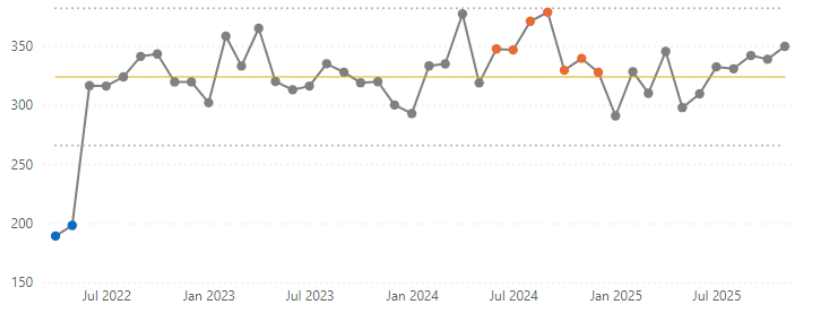
Total (WTE)



Substantive (WTE)



Bank (WTE)



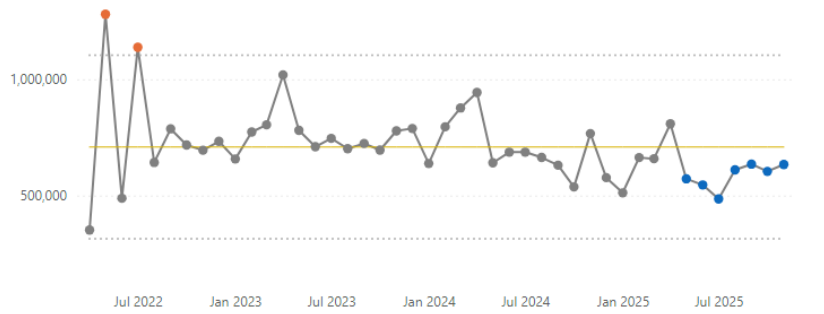
Key Information

Substantive WTE – There is a clear increase in Substantive WTE following recruitment of vacant posts within Mental Health Support Workers, Registered Nurses and Administration and Clerical (22.58 wte) and Planned Care Registered Nurses (17.52 wte), which in turn will reduce reliance on Agency and Overtime and in time Bank usage. Of which agency on the next slide, is at its lowest point now since the implementation of Allocate.

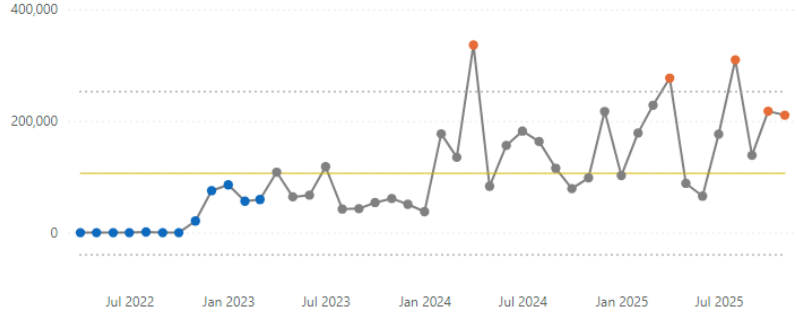
Substantive £ – Month 8 includes year to date recognition of additional band 2 to 3 pay award and rebanding uplift expenditure mainly relating to Healthcare Support Workers £0.6m.

Trend Analysis – Pay Agenda for Change

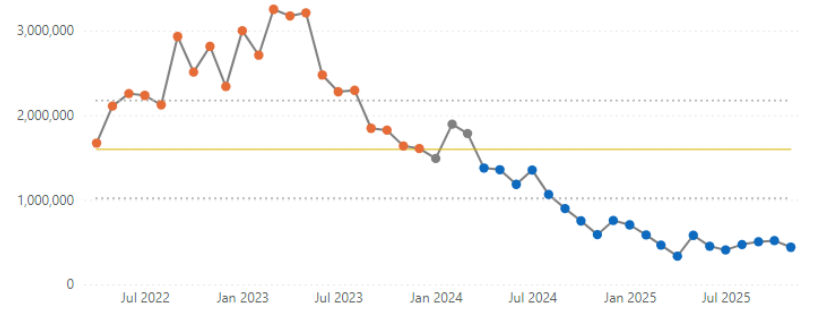
Overtime (£)



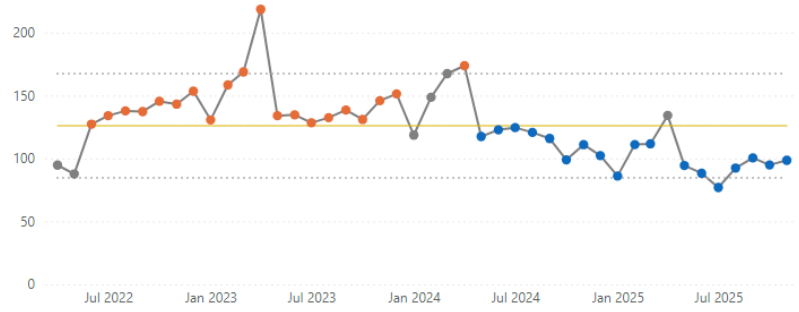
WLI (£)



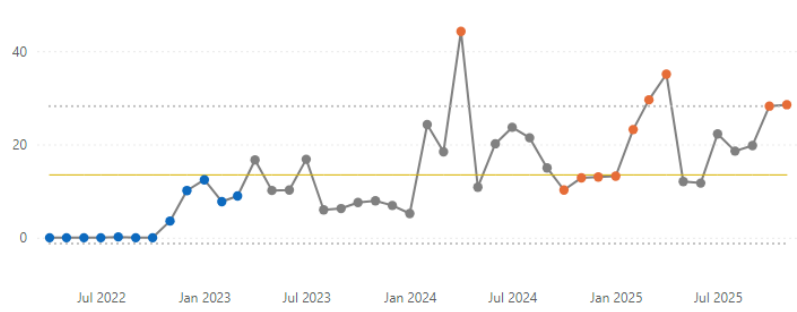
Agency (£)



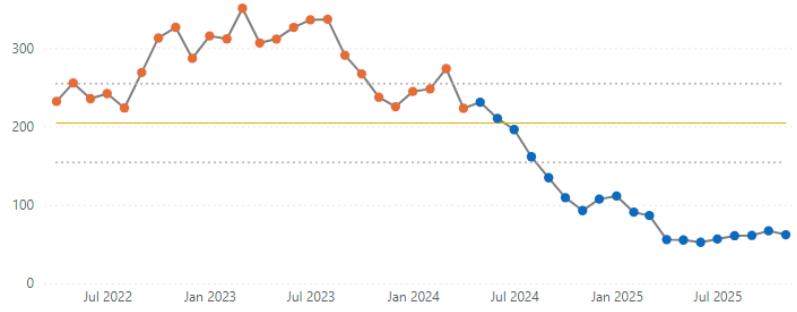
Overtime (WTE)



WLI (WTE)



Agency (WTE)

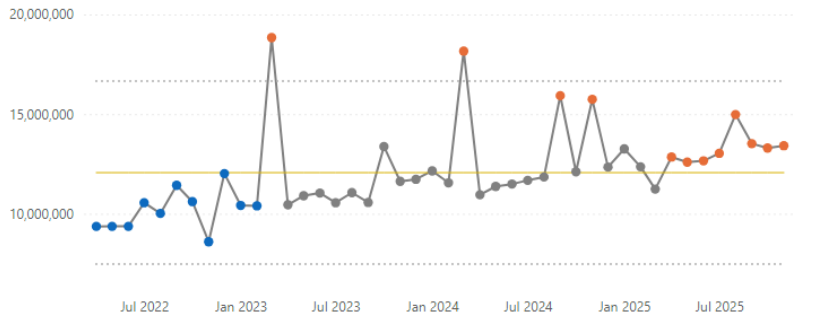


Key Information

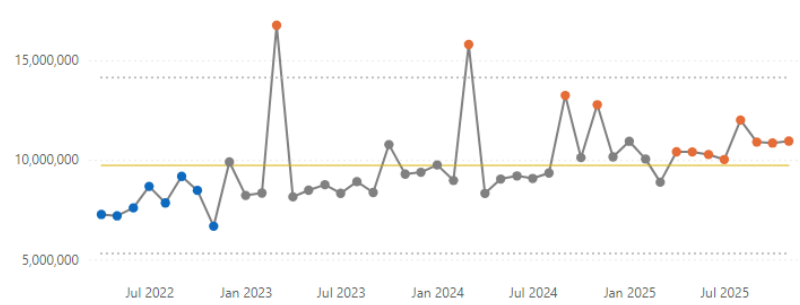
Waiting List Initiative – Continuation of increase in Waiting List Initiative expenditure within Medical, Nursing and Allied Health pay groups in Planned and Specialist Care relating to increased activity within Endoscopy, Ophthalmology and Orthopaedics to reduce waiting lists.

Trend Analysis – Pay Medical and Dental

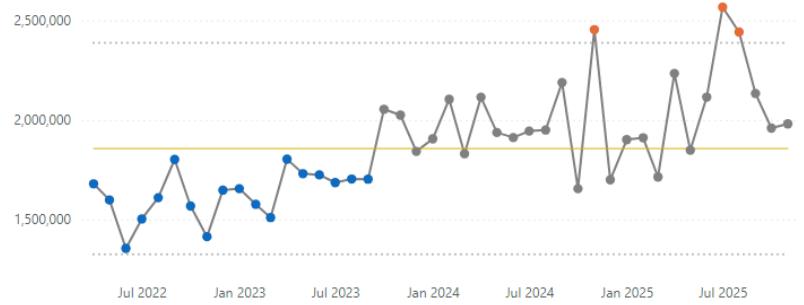
Total (£)



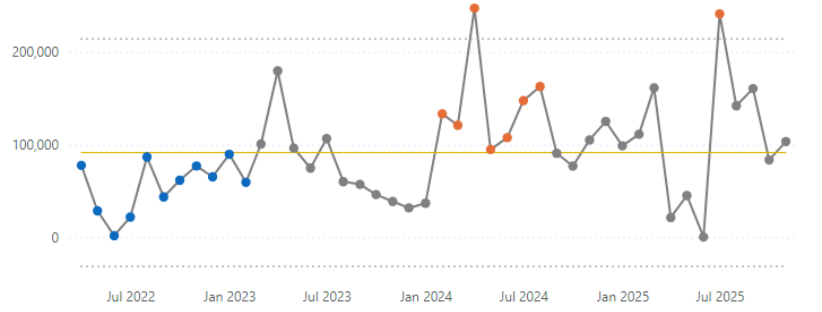
Substantive (£)



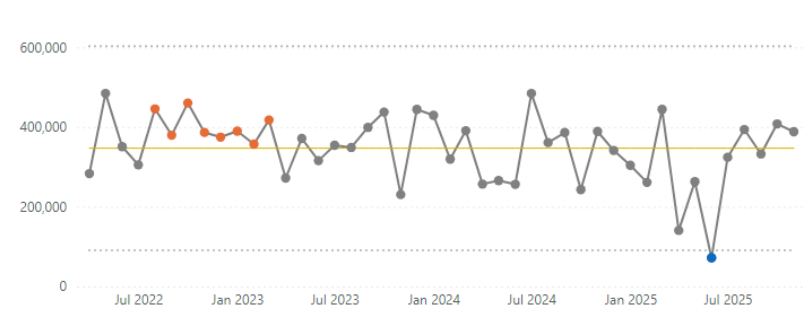
Additional Hours (£)



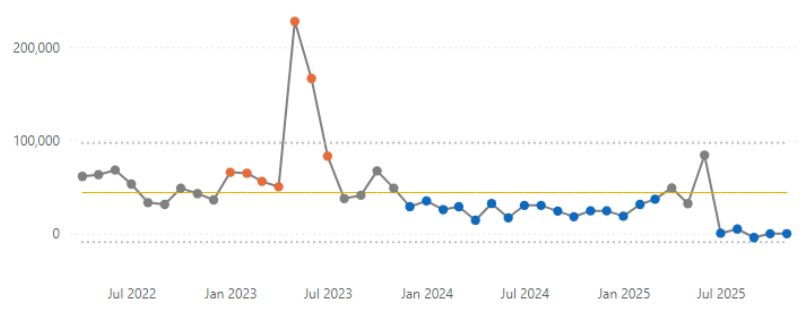
WLI (£)



On Contract Agency Premium (£)



Off Contract Agency Premium (£)



Key Information

Waiting List Initiative – Medical and Dental Waiting List Initiative expenditure has increased from prior month mainly within Orthopaedics, Ophthalmology, Endoscopy and Urology due to increased activity to reduce waiting lists.

Staffing Establishment Reports

Ward Staffing Level (WTE) for Nursing and Health Care Support Workers (HCSW)	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Operating Officer	**102.2%**	**2,633**	**2,298**	**(282)**	**281**	**51**	**53**
Community and Integrated Medicine	**103.2%**	**1,889**	**1,632**	**(209)**	**210**	**45**	**47**
Carmarthenshire Integrated System	103.5%	1,135	982	(124)	134	19	29
Ceredigion Integrated System	107.5%	327	269	(31)	39	18	26
Pembrokeshire Integrated System	99.4%	427	381	(54)	37	8	(8)
Mental Health and Learning Disabilities	**104.7%**	**287**	**236**	**(38)**	**50**	**1**	**13**
Planned and Specialist Care	**96.6%**	**457**	**430**	**(35)**	**21**	**5**	**(7)**
Cancer and Scheduled Care	94.6%	157	144	(17)	7	5	(4)
Children, Women and Family Health	97.6%	300	286	(18)	14	-	(3)
Grand Total	**102.2%**	**2,633**	**2,298**	**(282)**	**281**	**51**	**53**

All Other Staffing Levels (WTE) Excluding Medical and Ward Nursing & HCSWs	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Executive	**90.6%**	**89**	**89**	**(9)**	**-**	**-**	**(8)**
Chief Operating Officer	**93.7%**	**5,558**	**5,413**	**(486)**	**131**	**8**	**(343)**
Chief Operating Officer Management	81.6%	209	207	(45)	1	-	(44)
Community and Integrated Medicine	97.0%	1,351	1,310	(86)	38	1	(45)
Mental Health and Learning Disabilities	90.3%	916	903	(100)	12	-	(88)
Operational Allied Health and Health Sciences	97.2%	1,118	1,090	(54)	27	-	(26)
Planned and Specialist Care	95.0%	1,457	1,401	(121)	48	7	(65)
Primary Care, Community Strategy and Long Term Care	87.2%	507	502	(80)	5	-	(75)
Executive Director of Allied Health Professions and Health Sciences	**95.2%**	**866**	**808**	**(102)**	**57**	**-**	**(45)**
Executive Director of Finance	**89.9%**	**313**	**310**	**(37)**	**3**	**-**	**(33)**
Executive Director of Nursing, Quality and Patient Experience	**90.9%**	**175**	**174**	**(18)**	**-**	**-**	**(17)**
Executive Director of Public Health	**87.6%**	**143**	**142**	**(19)**	**1**	**-**	**(18)**
Executive Director of Strategy and Planning	**93.9%**	**48**	**48**	**(2)**	**-**	**-**	**(2)**
Executive Director of Workforce and Organisational Development	**74.6%**	**229**	**227**	**(87)**	**1**	**-**	**(86)**
Executive Medical Director	**87.0%**	**107**	**107**	**(10)**	**-**	**-**	**(10)**
Grand Total	**9**	**,528**	**7,318**	**(770)**	**193**	**8**	**(562)**

In-Month – Revenue vs Plan Variance (£'k)

Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	**(2)**					**(1)**		**(12)**	**(0)**	**(16)**
Chief Operating Officer	**(178)**	**(75)**	**667**	**(22)**	**170**	**1,955**	**(1,215)**	**(865)**	**(250)**	**188**
Chief Operating Officer Management	(9)	1	(4)	4	9	(3)		(108)	26	**(83)**
Community and Integrated Medicine	(123)	(16)	284	(70)	225	103	(87)	200	(188)	**329**
Mental Health and Learning Disabilities	(9)	(95)	85	7	2	326	(23)	(6)	39	**326**
Operational Allied Health and Health Sciences	(2)	19	14	36	(96)	(33)	(103)	46	(81)	**(200)**
Planned and Specialist Care	9	(3)	233	23	23	569	(561)	49	(22)	**320**
Primary Care, Community Strategy and Long Term Care	(44)	18	55	(22)	6	992	(441)	(1,045)	(23)	**(503)**
Executive Director of Allied Health Professions and Health Sciences	**(149)**	**(14)**		**(4)**	**32**	**(0)**	**0**	**(122)**	**(56)**	**(313)**
Estates and Facilities	(161)			(4)	32		0	(122)	(56)	**(311)**
Executive Allied Health Professions and Health Sciences	12	(14)				(0)				**(2)**
Executive Director of Finance	**38**	**6**	**(1)**	**(18)**		**(36)**		**(147)**	**(47)**	**(204)**
Digital	13	6	(1)	(18)		(36)		(139)	(44)	**(219)**
Finance	26					0		(8)	(3)	**15**
Executive Director of Nursing, Quality and Patient Experience	**8**	**(9)**		**(11)**	**0**	**1**		**38**	**(8)**	**19**
Executive Director of Public Health	**(52)**	**13**	**(3)**	**7**	**(7)**	**(4)**	**(472)**	**(50)**	**(7)**	**(574)**
Executive Director of Strategy and Planning	**4**	**0**	**(0)**			**36**	**0**	**41**	**(84)**	**(3)**
LTAs with other NHS Providers	4					34	0	0		**38**
Strategy and Planning	(0)	0	(0)			2		41	(84)	**(41)**
Executive Director of Workforce and Organisational Development	**(3)**	**(13)**	**1**	**14**	**(0)**	**16**	**(4)**	**(17)**	**128**	**121**
Executive Medical Director	**3**	**(6)**	**7**	**(10)**	**1**		**0**	**(51)**	**(1)**	**(57)**
Health Board Wide	**127**		**(0)**	**585**	**(25)**	**(17)**	**(72)**	**(47)**	**(383)**	**168**
Planned Deficit								**2,500**		**2,500**
Savings Identification								**(72)**		**(72)**
Grand Total	**(203)**	**(97)**	**671**	**542**	**171**	**1,949**	**(1,763)**	**1,196**	**(708)**	**1,758**

Year to Date – Revenue vs Plan Variance (£'k)

Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	**(9)**				**0**	**(11)**		**(24)**	**(1)**	**(46)**
Chief Operating Officer	**(1,421)**	**5**	**3,525**	**(1,443)**	**1,083**	**1,462**	**(4,986)**	**1,528**	**(1,179)**	**(1,424)**
Chief Operating Officer Management	(159)	(10)	(20)	33	40	(23)		(229)	59	**(309)**
Community and Integrated Medicine	(850)	(66)	1,027	(604)	499	286	(441)	942	(355)	**438**
Mental Health and Learning Disabilities	(96)	(353)	702	(334)	12	2,053	(233)	(25)	50	**1,775**
Operational Allied Health and Health Sciences	9	478	(49)	240	(248)	(182)	(281)	142	(528)	**(418)**
Planned and Specialist Care	(67)	(76)	1,288	(513)	921	1,654	(3,816)	395	(719)	**(934)**
Primary Care, Community Strategy and Long Term Care	(259)	31	578	(264)	(141)	(2,326)	(214)	303	314	**(1,977)**
Executive Director of Allied Health Professions and Health Sciences	**(540)**	**(115)**	**9**	**(23)**	**26**	**0**	**3**	**270**	**105**	**(264)**
Estates and Facilities	(636)		9	(23)	26		3	269	105	**(246)**
Executive Allied Health Professions and Health Sciences	96	(115)				0		1		**(18)**
Executive Director of Finance	**(116)**	**49**	**22**	**0**	**0**	**(341)**	**0**	**(383)**	**(195)**	**(964)**
Digital	(62)	(3)	22	0	0	(344)		(299)	(193)	**(879)**
Finance	(54)	51				3	0	(84)	(2)	**(85)**
Executive Director of Nursing, Quality and Patient Experience	**(253)**	**(58)**	**0**	**161**	**(2)**	**69**		**305**	**56**	**278**
Executive Director of Public Health	**(143)**	**113**	**(79)**	**(150)**	**(36)**	**(42)**	**(470)**	**126**	**(154)**	**(834)**
Executive Director of Strategy and Planning	**(24)**	**41**	**0**			**1,180**	**2**	**37**	**(98)**	**1,139**
LTAs with other NHS Providers	27					1,184	2	(2)		**1,211**
Strategy and Planning	(51)	41	0			(4)		39	(98)	**(72)**
Executive Director of Workforce and Organisational Development	**(88)**	**(23)**	**8**	**102**	**1**	**260**	**(20)**	**(187)**	**(111)**	**(57)**
Executive Medical Director	**(14)**	**(9)**	**110**	**(52)**	**14**		**(0)**	**(311)**	**32**	**(231)**
Health Board Wide	**146**		**(0)**	**555**	**151**	**79**	**273**	**4,671**	**(675)**	**5,200**
Planned Deficit								**20,000**		**20,000**
Savings Identification								**(4,726)**		**(4,726)**
Grand Total	**(2,462)**	**2**	**3,596**	**(848)**	**1,237**	**2,656**	**(5,197)**	**21,306**	**(2,220)**	**18,072**

End of Year – Revenue vs Plan Variance (£'k)

Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	**(55)**				**0**	**(16)**		**21**	**(3)**	**(53)**
Chief Operating Officer	**(2,439)**	**(131)**	**6,511**	**(2,679)**	**2,978**	**1,801**	**(5,308)**	**2,794**	**(3,008)**	**518**
Chief Operating Officer Management	(520)	9	(69)	32	76	(34)		(27)	25	**(507)**
Community and Integrated Medicine	(1,128)	(36)	2,161	(1,224)	835	550	(554)	1,568	(565)	**1,605**
Mental Health and Learning Disabilities	(183)	(539)	1,093	(706)	12	2,874	(233)	(25)	72	**2,365**
Operational Allied Health and Health Sciences	(2)	633	24	368	392	(302)	(524)	187	(779)	**(3)**
Planned and Specialist Care	(104)	(46)	2,373	(774)	1,805	2,363	(5,289)	709	(983)	**54**
Primary Care, Community Strategy and Long Term Care	(502)	(153)	929	(376)	(142)	(3,649)	1,292	383	(777)	**(2,996)**
Executive Director of Allied Health Professions and Health Sciences	**(499)**	**(171)**	**12**	**(39)**	**(70)**	**0**	**5**	**1,042**	**(87)**	**193**
Estates and Facilities	(643)		12	(39)	(70)		5	1,040	(87)	**219**
Executive Allied Health Professions and Health Sciences	144	(171)				0		1		**(25)**
Executive Director of Finance	**(44)**	**55**	**(61)**	**(130)**	**0**	**(485)**	**0**	**409**	**0**	**(256)**
Digital	89	3	(61)	(130)	0	(490)		414	(0)	**(175)**
Finance	(133)	51				5	0	(5)	0	**(82)**
Executive Director of Nursing, Quality and Patient Experience	**(273)**	**(94)**	**0**	**63**	**(2)**	**117**		**415**	**76**	**304**
Executive Director of Public Health	**(351)**	**166**	**(90)**	**(232)**	**(54)**	**(63)**	**(627)**	**(82)**	**(203)**	**(1,537)**
Executive Director of Strategy and Planning	**(97)**	**41**	**1**			**1,881**	**2**	**(29)**	**(101)**	**1,697**
LTAs with other NHS Providers	43					1,887	2	(4)		**1,929**
Strategy and Planning	(140)	41	1			(6)		(25)	(101)	**(232)**
Executive Director of Workforce and Organisational Development	**38**	**(32)**	**12**	**(155)**	**2**	**371**	**(30)**	**(64)**	**(142)**	**0**
Executive Medical Director	**8**	**11**	**210**	**(102)**	**21**		**(0)**	**(434)**	**45**	**(242)**
Health Board Wide	**(952)**	**0**	**(1)**	**848**	**48**	**(1,483)**	**(29)**	**2,813**	**(1,452)**	**(208)**
Planned Deficit								**30,000**		**30,000**
Savings Identification								**(2,116)**		**(2,116)**
Grand Total	**(4,664)**	**(155)**	**6,594**	**(2,427)**	**2,923**	**2,124**	**(5,987)**	**34,768**	**(4,875)**	**28,300**

End of Year – Savings Detail (£'k)

Clinical Care Group and Executive Functions (£'k)	Annual Savings Target	In-Year Identified Plans	In-Year Recurrent Delivery	In-Year Non Recurrent Delivery	In-Year Total Forecast Delivery	In-Year Forecast Shortfall	In-Year % Saving vs Budget	Recurrent Forecast Delivery	Recurrent Forecast Shortfall	Recurrent % Saving vs Budget
Chief Executive	**38**	**388**	**38**	**350**	**388**	**(350)**	**11.5%**	**38**	**(0)**	**1.1%**
Chief Operating Officer	**39,046**	**26,332**	**10,941**	**15,118**	**26,058**	**12,988**	**3.4%**	**14,656**	**24,390**	**1.9%**
Chief Operating Officer Management	762	714	0	714	714	47	5.6%	0	762	0.0%
Community and Integrated Medicine	10,483	6,537	2,842	3,695	6,537	3,945	2.7%	2,922	7,560	1.2%
Mental Health and Learning Disabilities	5,851	5,318	1,375	3,943	5,318	532	5.1%	1,375	4,476	1.3%
Operational Allied Health and Health Sciences	3,785	459	459	0	459	3,326	0.6%	459	3,326	0.6%
Planned and Specialist Care	11,638	8,437	3,799	4,365	8,163	3,475	3.9%	7,418	4,220	3.5%
Primary Care, Community Strategy and Long Term Care	6,529	4,867	2,466	2,401	4,867	1,662	4.5%	2,482	4,046	2.3%
Executive Director Of Allied Health Professions and Health Sciences	**2,063**	**316**	**316**	**0**	**316**	**1,747**	**0.6%**	**316**	**1,747**	**0.6%**
Estates and Facilities	2,053	316	316	0	316	1,737	0.6%	316	1,737	0.6%
Executive Allied Health Professions and Health Sciences	10	0	0	0	0	10	0.0%	0	10	0.0%
Executive Director Of Finance	**377**	**1,578**	**493**	**1,085**	**1,578**	**(1,201)**	**6.8%**	**527**	**(150)**	**2.3%**
Digital	271	1,079	384	695	1,079	(808)	6.3%	417	(147)	2.4%
Finance	106	500	109	390	500	(393)	8.4%	109	(3)	1.8%
Executive Director Of Nursing, Quality and Patient Experience	**243**	**670**	**201**	**470**	**670**	**(427)**	**7.2%**	**243**	**0**	**2.6%**
Executive Director Of Public Health	**107**	**980**	**107**	**873**	**980**	**(873)**	**14.9%**	**107**	**(0)**	**1.6%**
Executive Director Of Strategy and Planning	**1,902**	**1,674**	**518**	**1,156**	**1,674**	**228**	**2.8%**	**518**	**1,384**	**0.9%**
Strategy and Planning	61	734	61	673	734	(673)	19.7%	61	(0)	1.6%
LTAs With Other NHS Providers	1,841	940	457	483	940	901	1.7%	457	1,384	0.8%
Executive Director Of Workforce and Organisational Development	**247**	**3,017**	**247**	**2,770**	**3,017**	**(2,770)**	**19.9%**	**247**	**(1)**	**1.6%**
Executive Medical Director	**74**	**74**	**74**	**0**	**74**	**(0)**	**1.7%**	**74**	**(0)**	**1.7%**
Health Board Wide	**2,303**	**13,486**	**1,371**	**12,115**	**13,486**	**(11,183)**	**37.2%**	**1,485**	**819**	**4.1%**
Grand Total	**46,400**	**48,516**	**14,306**	**33,937**	**48,243**	**(1,842)**	**5.0%**	**18,211**	**28,189**	**1.9%**

Y Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Health, Social Care, and Early Years Group

Llywodraeth Cymru
Welsh Government

Our Ref: HJ/RJ

10 December 2025

Dear Colleague

2025/26 In-year financial position

I am writing to update you on the in-year financial position and will pick up any further detail at next Tuesday's leadership board meeting.

I can confirm that exceptionally Welsh Government will provide increased funding support to the Welsh Risk Pool on a non-recurrent basis to offset the cost increase beyond the pressure in your original plans. This will be to a maximum of £49m reflecting the month 7 minimum position forecast by NWSSP, and I will ask my team to work through the necessary mechanism with finance teams.

In addition, following the adoption of an all-Wales framework for Band 2/3, I can confirm that Welsh Government will on a non-recurrent basis provide funding support for the costs of resolution. Allocations will be made on actual values recorded in audited accounts for 2025/26.

During this last month, allocations have also been issued in support of 2025/26 pay awards, so organisations have received confirmation of funding for this issue.

Having now addressed these risks, NHS bodies continue to be expected to deliver their current financial positions and forecast as a minimum or improve those where possible.

Yours sincerely

Hywel Jones
Cyfarwyddwr Cyllid | Director of Finance

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ebost • Hywel.Jones038@llyw.cymru/
Email • Hywel.Jones038@gov.wales
• Gwefan www.llyw.cymru
• website: www.gov.wales

Y Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar
Health, Social Care, and Early Years Group

Llywodraeth Cymru
Welsh Government

Our Ref: HJ/RJ

10 December 2025

Dear Phil

2025/26 Target Control Total

You will have received my update letter issued to CEOs and DOFs on the in-year financial position and Welsh Governments confirmation to provide support on a non-recurrent basis to the pressures associated with Welsh Risk Pool, and resolution of the Band 2/3 position following the adoption of an all-Wales framework.

Welsh Government is supporting those issues non-recurrently on a consistent and equitable basis. As such, this will include Hywel Dda University Health Board and given the impact of these issues are built into your current forecast these will need to be reflected.

Our assessment is that the Welsh Risk Pool estimate in your current forecast deficit of £28.3m is £4.2m, and in-year band 2/3 pressure of £2m.

As such, recognition of these issues through non-recurrent funding results in the health board forecast improving to a £22.1m forecast deficit.

The Health Boards Target Control Total will be adjusted to reflect this position of a £22.1m forecast deficit, which the health board is expected to deliver.

Yours sincerely

Hywel Jones
Cyfarwyddwr Cyllid | Director of Finance

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ebost • Hywel.Jones038@llyw.cymru/
Email • Hywel.Jones038@gov.wales
• Gwefan www.llyw.cymru
• website: www.gov.wales

Swyddfeydd Corfforaethol, Adeilad Ystwyth
Hafan Derwen, Parc Dewi Sant, Heol Ffynnon Job
Caerfyrddin, Sir Gaerfyrddin, SA31 3BB

Corporate Offices, Ystwyth Building
Hafan Derwen, St Davids Park, Job's Well Road,
Carmarthen, Carmarthenshire, SA31 3BB

Ein cyf/Our ref: CEO.19013

Gofynnwch am/Please ask for: Kelly Sursona

Dyddiad/Date: 5th December 2025

Jacqueline Totterdell
Chief Executive NHS Wales

Jacqueline.Totterdell@gov.wales

Dear Jacqueline

2025/26 Strategic Cash Request

I write in accordance with Technical Update 3, dated 7 November 2025. This update requested that Chief Executives, as Accountable Officers, should formally notify you of requests for Strategic Cash assistance by 8 December 2025.

The current forecast deficit is £28.3m. This is comprised of the improved forecast deficit of £24.1m in line with our revised target control total plus the recognition of £4.2m for the Welsh Risk Pool (WRP) risk share increased contributions. This is the lower end (current best case) of the WRP advised additional requirements in-year and therefore may be subject to change.

On this basis, I need to formally request strategic cash assistance for 2025/26, as set out below:

Table 1: Revenue	**£'m**	
Deficit in-line with target control total	24.1	
Additional due to WRP	4.2	
Strategic Cash Request	**28.3**	
Working Capital	6.0	Modelled on cash spend for first seven months of the year.
Potential additional working capital requirement	7.0 – 8.0	Reimbursement for high cost WRP cases paid out in-year if not reimbursed before year-end
	4.0 – 5.0	Cash consequences arising due to the Band 2 to 3 re-banding back pay may also affect the working capital requirement.

Table 2: Capital	£'m	
Cash for owned assets	1.1	The actual working balances cash drawn may change should additional capital funding be provided by WG towards the end of the financial year.
Cash for IFRS leased assets	2.9	

These represent our best estimates at this time, as additional allocations are anticipated between now and year-end, and therefore may be subject to change. The working capital has been modelled on our expenditure for the first seven months of the year. There is some risk that this might be underestimated as we have seen an increase in elective recovery work activity and agency costs in September and October and will keep these under close monitoring. At present we do not anticipate that the working capital revenue will be required prior to 16 March 2026.

We have reviewed our creditor types to identify different payment policies that could be adopted with a cash strategy developed should the full amount of strategic cash assistance not be made available. These options all contain risks for the Health Board and represent a significant reputational concern for us, should they be enacted.

Priority creditors would need to be paid to maintain service levels. If no strategic cash assistance is made available and restrictions on creditor payments are not undertaken, we estimate that the Health Board will fully utilise our approved cash resource limits by 20 March 2026.

The cash management strategy developed in previous years was discussed at the Finance and Performance Committee at their October 2025 meeting. It was signalled to the Committee that the strategy would be invoked if required.

This letter has also been discussed at the 27 November 2025 Board meeting.
I am grateful for your support and look forward to receiving confirmation of any strategic cash assistance which you can provide.

Yours sincerely



Professor Phil Kloer
Chief Executive

Cc Huw Thomas, Hywel Jones, Matthew Denham-Jones, Jacqueline Salmon

4.2

11:55 AM, 10 Mins

4.2 - INVESTMENT AND BENEFITS REALISATION REPORT

Sian Jenkins (Hywel Dda UHB - Deputy Director of Finance)

For assurance

Attachments

Investment and Benefits Realisation Report FPC 16 December 2025.pdf

Appendix 1 Investment and Benefits Realisation Report.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Investment and Benefits Realisation Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Sian Jenkins, Deputy Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update on the status of investment cases. At this stage the investment cases are relatively recently approved therefore the benefits realisation has not been assessed.

Cefndir / Background

Hywel Dda University Health Board (HDdUHB) approved an Annual Plan on 27 March 2025 which represented a planned deficit of £31.5m. This includes provision for investments totalling £11.9m, expected recurrent savings of £19.0m, plus a non-recurrent benefit of underspends and non-recurrent savings of £25.4m. Therefore, total savings delivery for the year of £46.4m.

Recognising that appropriate scrutiny of investment plans is required ahead of final approval being granted, the Annual Plan earmarked funding to support a number of priority proposals which had been highlighted through the planning cycle, total value £11.9m. These cases have been routed through an investment scrutiny process lead by representatives of the Finance, Operations, Planning, Workforce functions, with recommendations reported through to Formal Executive Team for decision.

Asesiad / Assessment

Investments

Within the Annual Plan £11.9m was supported to afford priority investment cases, these plans have been scrutinised ahead of formal approval and award of funding. To date £10.2m has been approved on a recurrent basis, with a level of slippage identified in respect of in year spend for 2025/26 as a result of recruitment timescales and lead in times.

- **Process** – the cases included in the Annual Plan were split into three batches and a process of desktop review, feedback, follow-up meetings and recommendations to Formal Executive Team.

  The intention had been to conclude the review process by early June 2025, however, to ensure robust cases are presented to Formal Executive Team it has been necessary to allow more time for further work to be done on some cases. A handful of additional cases were also referred into the scrutiny process by Executive Directors.

- **Status** – all submitted cases have been through the initial review process, the majority have been considered by Formal Executive Team for decision. Included in **Appendix 1** is a status update across all of the investment cases. Key updates since the previous report are noted below.

  - In respect of the £2.0m provision for the recurrent costs of the All-Wales Band 2/Band 3 Healthcare Support Worker (HCSW) changes, the national framework was signed off in November 2025. Alongside the work already done within the Health Board to review Band 2 roles, payment can progress for all aspects and be actioned in the New Year. This includes the recognition payment, corrective payment and update of current payment terms going forward. Final detail on associated funding from Welsh Government (WG) is due to be confirmed which will enable a full assessment of the financial implication.

  - A case that was added to the scrutiny process during 2025/26 has been concluded, this is in respect of Emergency Urgent Care Centre nursing at Bronglais Hospital (BGH), spanning the Emergency Department (ED), Minor Injuries Unit (MIU) and Clinical Decision Unit (CDU). The proposal seeks to substantiate a number of historic staffing elements already live within the rotas, as such a large portion of the expenditure is already being incurred. No budget provision was made in the 2025/26 Annual Plan, rather existing variable pay budget will be reviewed to enable the case as part of the annual planning cycle.

- **Next Steps** – this process has provided positive learning which the panel are keen to apply in framing the ongoing process for consideration of proposals. This coincides with a recent learning event with Swansea University Value-Based Health and Care Academy '*Building Better Cases for Chage in Hywel Dda University Health Board*'.

  The aim is to finalise a set of standardised templates to guide service leads in developing proposals and progressing them through the appropriate governance route. This will include delivery milestones and benefits realisation.

Recognising that of the 2025/26 investments, cases are relatively recently being granted approval and are currently being implemented, further updates on delivery and benefits realised will be provided subsequently. Whilst decision outcomes remain to be confirmed for some cases, the associated funding is being reviewed on a monthly basis and factored into the financial position as appropriate.

Assure (to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **ACKNOWLEDGE** 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
- **NOTE** 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.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Receive assurance on the development and realisation of opportunities. This will be achieved through scrutiny of the bi-monthly savings and opportunities report to the Committee. 3.1.13 Review any investment/disinvestment strategy, including Procurement and Contracting Strategy, maintaining oversight of the investments and disinvestments, ensuring compliance with policies by: 3.1.13.1 Establishing the overall methodology, processes and controls which govern investments and disinvestments, including the prioritisation of decisions; 3.1.13.2 Ensuring that robust processes are followed; and 3.1.13.3 Evaluating, scrutinising and monitoring subsequent investments/ disinvestments.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086 (score 20) Risk of the Health Board not being able to meet the statutory requirement of breaking even in 2025/26 due to significant deficit position.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termau: Glossary of Terms:	BGH – Bronglais General Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili General Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush General Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)

Ariannol / Gwerth am Arian: **Financial / Service:**	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The impact on patient care is assessed within the savings schemes.
Gweithlu: **Workforce:**	The report considers the financial implications of our workforce.
Risg: **Risk:**	Financial risks are detailed in the report.
Cyfreithiol: **Legal:**	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: **Reputational:**	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Investment and Benefits Realisation Report

Finance and Performance Committee

16 December 2025

2025/26 Investment Case Update (1 of 3)

Key Commentary

Priority cases within the 2025/26 Annual Plan for which investment funding was supported, have been progressing through an internal review and scrutiny process during Q1.

- All cases considered through the initial review process
- To date 14 cases have been approved through Formal Executive Team
- 1 case has been updated and resubmitted for the scrutiny process to continue and will be considered as part of the 2026/27 planning cycle

The status update of each proposal in respect of the investment scrutiny process is outlined below and across the following 2 slides.

Annual Plan Category	CCG / Directorate	Description	Annual Plan Provision £	Approved 25/26 £	Approved Recurrent £	Status	Formal Executive Team consideration
Local Future Investments	Planned and Specialist Care	Acute Oncology Service (AOS) provision improvement	398,013	174,407	398,013	**Approved**	16/04/2025
Local Future Investments	Planned and Specialist Care	Ophthalmology IVT recovery plan - clinic staffing capacity	350,000	350,000	350,000	**Approved**	16/04/2025
Local Future Investments	Planned and Specialist Care	Ophthalmology IVT recovery plan - drug consumption	1,300,000	1,300,000	1,300,000	**Approved**	16/04/2025
Local Future Investments	Planned and Specialist Care	Endoscopy	700,000	439,796	475,719	**Approved**	16/04/2025
Local Future Investments	Allied Health and Health Scientists	Radiology diagnostic improvement	1,500,000	1,500,000	1,500,000	Recommendation made to Execs. Subsequent follow up to finalise approval. **Approved**	16/04/2025
Local Future Investments	Digital	Modular Electronic Health Record	1,800,000	1,540,000	1,800,000	Recommendation made to Execs. Subsequent follow up to finalise approval. **Approved**	16/04/2025
Local Pre-Commitment	Estates and Facilities	Additional fire wardens required at WGH	178,000	153,922	178,000	**Approved**	21/05/2025
Local Pre-Commitment	Director of Nursing	Legal Service	324,945	269,842	324,945	**Approved**	21/05/2025

2025/26 Investment Case Update (2 of 3)

Annual Plan Category	CCG / Directorate	Description	Annual Plan Provision £	Approved 25/26 £	Approved Recurrent £	Status	Formal Executive Team consideration
Local Pre-Commitment	Estates and Facilities	Maintenance Volume	400,000	0	0	Deferred, awaiting paper. Exec decision to release funding reserve, recognising new leadership arrangements for CCG and need for wider review of function to inform an investment plan. Any subsequent proposal will feed in through planning cycle. **Funding reserve released as a recurrent saving scheme.**	N/A
Local Pre-Commitment	Director of Workforce	International Recruitment (Medical)	200,000	0	0	Deferred, awaiting paper. Subsequent confirmation of WG funding to support recruitment. **No investment required, funding reserve released as a recurrent saving scheme.**	N/A
Local Pre-Commitment	Medical Director	VBHC - Heart Failure	624,000	0	0	Exec recommendation made. Exec ask to service that savings assessment re-visited, reassess and determine future, VBHC funding extended. Review of options in respect of service mitigation plans and recurrent cost requirement being assessed through Value & Sustainability Group, timeline set for end of October. **Financial reserve converted to a non-recurrent saving scheme for 25/26.**	21/05/2025
Local Pre-Commitment	Estates and Facilities	RAAC revenue pressure	150,000	150,000	150,000	**Approved**	04/06/2025
Local Future Investments	Director of Public Health	Child Obesity PH	300,000	80,000	0	Progressed through batch 2, require greater clarity ahead of making recommendation, awaiting paper. Exec decision to pause potential investment until latter stages of 25/26, non-recurrent saving to be transacted month on month in the interim. Non-recurrent funding allocated to support dietician capacity for selective eating disorders £80k.	TBC
Local Future Investments	Central Reserves	Nurse Staffing 25b Provisional Autumn 2024 Review	380,030	164,551	164,551	Progressed directly through Executive Team, Spring Review 25b. **Approved**	N/A
Local Future Investments	Central Reserves	Nurse Staffing 25a Provisional MH&LD	988,657	988,657	988,657	Progressed directly through Executive Team. **Approved**	N/A

2025/26 Investment Case Update (3 of 3)

Annual Plan Category	CCG / Directorate	Description	Annual Plan Provision £	Approved 25/26 £	Approved Recurrent £	Status	Formal Executive Team consideration
Local Future Investments	Central Reserves	Band 2/3 HCSW Pay Dispute	2,261,379			National/HR/corporate nursing process will determine appropriate costs, not an investment case per se. Provision scaled back from £2.3m to £2.0m Q1. November update: National framework agreed, recognition and corrective payments, plus ongoing payments to be transacted in new year. An element of WG funding anticipated, detail TBC.	N/A
Not included in the financial plan	Estates and Facilities	Additional fire wardens required at WGH	0	0	205,000	**Approved** (costs start Sept '26) In the absence of reserve funding, budget will be aligned through the 26/27 planning cycle.	04/06/2025
Not included in the financial plan	Estates and Facilities	Additional fire wardens required at GGH	0	153,922	205,000	**Approved** In the absence of reserve funding, costs in 25/26 will generate a deficit variance - budget will be aligned through the 26/27 planning cycle.	04/06/2025
Not included in the financial plan	Director of Public Health	Health Coaches - pursuing VBHC funding initially	0			Linked to VBHC funding to pilot. Progressed through batch 2, further work required, updated proposal submitted - scrutiny process to recommence aligned to the annual plan 26/27. Exec decision to pause potential investment until latter stages of 25/26, dependent on availability of VBHC funding.	TBC
Not included in the financial plan	Community and Integrated Medicine	BGH EUCC Nursing	0	1,330,000	2,210,000	Case considered at Executive team in November and supported, minimal impact 25/26 given recruitment timelines and existing staffing provision - level of costs already being incurred in the current run rate. **Approved**. Funding implications being reviewed in respect of existing variable pay budget through the 26/27 annual plan process. N.B. Total investment required £2,210k to substantiate existing workforce and expand in certain areas, £1,660km cost already	12/11/2025
Not included in the financial plan	Community and Integrated Medicine	GGH ED Nursing	0			Deferred, pending paper	TBC
Total			**11,855,024**				
Approved Total				**8.595,097**	**10,249,885**		

4.3

12:05 PM, 15 Mins

4.3 - PLANNING FOR 2026/27

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance), Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)

For assurance

Attachments

Planning for 2026-27 FPC 16 December 2025.pdf

Appendix 1 FY27 Annual Financial Plan.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planning for 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Spratt, Deputy Director of Finance Jennifer Thomas, Head of Corporate Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's approach and progress to developing the financial plan, set within the wider planning cycle.

Cefndir / Background

The Health Board is required, annually, to submit an Integrated Medium Term Plan (IMTP) that achieves financial balance across a three-year period. Since the Health Boards inception in 2009 it has not been able to submit an IMTP due to the significant financial deficit it has presided over.

The Health Board will be submitting a **Three-Year Financial Plan**, aspiring for a breakeven position for 2027/28 and beyond, aligned to Welsh Government (WG) criteria associated with £26.0m of conditionally recurrent funding allocated to the Health Board in 2024/25.

As part of the planning cycle this paper is presented to highlight the approach, principles, assumptions and financial assessment of the key components of the 2026-27 plan, i.e. Year 1 of the 2026-29 Three-Year Financial plan.

Asesiad / Assessment

Work on the 2026-29 financial plan has been underway since October 2025. The attached presentation, **Appendix 1,** looks to set out the key assumptions, principles and provide a first draft summary financial assessment for the 2026-27 financial year, Year 1 only.

The Health Board is awaiting the formal allocation letter from WG; however, the plan is predicated on an inflation uplift of 0.0%, with an updated funding notification expected following the Senedd Cymru elections in May 2026.

Further work will be undertaken in January 2026 to assess service risks and opportunities that will need to be incorporated within the overall financial plan, and these assessments will be refreshed with any updated values. There will also be a series of scrutiny meetings in the form of Executive Improving Together sessions (EITs), Sustainability Recovery and Executive Team.

The latest draft of the Financial Plan will be presented to Finance and Performance Committee in February 2026 for assurance review, including savings progress from service areas and approval of budget setting, before being presented to Public Board in March 2026 and onward submission to WG by 31 March 2026.

The financial roadmap (three-year trajectory) continues to be developed and updated, clearly identifying the actions that are required to ensure a financial break-even position is achieved for the 2027/28 financial year, meeting expectations set out as part of conditional funding arrangements from 2024/25. Updated scenarios across a three-year horizon to 2028/29 will be presented in the next Committee meeting, following a comprehensive assessment of Year 1, 2026-27 requirements.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **RECOGNISE** that the Health Board is proposing to submit a Three-Year Financial Plan, aspiring to a breakeven position for 2027/28 and beyond.
- **NOTE** this paper represents Year 1 of the Three-Year Financial Plan being developed for submission in March 2026.
- **DISCUSS** the content of the latest draft Financial Assessment for 2026/27.
- **DISCUSS** 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.
- **DISCUSS** the approach to be taken to recognise underspends on a recurrent basis and the basis of allocating savings targets to functions.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers; 3.1.5.2 Performance against the savings requirement; 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector

	Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1199 (score 25) Risk of the Health Board not being financial sustainability.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termau: Glossary of Terms:	BGH – Bronglais Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP– Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush Hospital

	WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The impact on patient care is assessed within the savings schemes.
Gweithlu: **Workforce:**	The report considers the financial implications of our workforce.
Risg: **Risk:**	Financial risks are detailed in the report.
Cyfreithiol: **Legal:**	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: **Reputational:**	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Planning for 2026/27

Financial Plan Draft Assessment – 2026/27

Finance and Performance Committee, 16 December 2025

Contents

1 Background and context

2 Principle components and approach

3 Key principles and assumptions

4 Draft financial plan assessment

5 Financial components

6 Key milestone deadlines

Contents

1 **Background and context**

2 Principle components and approach

3 Key principles and assumptions

4 Draft financial plan assessment

5 Financial components

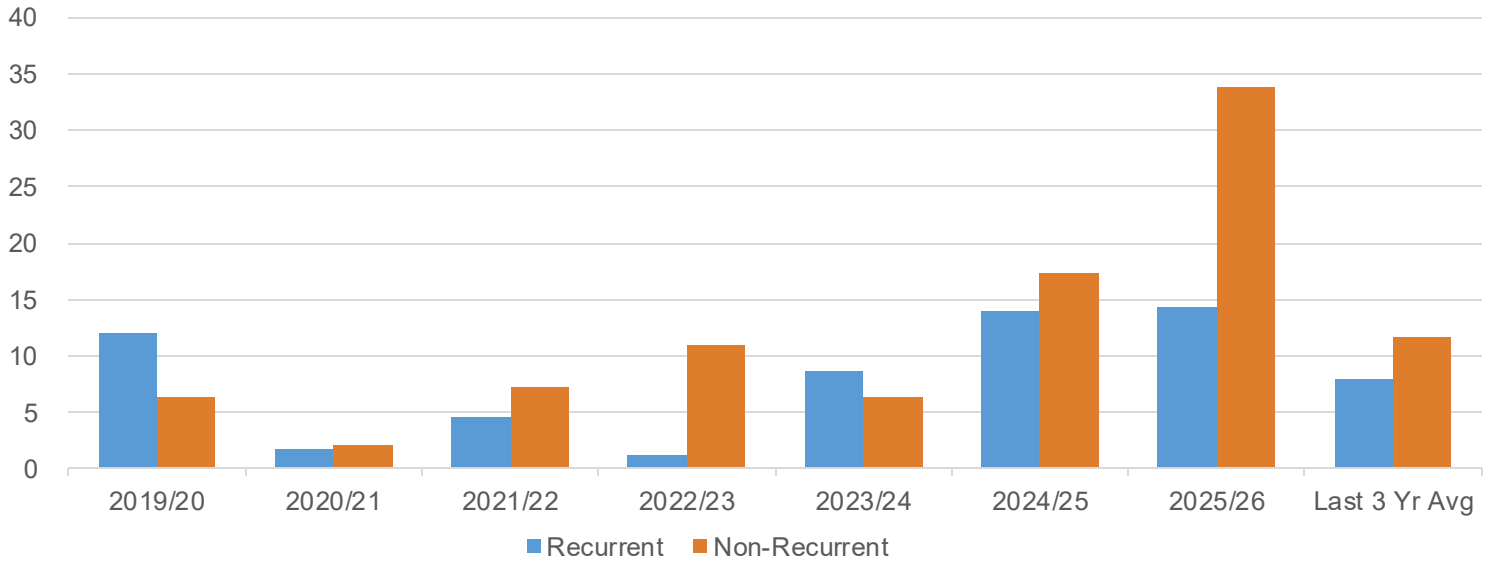
6 Key milestone deadlines

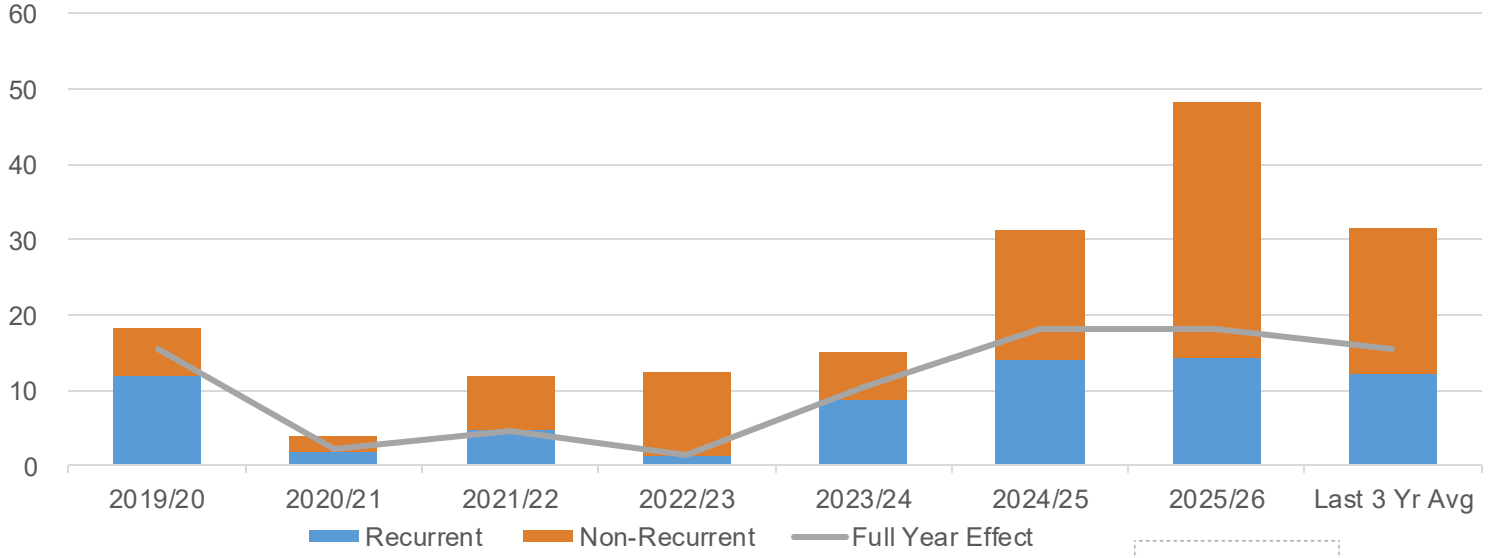
Background and Context

- The Health Board has a **revised annual plan deficit of £30.0m for 2025/26**, which is an improvement on the original annual plan deficit of £31.5m. Whilst this achieved the target control total set in 2024/25 of £31.5m, **Welsh Governments expectations are clear that a deficit of £22.1m is the revised target control total;**
- Given the scale of the challenge to bridge to a break-even position, the Health Board submitted an Annual Plan for 2025/26 and not an IMTP, but set within a three-year context;
- The Health Board is in Targeted Intervention, with a financial criteria to deliver breakeven by 2027/28;
- Significant change is required to meet the expectations clearly set out by Welsh Government;
- With challenges to deliver annual plans in the post pandemic era, 2024/25 and 2025/26 are likely to see a reversing of this trend with a reframed approach to internal escalation and accountability management.

Financial Year	WG Expectation £'m	Annual Plan £'m	Year End Position £'m	Plan v Actual Variance £'m	Comment
2019/20	25.0	25.0	34.9	9.9	After £10.0m clawback due to not achieving £15.0m
2020/21	25.0	25.0	24.9	(0.1)	After £116.1m of non-recurrent funding for COVID
2021/22	25.0	25.0	25.0	-	After £75.5m of non-recurrent funding for COVID
2022/23	25.0	25.0	59.0	29.0	After £22.2m of non-recurrent funding for COVID
2023/24	44.8	56.1	65.8	9.7	Original plan £112.9m, revised mid-year with £56.8m extra funding. £43m cond.
2024/25	31.5	31.5	24.1	(7.4)	After mid-year funding of £32.5m to reduce original £64.0m plan. £26m cond.
2025/26	22.1	30.0	22.1	(7.8)	As at M8, and after the original plan was improved from £31.5m

Savings Deliverability Assessment (£'m)





- 2025/26 Savings are as at Month 8 reporting
- The three-year average is based on 2023/24 to 2025/26
- The 2024/25 was a step change to previous years deliverability of savings, in comparison to recent years
- Historically, and currently, there remains an **over-reliance on non-recurrent** savings, where no year has been able to achieve a full year effect of recurrent schemes to the same level of total savings
- An **ambitious two-year savings aspiration** was set in 2024/25, covering 2024/25 and 2025/26, to ensure the health board sets the expectation of achieving an improved financial trajectory into 2025/26 and beyond

Financial Roadmap Assessment 2025-26 (Year 0)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The underlying assessment is identified at the start of the new financial year. Together with an assessment of the macro costs, demographics, allocation funding and savings, the 2025/26 financial plan was summarised as follows:

2025/26 Financial Plan Assessment	Recurrent £'m	Non-Rec £'m	Total £'m
2024/25 underlying deficit carried forward	51.1		51.1
Macro-economic inflation price modelling	15.5		15.5
Volume and mix growth modelling	3.2		3.2
Contractual or unavoidable	14.5	2.0	16.5
National investment commitments	0.1	0.7	0.8
Local investment choices – approved	0.4		0.4
Local investment choices – not yet approved	11.9	(1.5)	10.4
Budget allocation letter funding	(19.2)	(2.3)	(21.5)
Technical efficiency saving (75% of 2024/25)		(27.4)	(27.4)
Strategic and transformation savings	(19.0)		(19.0)
2025-26 Financial Deficit	**58.5**	**(28.5)**	**30.0**

Contents

1 Background and context

2 **Principle components and approach**

3 Key principles and assumptions

4 Draft financial plan assessment

5 Financial components

6 Key milestone deadlines

Planning Cycle Methodology and Owners

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Business Case Development to Delivery
Financial payback or resource shift detail evidenced

Key elements to deliver planning aspirations	Ownership
1 • **Long list** – Risk register framework	Clinical Service Groups
2 • **Short list** – Overlay risk register with further known key priorities	Clinical Care Group Triumvirates
3 • **Collaborative list** – Overlay for further strategic, operational and or policy priorities	Planning Co-ordination Group
4 • **Draft prioritised proposal** – criteria approach to ensure alignment and sensibility assessments are undertaken	Planning Co-ordination Group
5 • **Executive Team review** – amendments through Executive lens made	Executive Team
6 • **Committees and Board updates**	Directors and Deputies

Financial Plan 2026/27 Savings Approach

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- With a 0.0% core uplift now expected as part of the initial WG allocation letter, it is predicted that a mid-year allocation uplift could occur post the Senedd elections;
- Whilst the core uplift will be zero initially, Welsh Government have confirmed Pay Awards will be funded in full;
- A savings target will be required to cover, as a minimum, macro-economic price increases and the erosion of the deficit to demonstrate a continued improvement trajectory, inline with the targeted intervention de-escalation criteria;
- Health prevalence growth resource requirements, and targeted national and local investments, are proposed to be afforded within the mid-year allocation uplift assumption, and a staggered approach to delivering these might therefore be required;
- The financial roadmap proposes savings delivery increasing throughout the year, with March 2027 (Month 12 2026/27) being a breakeven / balanced financial position to ensure 2027/28 can be breakeven.

1 – Savings Targets Discussion

- Carry forward of 2025/26 under-delivery, and increase by 2.0% of non-ring fenced budgets

2 – Resolve Recurring Non-Current Underspends

- New treatment for budgets that have not been utilised for several years, currently c.£22-27m per annum

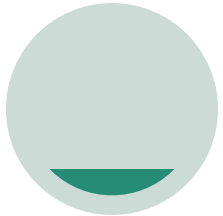
3 – Suggested ideas to exceed Savings Targets

- Updated savings targets to be supported by ideas per service. Not exhaustive, budget holders to update

Principle Components and Approach

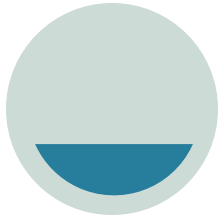
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

As a framework approach to identifying components that would require a financial appraisal with the planning cycle, the following key elements are defined, and an assessment will be undertaken to provide clarity for decision-making through the Planning Steering Group, Executive Team and Board. Timelines and organisation communication will be aligned to that coordinated by the Planning function.



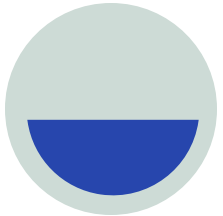
Macro-Economic Price Inflation

Macro-Inflationary items modelled based on latest economic / market conditions; highly likely to manifest and largely unavoidable. These items are pre-defined. A prior year review of funding assumptions verses actual costs will also be undertaken to adjust budgets up/ down as appropriate.



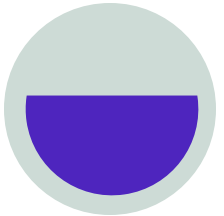
National Investments

New National All-Wales investments approved through national governance processes. Would be difficult to avoid investment as contradictory to approvals already given and Once for Wales ethos. Specific approval and business case will need to be evidenced.



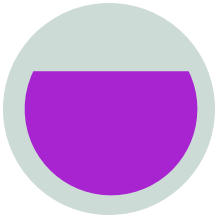
Pre-Committed Investments

Local investments approved through in-year governance processes. Local choice to endorse or unwind decision.



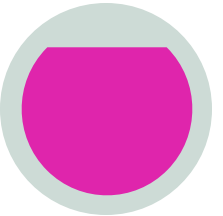
Volume and Mix Growth Modelling

Assessments to be undertaken against specific cost areas that are susceptible to social and health volume and mix growth demographics. A prior year review of funding assumptions verses actual costs will also be undertaken to highlight areas for action.



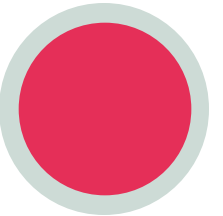
Investment Decisions

Local investments approved through the current planning cycle. Local choice to endorse or unwind decision. Collated through the planning cycle led by the Planning function.



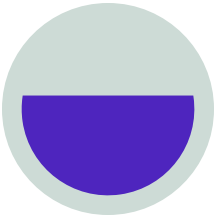
In-Year Assessment

Assessment of the key in-year operational driver changes to the deficit. Check and challenge reviews will be undertaken to ensure consistency and appropriateness. Local choice to endorse or take mitigating action to change current practice.



FYE Assessment

Assessment of the full year effect of the key operational drivers. Check and challenge reviews will be undertaken to ensure consistency, appropriateness and realism of delivery of further steps up or down. Local choice linked to decision regarding appropriateness of in-year assessment.



Service Change Savings

Opportunities for service changes (house-keeping and transformational) to mitigate the existing, and any additional, increases in expenditure, and to erode the pre-existing deficit. Savings schemes to follow the BRAG definitions for assessing deliverability.

Proposed priority order of approval of income or expenditure – all need Executive Team and Board ratification

Approval of opportunities and savings requirements to offset any impacts of Income or Expenditure changes

Contents

1 Background and context

2 Principle components and approach

3 **Key principles and assumptions**

4 Draft financial plan assessment

5 Financial components

6 Key milestone deadlines

Key Principles

- **Budgets will be delegated** from the Accountable Officer (CEO) **to Delegated Officers** (Executive Directors) and their immediate **Deputies** (Executive Function Leads and Clinical Care Group Directors);
- **Consolidation of budgets** will be **undertaken for key areas** to align holistic oversight with appropriate Delegated Officers;
- The **Workforce** plan to be **within existing budgets** only, or specifically included within investment decisions;
- Resourcing requirements for **25A and 25B wards** are to be conducted by **Corporate Nursing Team only**;
- **Only assured** (Green and Amber) **savings plans will be included** within the final planning submission;
- The **Opportunities Framework and Service insight** is to be used to generate sufficient savings opportunities to achieve the targets set for each Clinical Care Group/Executive Function;
- **Saving target** will be set as the value required to achieve the required target to achieve three-year break-even position by March 2028 (Year 2). Year 1 being 2026/27.
- **Clinical Care Group/Executive Function savings targets** will be the minimum of the Welsh Government expectation (likely to be 2%), **plus** any residual recurrent savings gap from the savings requirement set in 2025/26;
- **A decision will need to be made on material underspending functions**, and removal of budgets or conversion to recurrent savings scheme will be required.

Key Assumptions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- The Health Board will be submitting a **Three-Year Financial Plan**, aspiring to a breakeven position for 2027/28 and beyond;
- It is expected that the Health Board will receive a **zero-allocation uplift** initially for 2026/27, and therefore, the income assumptions are aligned to this. Should further allocations be received, updates will be made as appropriate;
- The assessments included within this update are draft and will be updated following ongoing work locally and nationally;
- Specified **macro-economic price** components are **proposed for inclusion** within the financial plan, pending service, Executive and Finance & Performance Committee scrutiny. This includes prior year assumption updates (up and down);
- Identified **prevalence of demand pressures** from academic publications and their costs, from the most recent reference cost returns, of £12.4m will be included in each financial year **and** an assumed **additional £2.0m quality and outcomes** requirement in each financial year. This will create a **maximum cap** for **demand driven** (volume and mix growth) **and discretionary investments** (national and local investments);
- Specified **volume and mix growth** components will **require a decision** to recognise, or expectation that services mitigate cost increases or realise savings opportunities;
- **National and Local investments** will **only include statutory, mandated or high-risk** items unless there is clear payback;
- **Key operational drivers** – with significant level of budgets allocated to services in the 2022/23 and 2023/24 financial plans, plus further funding in the 2025/26 planning cycle for evidenced step up in costs from 2024/25, **no further funding is proposed**, with budget holders expected to mitigate increases with underspends from other segments of their budget;
- **Savings targets** will be, **as a minimum, set at the nationally defined ring-fenced** budgeted requirements.

Key Focus Areas for Budget Setting

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- **Pay cleansing** – to update cost centre and band discrepancies within existing budgets, ensuring cleansing of under and over established areas to allow for more accurate mix budget changes to be made through the annual spine point rightsizing exercise;
- **Workforce mix across substantive and temporary** – a revised approach is required to better align workforce planning assessments with budgets, to ensure a comparison at budget level to actuals can be undertaken for the quantity of workforce required within Variable Pay and Premium Agency generated by Substantive Pay vacancies. This will allow actuals and budgets to be aligned to allow improved in-year comparison, insight and control;
- **Premium pay reserve funding** – following the Workforce mix review above, it is proposed to recurrently recognise the centrally held premium pay reserve within services to allow for proactive affordable resource planning actions to be made;
- **Underlying assessment of positions** – to obtain clarity on the existing realistic run rates, an informed review of underlying positions are required. Ensuring over-estimating of budget requirement is avoided, gross positions will be reviewed together with future funding modelling assessments;
- **Mid-year budget changes** – further review principles to reduce mid-year budget changes ensuring a plan that is set at the start of the year to the baseline for comparisons, excluding new funding allocations from WG;
- **Profiling of budgets** – ensuring budgets are appropriately phased to align with spend profile and seasonality.

Contents

1 Background and context

2 Principle components and approach

3 Key principles and assumptions

4 **Draft financial plan assessment**

5 Financial components

6 Key milestone deadlines

Underlying Deficit Assessment

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

As part of the underlying deficit assessment any modelling assumption deviations from the prior planning cycle are included, together with the recurrent impact of savings plans and non-recurrent underspends

Current Financial Performance (as at Month 8)	£'m
2025-26 Planned Deficit	**30.0**
Savings gap / (improvement)	(2.1)
Under / (Over) delivery of savings schemes	0.3
Core operational variation	(3.7)
Gross Forecast	**24.5**
Future Mitigating Actions	(2.4)
2025/26 forecast end of year deficit	**22.1**

2025/26 Underlying Deficit Impact	£'m
2025/26 forecast end of year deficit	**22.1**
Add non-recurring savings	27.8
Add non-recurring Accountancy gain	6.1
Add net non-recurring unplanned pressures / gains	2.5
2025/26 Planned Underlying deficit	**58.5**
2025/26 carried forward recurrent savings gap	0.8
Underlying deficit as at 31 March 2026	**59.3**

Financial Plan Assessment

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The underlying assessment is identified at the start of the new financial year. Together with an assessment of the macro costs / demographics, allocation funding and savings, the 2026/27 financial plan is summarised as follows

Slide Ref	2026/27 Financial Plan Assessment (£'m)		Recurrent	Non-Recurrent	Total
	Underlying deficit carried forward		59.3		**59.3**
1	Macro-economic inflation price modelling		12.7		**12.7**
2	Contractual or unavoidable		1.6		**1.6**
3	Prevalence, Quality and Outcomes	Volume and mix growth modelling	2.2		**2.2**
4		National investment commitments	1.1	0.8	**1.9**
5		Local investment choices – approved	1.0		**1.0**
6		Local investment choices – not yet approved	4.8		**4.8**
7		Assessment cap of £14.4m – options, choices and risks	4.5		**4.5**
8	Budget allocation letter funding / anticipated WG funding		-	(1.5)	**(1.5)**
9	Non-recurrent savings / underspends (challenge to convert to recurrent)			(27.8)	**(27.8)**
	Additional savings requirement		(20.2)		**(20.2)**
Financial Deficit			**67.0**	**(28.5)**	**38.5**

Contents

1 Background and context

2 Principle components and approach

3 Key principles and assumptions

4 Draft financial plan assessment

5 **Financial components**

6 Key milestone deadlines

Macro-Economic Inflationary Price Modelling

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Secondary Care Drugs	1.1	-	**1.1**	Community and Integrated Medicine increase in price per issue of £1.97
Primary Care Prescribing	1.4	-	**1.4**	CAT-M 4p price increase and Baseline 34p price increase
Continuing Health Care (CHC)	3.3	-	**3.3**	Based on 5.5% increase in price. Includes Real Living Wage impact that will be non-recurrently funded
General Non-Pay Inflation (CPI)	3.7	-	**3.7**	Based on 4.1% CPI Inflation in October 2025
Energy and Fuel	0.2	-	**0.2**	Price and Electricity increase above CPI as per NWSSP correspondence
Specific Consumables Price	-	-	**-**	No specific deviation from general inflation recognised above in CPI
Specific Contract Price	0.9	-	**0.9**	Mainly Digital and Waste Contract increases above CPI inflation
Medical and Dental and Agenda for Change Pay Award uplift for vacancies	0.1	-	**0.1**	WG only fund staff in post, not vacancies, so this element is an impact to the financial plan following the 2025/26 pay award.
National Insurance funding shortfall	2.0	-	**2.0**	Shortfall in National Insurance uplift funding in 2025/26
Total	**12.7**	**0.0**	**12.7**	

Contractual or Unavoidable

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
JCC Price	-	-	-	0.0% inflation increase aligned to 0.0% WG inflation funding expectation
JCC Investments	-	-	-	As above
LTA NHS Wales Investments	-	-	-	As above
LTA NHS Wales Price	-	-	-	As above
SLA Non-NHS Wales Price	-	-	-	As above
SLA NHS Wales Price	-	-	-	As above
SLA NHS Wales Investments	-	-	-	As above
NICE High-Cost Horizon Drugs	1.6	-	**1.6**	Haematology, cancer and acute adoption of drugs
Total	**1.6**	**0.0**	**1.6**	

Volume and Mix Growth Modelling

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Secondary Care Drugs	1.4	-	**1.4**	Mainly Cancer and Scheduled Care service area, with growth in issues of 5.33%, equating to an additional 3,422 issues
Primary Care Prescribing	-	-	**-**	No volume growth expected above 25-26 growth levels
Continuing Health Care (CHC)	0.8	-	**0.8**	MHLD CHC number of days commissioned care increased by 5,566 from 24/25 due to increased number of patients
Energy and Fuel	-	-	**-**	No growth in volume consumption anticipated
Medical and Dental and Agenda for Change spine point changes	TBC	-	**TBC**	WG do not fund spine point changes / incremental drift as part of pay award – modelled based on Payroll demographic at M09
Total	**2.2**	**0.0**	**2.2**	

National Pre-Committed and Future Investments Approved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Return on Investment	Additional Comments
Welsh Risk Pool	TBC	-	**TBC**		Await formal notification from NWSSP
Pathology Laboratory Information Management System (LIMS)	-	0.8	**0.8**		Based on latest LIMS development plan schedule from DHCW dated May 2025
Radiology Informatics System Procurement (RISP)	0.1	-	**0.1**		Based on latest schedule from DHCW
National Resident Doctors pay reform	-	TBC	**TBC**		New pay structure to be implemented
NHS Wales hearing care: future approach for audiology services	1.0	-	**1.0**		£1.0m per HB for 3 years
Climate Adaptation plan	-	TBC	**TBC**		Query if this is fully capital funded or revenue consequences
Total	**1.1**	**0.8**	**1.9**		

Local Pre-Committed and Future Investments Approved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Return on Investment	Additional Comments
LinAc 5, plus SWWCC satellite in HD	1.0	-	**1.0**		Assumes 50/50 of 5th Linac business case with Swansea Bay, business case approved in principle, 6th and 7th LinAc plans in progress.
Total	**1.0**	**-**	**1.0**		

Local Pre-Committed and Future Investments Unapproved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Return on Investment	Additional Comments
Nursing Regulations Listening to People	TBC	0.00	**TBC**		Replacing Putting Things Right
Revenue impact of Capital Projects	TBC	0.00	**TBC**		Assessment in progress
Clinical Services Plan	TBC	0.00	**TBC**		Lowest cost options of CSP post consultation are c£8m exc relocation costs. Phasing to be confirmed
Paediatric Diabetes Funding	0.00	0.03	**0.03**		Awarded in FY25-26 over two years
Withybush Medicine Medical staffing	0.96	0.00	**0.96**		Agreed September 2025
National Bereavement Framework	0.54	0.00	**0.54**		Framework model to be implemented in line with other Health Boards
Carmarthen Hwb Utilities	0.40	0.00	**0.40**		£417k additional in FY27-28 to support new site
Pentre Awel running costs	0.04	0.00	**0.04**		£279k additional in FY27-28 to support new site
Picton Terrace running costs	0.07	0.00	**0.07**		Additional full-year effect funding over and above £253k previously funded in FY25-26
Carmarthen Hwb / Picton Terrace Parking Costs	0.15	0.00	**0.15**		Expected additional parking costs with the relocation
Care Cube CHC Database	0.03	0.00	**0.03**		Procurement of new system in MH&LD to support CHC, £24k additional in FY27-28
Additional Breast Consultants Appointment	0.18	0.00	**0.18**		Recruitment of two consultants to one vacancy post
Swansea Bay CT Scanner Simulator	0.10	0.00	**0.10**		Investment for CT Scanner Simulator for 3D imaging
Sub Total	**2.47**		**2.50**		

Local Pre-Committed and Future Investments Unapproved

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Return on Investment	Additional Comments
VBHC – Fracture Liaison Service	TBC	TBC	**TBC**		Assessment required for potential part year funding requirement
VBHC – Vascular Podiatry	TBC	TBC	**TBC**		Assessment required for potential part year funding requirement
VBHC – Chronic Pain Management	0.50	0.00	**0.50**		Estimated cost pre full business case, SBAR presented to V&S October 2025
Public Health – Health Coaches	0.60	0.00	**0.60**		Full Business case review and decision required
C&YP Weight Management	0.10	0.00	**0.10**		£126k additional in FY27-28
BGH & GGH Fire Wardens	0.40	0.00	**0.40**		Investment approval panel June 2025
Community Health Pathways	0.20	0.00	**0.20**		Funding required 26/27 £186k to enable national funding contribution and further evaluation
GGH Theatres	TBC	TBC	**TBC**		Active review and assessment underway, investment case to follow. Initial focus GGH
VBHC – Inflammatory Bowel Disease (IBD) pathway	0.10	0.00	**0.10**	(0.20)	V&S paper submitted in Sept, investment to enable drug saving release of £243k
Medical Rate Card	0.40	0.00	**0.40**		V&S paper November, minimum £0.4m included, range could be up to £2.3m, pending outcome of LMC/BMA discussions
Regional Cellular Pathology	TBC	TBC	**TBC**		Expected revenue impact of the Regional Pathology implementation with Swansea Bay
Grand Total	**4.77**	**0.03**		**(0.20)**	

Prevalence

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

This is full cost estimates based on 2023/24 Programme Budgeting Costs//Patient Level costs, source of activity increase Aberystwyth University review of prevalence.

Investment Description (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Atrial fibrillation & related events	0.5	-	**0.5**	3% per annum (£1.60m 3 years)
Breast Cancers	0.4	-	**0.4**	3.33% per annum (£1.2m over 3 years)
Colorectal Cancers	0.6	-	**0.6**	5% per annum, Lower Gastrointestinal cancers
Lung Cancer	0.3	-	**0.3**	11% increase over 3 years
MI and Cardiovascular	0.0	-	**0.0**	Not seeing growth or decline
Dementia	1.0	-	**1.0**	3% per annum, 9% increase over 3 years
Diabetes Type 2	0.3	-	**0.3**	1% per annum, Community management until severe cases such as amputations
Heart failure and chronic heart disease	0.2	-	**0.2**	1% per annum (Heart Failure PBC costs primary & secondary care)
Mental Health demand	0.6	-	**0.6**	This is an estimate of 1% per annum
Elective Care Pathways MSK	2.0	-	**2.0**	We are seeing older age groups + c 10% over 3 years
Trauma and injuries	4.0	-	**4.0**	We are seeing older age groups + c 10% over 3 years
Ophthalmology	1.0	-	**1.0**	We are seeing older age groups + c 10% over 3 years
CHC	1.0	-	**1.0**	We are seeing c 1.5% complexity inflation increase – cost of delivery (living wage)
Urgent Care – ED	0.5	-	**0.5**	Assuming 1% growth in demand per annum as per last 10 years – cost of delivery
Primary Care	0.0	-	**0.0**	Contract increase for GPs would be initiated by Welsh Government, funded assumed
Total	**12.4**	-	**12.4**	

Review of prevalence data framed below informed by Aberystwyth University research. Challenge t identifr reducing prevalence of disease. Evidence of reducing birth rate impacting the population demographic and fewer children, however this is alongside the impact of the cost of caring for childr re expensive, largely driven by new technology and in particular genomic medicine.

Prevalence – Further Considerations

- Welsh Government populations projections (Source: Stats Wales national population projections - based upon 2022), shows that overall for Wales between 2025 and 2029 key population changes are forecast to be:
- The population aged 65+ will increase from an estimate of 706,000 in 2025 to 764,000 in 2029, an increase of 8.2% or 2.05% per annum
- The population aged 15 years of age or under will decrease from 536,000 in 2025 to 510,000 in 2029, a decrease of 4.8% or 1.2% per annum
- The female population will increase from 1,636,000 in 2025 to 1,668,000 in 2029, an increase of 2% or 0.5% per annum (23,700 of this increase is those aged 65+ years of age)
- The male population will increase from 1,579,000 in 2025 to 1,611,000 in 2029, an increase of 2% or 0.5% per annum (27,100 of this increase is those aged 65+ years of age).
- Given the rural nature of the Hywel Dda geography, the above over-arching change of an increasingly ageing population may be more pronounced in Hywel Dda UHB than the overall Wales figures above (requirement to check against previous prevalence population work).
- On the basis of the above the assumed 3% YoY growth in dementias per annum may be high as those aged > 65yrs across Wales is +2% per annum (requirement to check the Aberystwyth demographic data), the previous work stated + 10% older age groups in 3 years, this needs to be checked, also affects elective MSK, trauma and Ophthalmology
- The stated ED growth of 1% per annum over last 10 years (and assumed going forward) is being checked with the service.

Funding Allocations: New

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Allocation assessment from Welsh Government, awaiting formal allocation letter:

Core and Ringfenced allocation – New allocations (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Core Cost and Demand Uplift 2025/26	0.0	-	**0.0**	0.0% inflation funding expected
Mental Health Services Core Cost and Demand	0.0	-	**0.0**	0.0% inflation funding expected
Other	0.0	-	**0.0**	
Real Living Wage	-	1.5	**1.5**	£12.21/hr to £12.71/hr
Total	**0.0**	**1.5**	**1.5**	

Key Information

- Assumed that WG will fund pay awards in full (excluding vacancies), and therefore no cost pressure in 2026-27
- Assumed WG will continue to fund Ministerial Priorities
- Assumed WG **will not** provide anything to cover macro-economic inflationary and growth rises

Assumed Funding Allocations (1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Allocations received annually from Welsh Government on a non-recurrent basis, assumed to continue into 26-27:

Assumed Funding Allocations (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Conditionally Recurrent funding 23-24	43.0	-	**43.0**	
Conditionally Recurrent funding 24-25	26.0	-	**26.0**	
25/26 Pay Award	22.7	-	**22.7**	
25/26 National Insurance	10.3	-	**10.3**	
25/26 Band 2-3 Pay Award	2.9	-	**2.9**	
Medical Training Post	-	1.4	**1.4**	
Prevention and Early Years	-	0.7	**0.7**	
Bro Myrddin	-	0.6	**0.6**	
Dementia Action Plan	-	1.7	**1.7**	
Digital Priority Investment Fund	-	1.3	**1.3**	
Neurodivergence	-	1.0	**1.0**	

Assumed Funding Allocations (2 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Allocations received annually from Welsh Government on a non-recurrent basis, assumed to continue into 26-27:

Assumed Funding Allocations (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Mental Health 111/Press 2 Service	-	0.3	**0.3**	
Substance Misuse	-	2.5	**2.5**	
JCC - Tier 4 CAMHS Strategy	-	0.2	**0.2**	
VBHC Atrial Fibrillation	-	0.2	**0.2**	
3Ps Policy - Single Point of Contact	-	0.3	**0.3**	
Transforming Urgent & Emergency Care	-	2.7	**2.7**	
RSV & Shingles Vaccinations	-	1.2	**1.2**	
Welsh Risk Pool	-	(3.6)	**(3.6)**	
Invest to Save Facilities schemes	-	(0.1)	**(0.1)**	
Total	**104.9**	**11.9**	**116.8**	

Financial Plan 2026/27 Savings Scenario

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- Savings aspirations are set based on the carried forward recurrent residual delivery from 2025/26, plus an additional 2.0% of non-ring fenced budgets.
- **Note:** carried forward values are based on Month 8 (November) and, together with when final budgets are confirmed, the final saving values will be updated.

Executive Director | Clinical Care Group (£'m)		Carried Forward Under / (Over) Delivery	Additional 2.0% Non-Ring Fenced	Total Savings Target for 2026/27
Chief Executive Officer		-	0.1	0.1
Chief Operating Officer	Chief Operating Officer Management	0.8	0.3	1.1
	Community and Integrated Medicine	7.5	4.9	12.4
	Mental Health and Learning Disabilities	4.5	2.0	6.5
	Operational Allied Health	3.3	1.6	4.9
	Planned and Specialist Care	4.2	4.2	8.4
	Primary Care and Community Strategy	4.0	2.1	6.1
Executive Allied Health and Estates & Facilities		1.7	1.0	1.7
Finance and Digital		(0.1)	0.4	0.3
Nursing, Quality & Patient Experience		-	0.2	0.2
Public Health		-	0.1	0.1
Strategy & Planning and LTAs		1.4	1.2	2.6
Workforce & Organisation Development		-	0.3	0.3
Medical Director		-	0.1	0.1
Central Income – Health Board Wide		0.8	0.7	1.5
Total		**28.2**	**19.3**	**47.5**

Non-recurrent benefit to be considered for budget setting

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Non-recurrent support to the position cause an underlying impact, which could be negated within budget setting

Clinical Care Group as at Month 8 2025/26 (£'m)	EOY Forecast Underspend	Monthly Underspend Savings	Non-Recurrent Saving	Total Non-Recurrent Benefit	75%	66%	50%
Chief Operating Officer Management	0.5	0.7	0.0	**1.2**	0.9	0.8	0.6
Community and Integrated Medicine	0.0	0.9	2.8	**3.7**	2.8	2.4	1.9
Mental Health and Learning Disabilities	0.0	0.8	3.1	**3.9**	2.9	2.6	2.0
Operational Allied Health and Health Sciences	0.0	0.0	0.0	**0.0**	0.0	0.0	0.0
Planned and Specialist Care	0.0	1.0	3.4	**4.4**	3.3	2.9	2.2
Primary Care, Community Strategy and Long Term Care	3.0	2.4	0.0	**5.4**	4.1	3.6	2.7
Executive Functions (see breakdown detail in next slide)	2.5	5.6	7.1	**15.2**	11.6	10.0	7.8
Total	**6.0**	**11.4**	**16.4**	**33.8**	**25.6**	**22.3**	**17.2**

Totals £27.8m, which is the 2025/26 non-recurrent savings delivery after excluding the £6.1m accountancy gain

Non-recurrent benefit to be considered for budget setting

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Non-recurrent support to the position cause an underlying impact, which could be negated within budget setting

Executive Functions as at Month 8 2025/26 (£'m)	EOY Forecast Underspend	Monthly Underspend Savings	Non-Recurrent Saving	Total Non-Recurrent Benefit	75%	66%	50%
Chief Executive	0.1	0.1	0.2	**0.4**	0.3	0.3	0.2
Digital	0.2	0.6	0.1	**0.9**	0.7	0.6	0.5
Finance	0.1	0.4	0.0	**0.5**	0.4	0.3	0.3
Health Board Wide	0.2	2.0	2.0	**4.2**	3.2	2.8	2.1
LTA's with Other NHS Providers	0.0	0.0	0.5	**0.5**	0.4	0.3	0.3
Medical	0.2	0.0	0.0	**0.2**	0.2	0.1	0.1
Nursing	0.0	0.2	0.2	**0.4**	0.3	0.3	0.2
Public Health	1.5	0.3	0.6	**2.4**	1.8	1.6	1.2
Strategy and Planning	0.2	0.2	0.5	**0.9**	0.7	0.6	0.5
Workforce	0.0	1.8	1.0	**2.8**	2.1	1.8	1.4
Health Board Wide – Amber scheme	0.0	0.0	2.0	**2.0**	1.5	1.3	1.0
Total	**2.5**	**5.6**	**7.1**	**15.2**	**11.6**	**10.0**	**7.8**

Contents

1 Background and context

2 Principle components and approach

3 Key principles and assumptions

4 Draft financial plan assessment

5 Financial components

6 **Key milestone deadlines**

Key Milestone Deadlines

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Item	Deadline	Delivery Owner
Executive Team sign-off of financial approach and assumptions	15/10/2025	Formal Executive Team
FPC sign-off of financial approach and assumptions	28/10/2025	Huw Thomas and Andrew Spratt
Macro-economic, growth modelling and cost driver assessment first draft	14/11/2025	Finance Team and Budget Holders
Assessment of savings plans following 14 November Planning workshop	18/11/2025	Budget Holder, supported by Finance
Welsh Government (WG) core funding uplift confirmed	Dec 2025	Welsh Government
First Draft – Executive Team review of Financial Plan before FPC	10/12/2025	Facilitated by Huw Thomas
First Draft – FPC review of Financial Plan	16/12/2025	Huw Thomas and Executive Leads
Finance Senior Team and DOF review of macro economic cost review / Opportunities/Savings framework	19/01/2025	Huw Thomas and Senior Finance team, BC reps
EITS/Escalation meetings, focusing on Plans and Savings	Jan/Feb 2026	Lead Exec, Service Lead, Finance, Exec Reps.
Second Draft – Executive Team review of Financial Plan before FPC	18/02/2026	Huw Thomas and Executive Leads
Second Draft – Finance Plan presented to FPC for assurance review, including savings progress from service areas. Once FPC have approved, budgets will be entered onto the ledger by the Finance team	24/02/2026	Huw Thomas and Executive Leads
Accountability Letters issued to delegated Executive Directors	12/03/2026	Phil Kloer and Finance Team
Third/Final Draft – Executive Team review of Financial Plan before Board	18/03/2026	Huw Thomas and Executive Leads
Third/Final Draft – Annual Plan presented to Board for approval	26/03/2026	Lee Davies and Executive Team
Annual Plan and supporting templates submitted to WG	31/03/2026	Lee Davies

Savings Development and Timelines

Delivering better value requires the reduction of low value activity and needs to ensure there is an assurance process which achieves this. The following expectations are designed to ensure clarity, fairness and momentum, ensuring patients' needs are at the forefront of services:

- Identify all potential savings ideas by Christmas as "blue" opportunities, with a focus upon service redesign. These do not need to be complete plans, just surfaced opportunities captured in the existing PID template.
- Convert at least 50 percent of these ideas into amber/green by late January.
- Convert 75 percent by February and 100 percent by the final plan submission in March. This gives us a realistic, stepped trajectory rather than a March scramble.
- Use the three pillars and nine domains to support thinking. This may make any QIA process far easier.
- Be honest about recurrent verses non-recurrent status and timelines for delivery, support and enablers required to ensure achievement. Where savings are non-recurrent, explain why and by when they could become recurrent.
- Apply scrutiny locally. As the role of FCSG is reviewed centrally, CCG-level discipline remains vital. Scrutiny should happen closest to delivery.
- Demonstrate the behavioural impact. Consider whether proposals risk unintended consequences.
- Do not be bounded by structural silos, e.g. if an action in one CCG will have a consequence in another, or an opportunity requires action elsewhere discuss how to collaborate on the required actions to ensure the best outcomes for the population.

4.4

12:20 PM, 10 Mins

4.4 - PROCUREMENT SCRUTINY

Gemma Deverill (NWSSP - Procurement)

For assurance

Attachments

Procurement Scrutiny FPC 16 December 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Procurement Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Gemma Deverill, Deputy Head of Procurement

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to inform the Finance and Performance Committee (FPC) that:

1. Outcome of the procurement exercises which have been undertaken on behalf of Hywel Dda University Health Board (HDdUHB). In line with Welsh Government (WG) approval procedures, the Health Board is required to approve the following new contracts, as they have each have a cumulative contract value in excess of £1m over the term of the contract for HDdUHB.

Cefndir / Background

1. Citrix Hardware Replacement

Proposed Outcome

Duration of Contract	Proposed Supplier (s)	Current Annual Local Contract Value	Proposed Annual Value of New Contract	Proposed Total Value of New Contract
TBC - This will be confirmed post FPC and will be included within the Board paper.	TBC - This will be confirmed post SRC and will be included within the Board paper.	N/A	TBC - This will be confirmed post FPC and will be included within the Board paper.	TBC - This will be confirmed post FPC and will be included within the Board paper.

2. Insourcing of Theatre Scrub Team

Duration of Contract	Proposed Supplier (s)	Current Annual Local Contract Value	Proposed Annual Value of New Contract	Proposed Total Value of New Contract
TBC - This will be confirmed post FPC and will be included within the Board paper.	TBC - This will be confirmed post SRC and will be included within the Board paper.	N/A	TBC - This will be confirmed post FPC and will be included within the Board paper.	TBC - This will be confirmed post FPC and will be included within the Board paper.

3. Car Park Management

Proposed Outcome

Duration of Contract	Proposed Supplier (s)	Current Annual Local Contract Value	Proposed Annual Value of New Contract	Proposed Total Value of New Contract
1 April 2026 to 31 March 2029 with an option to extend to 31 March 2031	TBC - This will be confirmed post SRC and will be included within the Board paper.	£225,000 ex VAT	TBC - This will be confirmed post FPC and will be included within the Board paper.	TBC - This will be confirmed post FPC and will be included within the Board paper.

Asesiad / Assessment

1. Citrix Hardware Replacement

HDdUHBs Digital Directorate have received funding from WG to replace their Citrix Hardware environment and associated licencing. The existing Citrix hardware has reached end-of-life and is no longer supported by vendors for component replacements or security updates which means in the event of a system failure there is no assurance that recovery could be achieved promptly. Citrix is an IT system designed to deliver applications to user devices, it is primarily used to provide access to the Welsh Patient Administration System (WPAS), as per the Digital Health and Care Wales (DHCW) system design.

A mini-competition is in process utilising the National Procurement Service (NPS) IT Products and Services (ii) Framework and Lot 5 IT Solutions.

The contract term and value will be confirmed post-FPC and will be included within the report to Board on 29 January 2026.

2. Insourcing of Theatre Scrub Team

HDdUHB's Planned and Specialist Care Clinical Care Group (CCG) has identified service-impacting constraints within Theatres that requires an insourcing solution to support with a number of Specialities, including but not limited to Ear, Nose and Throat (ENT), and Ophthalmology. The insourced solution requires a Theatre Scrub Team, currently, Healthcare Business Solutions are in contract however are unable to meet staffing levels and therefore an urgent mini-competition is required.

A mini-competition is in process utilising the NHS Shared Business Services framework for Insourcing of Clinical Services (SBS10203).

The contract term and value will be confirmed post-FPC and will be included within the report to Board on 29 January 2026. Please note this is a zero-commitment contract.

3. Car Park Management

A mini-competition is currently underway via the NHS Shared Business Services framework for Sustainable Transport and Infrastructure - Lot 8: Car Park Management. The contract will initially cover the car parks at Glangwili Hospital (GGH) and Prince Philip Hospital (PPH), however, it also includes provision for extending the service to other Health Board sites, Withybush Hospital (WGH) and Bronglais Hospital (BGH), should funding become available during the contract term.

The tender has now closed, and only one bid - the incumbent provider - has been received. Evaluation is scheduled to take place during December 2025 to enable approval at the January 2026 Board meeting.

The contract term will run from the 1 April 2026 to the 31 March 2029 with the option to extend to the 31 March 2031 in twelve month increments.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to scrutinise and recommend for 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.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.9 Conduct detailed scrutiny of all aspects of financial performance, the financial implications of significant revenue expenditure (all those over £1million requiring Board approval), business cases (except those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board. 3.1.10 Scrutinise major procurements plans and tenders, and provide assurance to the Board as part of its approval process.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable

Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

5

12:30 PM, 0 Mins

5 - PERFORMANCE

5.1

12:30 PM, 5 Mins

5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT

Anthony Tracey (Hywel Dda UHB - Digital Director)

For assurance

Attachments

IPAR FPC 16 December 2025.pdf

M8 December 2025 IPAR Overview.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Performance Update for Hywel Dda University Health Board – Month 8 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance In association with all Executive Leads
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report relates to the Month 8, 2025/26 Integrated Performance Assurance Report (IPAR) which summarises progress against a range of national and local performance measures. The IPAR consists of this SBAR and the following supporting documents:

- IPAR overview – includes data, issues and actions for the Health Board's key performance improvement measures.
- IPAR dashboard – provides statistical process control (SPC) charts for each of our performance measures. The dashboard can be accessed via the Health Board internet site. For help navigating the IPAR dashboard, email the Performance Team: GenericAccount.PerformanceManagement@wales.nhs.uk.

We have adopted the '3As assessment' approach to highlight either an alert, advise or assure status for each of our key performance metrics:

- **Alert (may require discussion):** There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
- **Advise (to monitor):** There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
- **Assure (to note):** There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Please note:

- The Audiology national data submission for Hywel Dda is delayed until a robust data cleansing exercise is complete. Timescales for data submission will be provided in future documents.

- Finance deficit position – due to a revised allocation from Welsh Government that has improved the deficit position, the revised ledger data is not available at time of preparing this report. Therefore, the narrative slide in the IPAR Overview has been removed for this iteration.

Cefndir / Background

Welsh Government published the 2025/26 NHS Wales Performance Framework in January 2025. The framework outlines the Ministerial priorities for this financial year, along with key targets.

Asesiad / Assessment

Performance overview

The table below summarises the latest position for the 2025/26 ministerial priorities and our local key performance metrics. Additional data, details of key issues and actions being taken to address can be found in the supporting document *IPAR overview*.

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% R1 eyecare appts attended in target or 25% delay	95%	Oct 2025	56.1%	Concerning	Missing target	n/a	Alert
% R1 eyecare patients waiting within 25% delay to target date	95%	Oct 2025	37.5%	Concerning	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Nov 2025	1,219	Concerning	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Nov 2025	71.3%	Improving	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Nov 2025	2,693	Concerning	Missing target	n/a	Alert
% child neurodevelopment assess waits <26 weeks	80%	Oct 2025	21.5%	Improving	Missing target	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Oct 2025	57.2%	Concerning	Missing target	n/a	Alert
Median time ambulance emergency category calls	8	Oct 2025	10	n/a	n/a	n/a	Alert
E. coli: Number of confirmed cases (in-month)	21	Nov 2025	35	Usual	Hit and miss	n/a	Alert
S. aureus: Number of confirmed cases (in-month)	6	Nov 2025	8	Usual	Hit and miss	n/a	Alert
% uptake of flu vacc - 65+ years	75%	Oct 2025	44.7%	n/a	n/a	n/a	Alert
% Autumn 2024 COVID booster uptake for eligible residents	75%	Oct 2025	35.9%	n/a	n/a	n/a	Alert
% Spring COVID booster uptake for eligible residents	75%	Jun 2025	39.0%	n/a	n/a	n/a	Alert
Financial in month deficit	n/a	Nov 2025	-£4,370,000	Improving	n/a	Trajectory met	Alert
Number of Pathways of Care delayed discharges	n/a	Nov 2025	207	Usual	n/a	Within 5% of Trajectory	Advise
Ambulance handover > 45 minutes Hywel Dda	0	Nov 2025	710	Improving	Missing target	n/a	Advise
Ambulance handovers > 1 hour Hywel Dda	0	Nov 2025	606	Usual	Missing target	Trajectory met	Advise
Ambulance handover > 4 hours Hywel Dda	0	Nov 2025	187	Usual	Missing target	Trajectory met	Advise
% pts on single cancer pathway within 62 days	75%	Oct 2025	66%	Improving	Missing target	Trajectory met	Advise
C. difficile: Number of confirmed cases (in-month)	8	Nov 2025	13	Usual	Hit and miss	n/a	Advise
Pts waiting 8 wks+ for specified diagnostic	0	Nov 2025	1,656	Improving	Missing target	n/a	Advise
Patients waiting 104 weeks+ RTT	0	Nov 2025	70	Improving	Missing target	n/a	Advise
Patients waiting over 52 weeks RTT	0	Nov 2025	11,370	Improving	Missing target	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	n/a	Nov 2025	44.1%	Improving	n/a	n/a	Advise
Follow-up appts - delayed >100%	0	Nov 2025	15,842	Improving	Missing target	n/a	Advise
% sickness absence rate of staff	6.60%	Nov 2025	6.60%	Concerning	Hitting target	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Sep 2025	89.6%	Usual	Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Sep 2025	77.1%	n/a	n/a	n/a	Advise
% of practices achieving National Access Standards	100%	Mar 2025	95.7%	n/a	n/a	n/a	Advise
Waits over 52 weeks: new outpatient appointment	0	Nov 2025	1	Improving	Missing target	n/a	Assure
Median time ambulance arrest category calls	8	Oct 2025	7	n/a	n/a	n/a	Assure
% MH assess within 28 days (age 0-17)	80%	Oct 2025	89.7%	Improving	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Oct 2025	97.8%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 0-17)	80%	Oct 2025	81.8%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Oct 2025	100.0%	Improving	Hitting target	n/a	Assure
Consultations delivered through PIPS	n/a	Sep 2025	2,086	Improving	n/a	Trajectory missed by over 5%	Assure

Triangulating our data: 1st April 2022 to 30th November 2025.

- Quality safety and risk – the number of incidents causing moderate harm or above reported by month, continues to decreased since July 2025 (183), with November reporting 134. The number of patient falls has increased for the last three months (Nov '25 = 242). Medication errors have decreased for the fifth consecutive month (Nov '25 = 88), since June '25 (147). We continue to have significant numbers of high and extreme risks on the risk register with 538 in November 2025, highest recorded. There has been a significant decrease in the number of new complaints received since September 2025 (254) with 69 in November. The number of new infections decreased with October reporting 63 cases. 33 of these cases were E. coli and 13 were C. difficile.
- Workforce – In month, staff sickness increased since June 2025 to 7% in November 2025. Short-term sickness decreased to 2.2% for November 2025. Long-term sickness increasing trend has continued with November increasing to 4.9%. Note: The sickness metric reported in the alert section of this SBAR includes 12 month rolling data. Nursing and midwifery agency usage continues to decrease since March 2024. In October it was 68.22 whole time equivalent (WTE). Rolling 12-month staff turnover percentage decreased from November 2024 (8.4%) with November 2025 at 6.9%

Quality, safety and risk	Best	Worst	Latest	Trend
Reported incidents causing moderate harm or above	128	305	134	
Patient falls	189	301	242	
Medication errors	61	147	88	
Pressure damage developing or worsening during care	55	215	64	
New complaints by month received (ward level not available)	69	252	69	
Number of high and extreme risks (health board & function only)	379	538	538	
Infections: new cases	53	81	63	
Infections: C. difficile cases	9	23	13	
Workforce				
Number of staff/contractor related incidents	98	186	149	
Sickness - short term	1.7%	2.8%	2.2%	
Sickness - long term	3.3%	4.9%	4.9%	
Number of vacancies	To follow			
Staff turnover (12 month rolling)	6.9%	9.8%	6.9%	
Nursing and midwifery vacancies	To follow			
Nursing and midwifery agency (WTE)	56.38	379.79	68.22	
Bank (WTE)	212.99	352.85	322.26	

Argymhelliad / Recommendation

The Committee is asked to **DISCUSS** the IPAR – Month 8 2025/2026 report and to **SEEK ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.1 The financial performance and delivery against Health Board financial plans and objectives and • give early warning of potential performance issues, • make recommendations for action to continuously improve the financial position of the organisation, • focus on the financial impact of in-year and medium-long term plans, the impact of financial issues on service delivery, quality and patient experience, and any specific issues where financial performance is showing deterioration or there are areas of concern. 2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are outlined throughout the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2025/2026 NHS Performance Framework
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Contained within the body of the report

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Better use of resources through integration of reporting methodology
Ansawdd / Gofal Claf: Quality / Patient Care:	Use of key metrics to triangulate and analyse data to support improvement

Gweithlu: **Workforce:**	Development of staff through pooling of skills and integration of knowledge
Risg: **Risk:**	Better use of resources through integration of reporting methodology
Cyfreithiol: **Legal:**	Better use of resources through integration of reporting methodology
Enw Da: **Reputational:**	Yes
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Integrated Performance Assurance Report (IPAR) Overview

As at 30th November 2025



For further details see the ‘System measures’ section of the latest IPAR dashboard.

Contents

Overview
Key improvement measure summary

Planned care
Outpatients – new and follow-ups
Referral to treatment
Ophthalmology R1 (high-risk patients)

Urgent and emergency care
Ambulances – Hywel Dda
Emergency departments – Hywel Dda
Ambulances – Bronglais Hospital
Emergency departments – Bronglais Hospital
Ambulances – Glangwili Hospital
Emergency departments – Glangwili Hospital
Ambulances – Prince Philip Hospital
Emergency departments – Prince Philip Hospital
Ambulances – Withybush Hospital
Emergency departments – Withybush Hospital
Pathway of Care Delays (PoCD)

Cancer
Single cancer pathway

Mental Health
Mental health assessments within 28 days
Therapeutic interventions following primary mental health assessment
Psychological therapy waits
Neurodevelopmental assessment waits

Diagnostics and therapies
Diagnostic waits over 8 weeks
Therapy waits over 14 weeks

Infections
C. difficile and E.coli cases
S. Aureus

Workforce
Staff sickness

Statistical process control (SPC) charts

Why use SPC charts? Anatomy of a SPC chart I al variation within SPC charts Understanding SPC icons

This document summarises performance against our key improvement measures for 2025/26. This includes measures relating to our enhanced monitoring from Welsh Government, along with the Minister for Health and Social Care's priorities for this financial year. We have also included measures for delayed ways of care, nurses in post and financial balance as these measures have a significant impact on our performance in other areas.

For data on all performance measures we are tracking, see our IPAR dashboard: Integrated Performance Assurance Report (IPAR) dashboard as at 30th November 2025

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% R1 eyecare appts attended in target or 25% delay	95%	Oct 2025	56.1%	Concerning	Missing target	n/a	Alert
% R1 eyecare patients waiting within 25% delay to target date	95%	Oct 2025	37.5%	Concerning	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Nov 2025	1,219	Concerning	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Nov 2025	71.3%	Improving	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Nov 2025	2,693	Concerning	Missing target	n/a	Alert
% child neurodevelopment assess waits <26 weeks	80%	Oct 2025	21.5%	Improving	Missing target	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Oct 2025	57.2%	Concerning	Missing target	n/a	Alert
Median time ambulance emergency category calls	8	Oct 2025	10	n/a	n/a	n/a	Alert
E. coli: Number of confirmed cases (in-month)	21	Nov 2025	35	Usual	Hit and miss	n/a	Alert
S. aureus: Number of confirmed cases (in-month)	6	Nov 2025	8	Usual	Hit and miss	n/a	Alert
% uptake of flu vacc - 65+ years	75%	Oct 2025	44.7%	n/a	n/a	n/a	Alert
% Autumn 2024 COVID booster uptake for eligible residents	75%	Oct 2025	35.9%	n/a	n/a	n/a	Alert
% Spring COVID booster uptake for eligible residents	75%	Jun 2025	39.0%	n/a	n/a	n/a	Alert
Financial in month deficit	n/a	Nov 2025	-£4,370,000	Improving	n/a	Trajectory met	Alert
Number of Pathways of Care delayed discharges	n/a	Nov 2025	207	Usual	n/a	Within 5% of Trajectory	Advise
Ambulance handover > 45 minutes Hywel Dda	0	Nov 2025	710	Improving	Missing target	n/a	Advise
Ambulance handovers > 1 hour Hywel Dda	0	Nov 2025	606	Usual	Missing target	Trajectory met	Advise
Ambulance handover > 4 hours Hywel Dda	0	Nov 2025	187	Usual	Missing target	Trajectory met	Advise
% pts on single cancer pathway within 62 days	75%	Oct 2025	66%	Improving	Missing target	Trajectory met	Advise
C. difficile: Number of confirmed cases (in-month)	8	Nov 2025	13	Usual	Hit and miss	n/a	Advise
Pts waiting 8 wks+ for specified diagnostic	0	Nov 2025	1,656	Improving	Missing target	n/a	Advise
Patients waiting 104 weeks+ RTT	0	Nov 2025	70	Improving	Missing target	n/a	Advise
Patients waiting over 52 weeks RTT	0	Nov 2025	11,370	Improving	Missing target	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	n/a	Nov 2025	44.1%	Improving	n/a	n/a	Advise
Follow-up appts - delayed >100%	0	Nov 2025	15,842	Improving	Missing target	n/a	Advise
% sickness absence rate of staff	6.60%	Nov 2025	6.60%	Concerning	Hitting target	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Sep 2025	89.6%	Usual	Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Sep 2025	77.1%	n/a	n/a	n/a	Advise
% of practices achieving National Access Standards	100%	Mar 2025	95.7%	n/a	n/a	n/a	Advise
Waits over 52 weeks: new outpatient appointment	0	Nov 2025	1	Improving	Missing target	n/a	Assure
Median time ambulance arrest category calls	8	Oct 2025	7	n/a	n/a	n/a	Assure
% MH assess within 28 days (age 0-17)	80%	Oct 2025	89.7%	Improving	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Oct 2025	97.8%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 0-17)	80%	Oct 2025	81.8%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Oct 2025	100.0%	Improving	Hitting target	n/a	Assure
Consultations delivered through PIPS	n/a	Sep 2025	2,086	Improving		Trajectory missed by over 5%	Assure

Alert
(may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

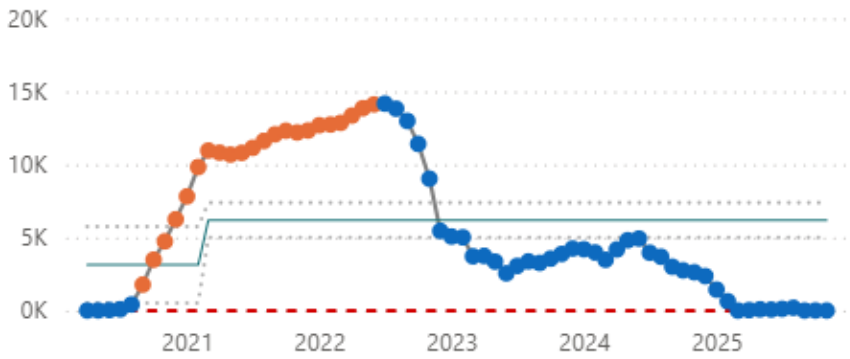
Advise
(to monitor)
There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

Assure
(to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Waits over 52 weeks for a first outpatient and delayed follow up appointments
(Ministerial priority)

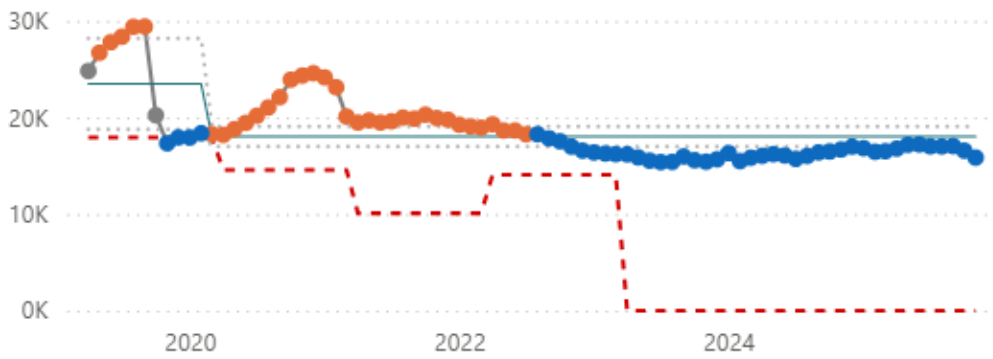
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting >52 weeks for first outpatient appointment



Performance shows improving variation; however, there was 1 breach recorded in November 2025.

Follow up outpatient appointments delayed over 100% past target date



Performance in November 2025 was 15,842. The chart is showing improving variation.

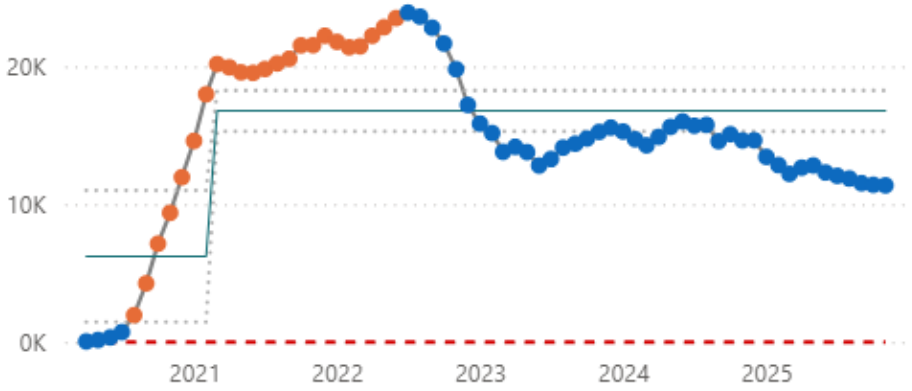
Key challenges / issues	Key actions / initiatives	Due date
• The Health Board achieved zero 52-week waits for a first outpatient appointment across all specialties apart from Rheumatology (1) at the end of November 2025. This was due to consultant availability and has been re-booked.	• Outpatient Transformation Programme in place, with targeted actions for each specialty covering all National Planned Care Programme priorities, including referral management, clinical triage, and maximising the use of self-management pathways like See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).	31/03/26
• 52-week outpatient waits have significantly reduced from the June 2024 peak (4,930).	• Delayed follow-up wait reduction to below 12,000 supported by national clinical leadership and CIN (Clinical Implementation Network) guidelines.	31/03/26
• Most specialties are expected to maintain targets, with recovery funding prioritised for Ear, Nose & Throat (ENT), Neurology, and Rheumatology.	• 2025/26 demand and capacity plans are being used within all Planned Care services and aim for zero patients waiting over 36 weeks in key specialties, optimising capacity and forecasting.	31/03/26
• Active management and triage of referrals has resulted in no waiting list growth, whilst a large reduction in 36-week new outpatient breaches since June 2024 signifies positive indications for further recovery in future.	• The Welsh Government First Outpatient Plan "A" is continuing until March 2026. The local plan to deliver over 13,000 additional appointments contributes to NHS Wales' goal of reducing outpatient waits by 200,000 by March 2026, with a focus on eliminating breaches to 26 weeks in most specialties.	31/03/26
• Initiatives for reducing new outpatient waits have increased follow-up waits as more patients progress through pathways.	• The Welsh Government First Outpatient Plan "B" is being progressed, with support from insourced specialties and outpatient staff. These projects are managed by a well-established transformation team, including a senior project manager and are underpinned by a Senior Governance Review Panel.	31/03/26

Waits over 52 and 104 weeks from referral to treatment

(Enhanced monitoring condition and Ministerial priority)

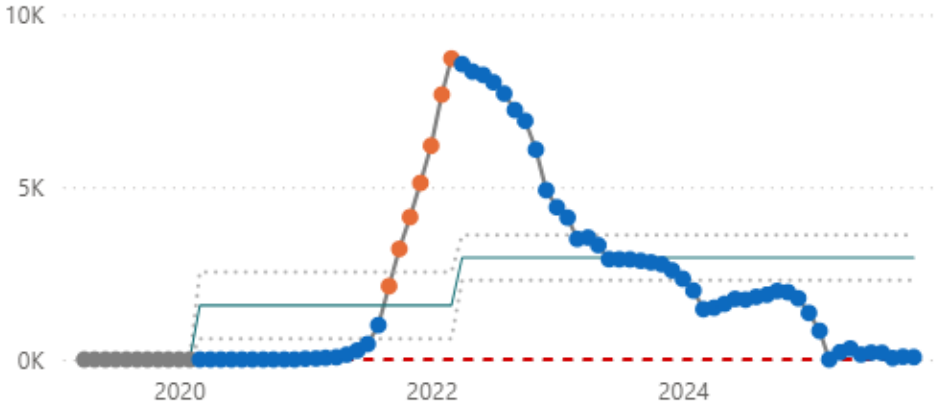
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting over 52 weeks from referral to treatment



Improving variation is showing, with 11,370 breaches recorded in November 2025, a reduction for six consecutive months.

Patients waiting over 104 weeks from referral to treatment



Improving variation is showing, however, the target has not been met since March 2025.

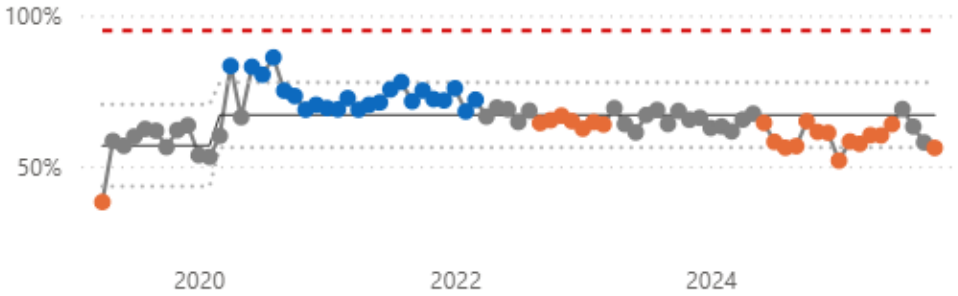
Key challenges / issues	Key actions / initiatives	Due date
• Due to a reduced level of theatre staffing and cancellations, ENT (35) and Ophthalmology (10) recorded breaches over 104 weeks for RTT. The 22 breaches in orthopaedics were due to reduced capacity and sub-specialty demand. The small breaches in the other specialties are due to a variety of reasons including awaiting diagnostics. All patients that breached in November are dated in December, however, 99.9% of our patients are now waiting less than 2 years from referral to treatment. • Patient complexity and co-morbidities affect suitability for outsourced or day-case procedures, impacting treatment timelines. • Getting It Right First Time (GIRFT) ambitions are influenced by clinical confidence and pre-op process variations across specialties. • Additional risks include prioritisation of cancer backlogs, regional vascular capacity issues, and urgent cases consuming rescheduled theatre slots. • Inpatient/day case activity exceeds pre-pandemic levels, but challenges remain with late starts, early finishes, and allow (non-utilised) theatre lists due to workforce constraints.	• Specialties are working into quarter 4 to maintain and improve their 104-week positions. • The directorate continues to focus on maintaining waiting time targets in 2025/26 using demand and capacity forecasts to highlight risks and guide funding allocation. • Theatre Optimisation workstream led by the Clinical Care Group aims to improve productivity and meet GIRFT standards across specialties. This includes a full staffing review and implementing evidence-based guidelines on appropriate staffing and list loading per procedure bundle with a view to eliminating variation between sites. The Theatre steering group will also be looking at theatre utilisation of funded sessions. • 2026/2027 Demand and Capacity plans are being developed alongside the annual planning requirement.	31/12/25 31/03/26 31/03/26 31/03/26

Ophthalmology R1 (high-risk patients) performance

(Enhanced monitoring condition and Ministerial priority)

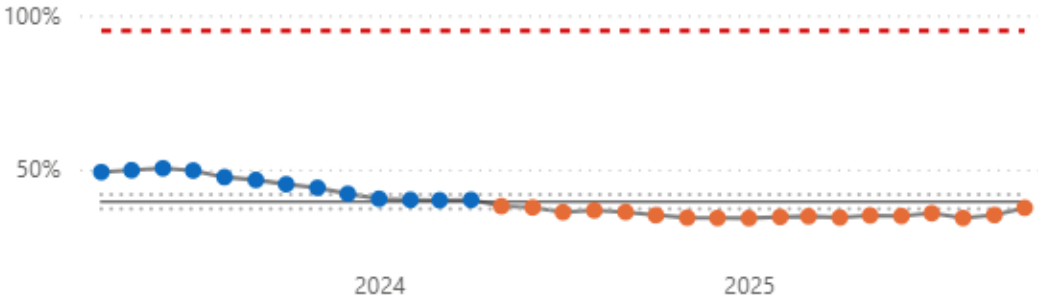
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



Performance is showing concerning variation of 56.13% for October.

% R1 patients waiting within their clinical target date or within 25% beyond their clinical target date



Performance is showing concerning variation of 37.54% for October.

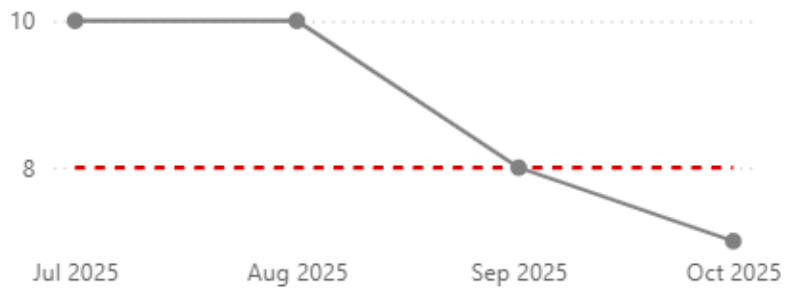
Key challenges / issues	Key actions / initiatives	Due date
• Three vacancies in specialty and specialist (SAS) doctor rota. Two SAS doctors commenced in September and completed induction. One doctor has commenced in post October 2025. Gaps in the rota are currently covered with additional duty hours.	• Recruitment into SAS vacancies	Completed
• Advertisement of regional consultant posts has been agreed to go live end of December 2025. The Service Level Agreement (SLA) needs to be drawn up with Swansea Bay, dates to be confirmed.	• Regional recruitment into two substantive consultant posts to stabilise service. Regional solutions for Age Related Macular Degeneration (AMD), Glaucoma, Cataract and Vitreoretinal subspecialties being explored with subspecialty leads now identified.	31/03/26
• Recruitment to posts identified in Eye Care Measures (R1) Situation, Background, Assessment and Recommendation (SBAR) have now been recruited and training has commenced for those in post with clear competency pathways and timelines.	• Additional staffing onboarding to improve Eye Care Measures (R1) delivery.	Completed
• Some additional activity for R1 delivery was secured through waiting list initiative (WLI) sessions, however due to the insourcing project for outpatients we have been unable to deliver these clinics. This, and the increased capacity required for referral to treatment patients, will affect our R1 appointments attended delivery trajectory.	• Internal solutions for Intravitreal injections (IVT) delivery have been provided to increase injections delivered per week.	31/12/25
• Clinic delivery restricted by staffing levels in outpatient departments, with two clinics recently rejected due to no outpatient staffing, however the Clinical Care Group is working on solutions.	• External solution for IVT delivery has been secured through outsourcing, whilst workforce is recruited to build sustainable service.	Live
• Intravitreal injection clinics in Amman Valley is currently restricted by other services, however the Clinical Care Group is working on solutions.	• SBAR to be developed to identify requirements for outpatient delivery in Ophthalmology in line with annual planning process 2026/2027.	31/12/25
• Reducing sites and increasing delivery on fewer sites will ensure staff can be trained and supervised appropriately and work towards the top of their licence.	• SBAR to be developed to outline the needs of the Ophthalmology service in outpatients in Amman Valley Hospital for solutions to be sought.	Completed
	• Due to implementation delays, the R1 waiting position is now projected to improve to 49% by March 2026, with the 65% target deferred to September 2026, contingent on recruitment and resource allocation. Revised trajectory to be provided in next IPAR report.	30/09/26

Urgent and Emergency Care – Ambulances – Hywel Dda

(Enhanced monitoring condition and Ministerial priority)

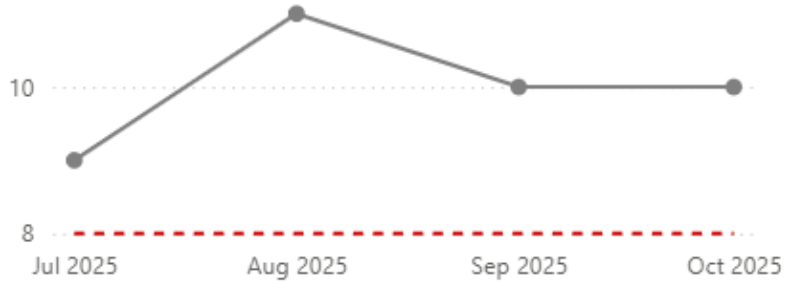
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Median emergency ambulance response time to purple: arrest category calls



In October, there were 131 purple incidents out of a total of 4,359. Median response time was 06:35 minutes.

Median emergency ambulance response time to red: emergency category calls



In October, there were 575 emergency incidents out of a total of 4,359. Median response time was 09:46 minutes.

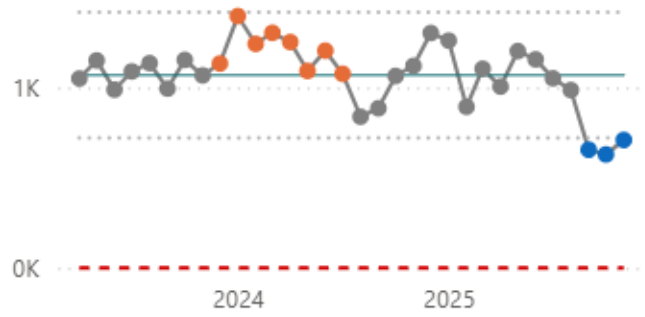
Key challenges / issues	Key actions / initiatives	Due date
• As of the 1st July 2025, new response category changes are now measured on a median response and clinical outcomes for ARREST and EMERG calls. • As of the 2nd December 2025 further response category changes are being introduced and AMBER and GREEN calls will now be categorised as ORANGE now, YELLOW soon, GREEN planned.	• Ongoing reviews of WAST resource escalation action plan (REAP) which identifies potential service pressures and is a system for managing and mitigating the impacts	Weekly ongoing
	• Dynamic review of demand and area specific pressures using the clinical safety plan. Clinical safety plan provides a framework for WAST to respond to situations where the demand for services is greater than the available resources.	Daily – Hourly ongoing
	• Same day emergency care (SDEC) access for WAST clinicians. SDEC extended to front door of ED – positive feedback from clinicians. Consultant connect is being in the process of being updated.	Weekly ongoing
• Overall attended demand in Hywel Dda health board area for November 2025 on average has been high and above forecast.	• 111 press 2 assisting WAST clinicians to support the management of mental health patients.	Active
• Hospital delays in ambulance hand over for WAST ambulance crews, 2,135 hours lost at the 4 acute Hywel Dda hospital sites during November 2025.	• Porth Preseli and Eastgate clinical streaming hubs staffed with Advanced Paramedic Practitioners supporting multidisciplinary approach to admission avoidance and to support equitable coverage in Ceredigion. Improvements being made with uplifting cover.	Weekly ongoing
• There have been 36 immediate release requests in November 2025 with an acceptance rate of 83.33%.	• WAST resourcing reviews and targeted overtime allocation	Weekly review – ongoing
	• Wait 45 initiative implemented, which will reduce length of ambulance wait times out	Live

Urgent and Emergency Care – Emergency Departments - Hywel Dda

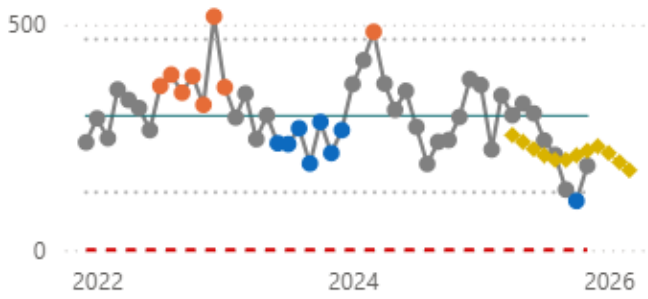
(Enhanced monitoring condition and Ministerial priority)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



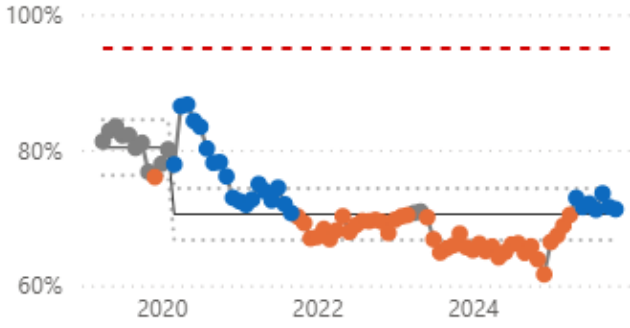
Ambulance handovers taking over 4 hours



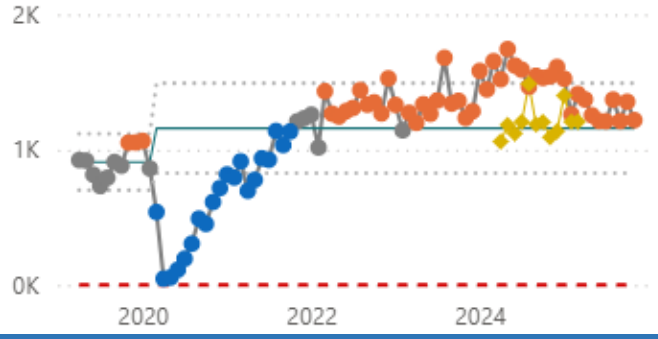
>45 Minutes handovers:
Latest data is showing improving variation
710 handovers > 45 minutes out of a total of 2,126 handovers.

>4 hours handovers:
Latest data is showing usual variation. 187 handovers > 4 hour out of a total of 2,126, 8.8%.

Patients waiting less than 4 hours in A&E/MIU



Patients waiting over 12 hours in A&E/MIU



Waits < 4 hours:
Latest data is showing improving variation.
71.25% of patients were seen within 4 hours, 10,150 out of 14,246 new attendances.

Waits > 12 hours:
Latest data is showing concerning variation.
1,219 patients waited over 12 hours, out of 14,246 new attendances, 8.6%.

Key actions / initiatives – tactical urgent and emergency programme

In response to long-standing performance challenges within Urgent and Emergency Care (UEC) which has resulted in sub-optimal patient experience and performance, the Executive Team has issued a series of instructions to be enacted at pace, in order to deliver a step change improvement, known as the UEC Accelerated Transformation Programme. The primary aim of the programme is to minimise attendance at an ED by providing appropriate, alternative pathways for patients. During the next two weeks, Welsh Government has asked all health boards to take urgent, focused action to improve patient flow and reduce delays to discharge of patients from our care. This Early and Weekend Discharge Winter Sprint Fortnight runs from 8–22 December and aims to strengthen resilience across both health and social care. Working in partnership with teams across our whole system, including our local authorities, is crucial in enabling better patient outcomes and experience, reduced harm from delays, and more beds available for those who need them most.

Please see the updates for each of our 4 acute site for the relevant issues faced and key actions we are taking to address:

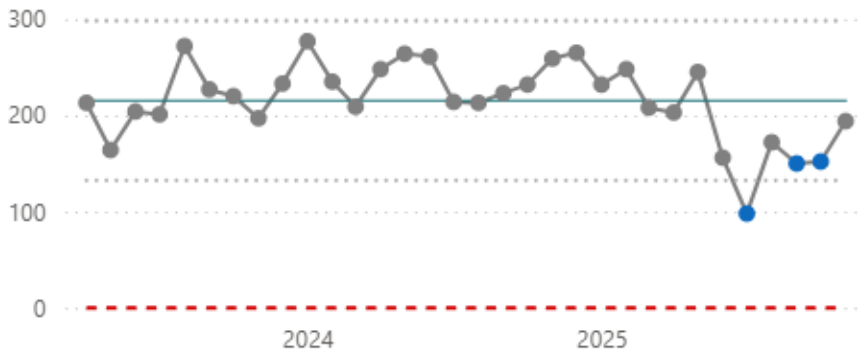
- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital

Urgent and Emergency Care – Ambulances - Bronglais Hospital

(Enhanced monitoring condition and Ministerial priority)

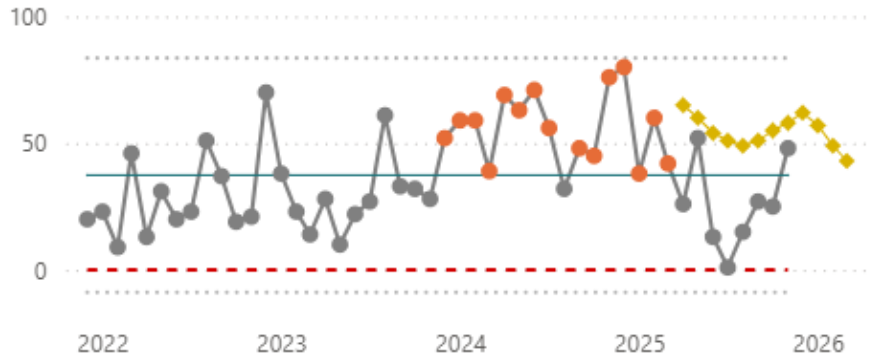
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



November data is showing usual variation. 194 handovers >45 minutes reported out of a total of 397 handovers, 48.8%.

Ambulance handovers taking over 4 hours



November data is showing usual variation. 48 handovers >4 hours was reported out of 397 total handovers 12%.

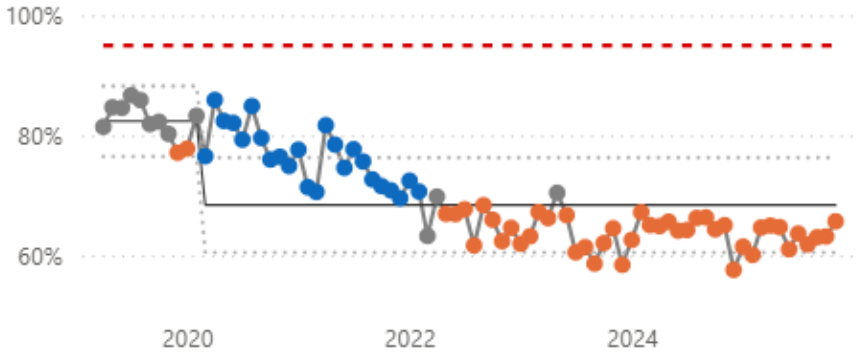
Key challenges / issues	Key actions / initiatives	Due date
• Staffing shortages - high number of consultant sickness between 4 and 6 off out of 13), an increase in junior doctor sickness and Health Care Support Worker deficits	• Welsh Government initiative "Winter Sprint" commencing from 08.12.25 for two weeks with a focus on increased and earlier discharges, weekend discharges, strengthening of front door processes, enhanced community capacity and strong partnership between health and social care	08/12/25
• High infection rates with number of patients requiring side rooms/barrier nursing across the Emergency Department and wider site	• Safe alternatives to hospital - GP medical referrals to Clinical Streaming Hub will be streamed via the Clinical Streaming Hub to divert away from the front door as appropriate	08/12/25
• Continued demand on ambulance arrivals and walk ins	• Daily reviews of Top 20 clinically optimised patients	Active
• Limited discharges due to high sickness rates in clinicians have increased use of surge areas therefore reduced availability of beds	• Senior decision makers the front door	Active
• Overcrowding and increase in corridor care within the department continues to disrupt the overarching flow	• Our Next Patient – supporting faster moved from the Emergency Department to the wards	Active
• High number of clinical optimised patients across the acute site is impacting the timely ability to transfer patients out of hospital	• Maximise Short Stay Triage and frailty pathways	Active
	• Immediate ambulance releases are always prioritised where possible	Active

Urgent and Emergency Care – Emergency Departments - Bronglais Hospital

(Enhanced monitoring condition and Ministerial priority)

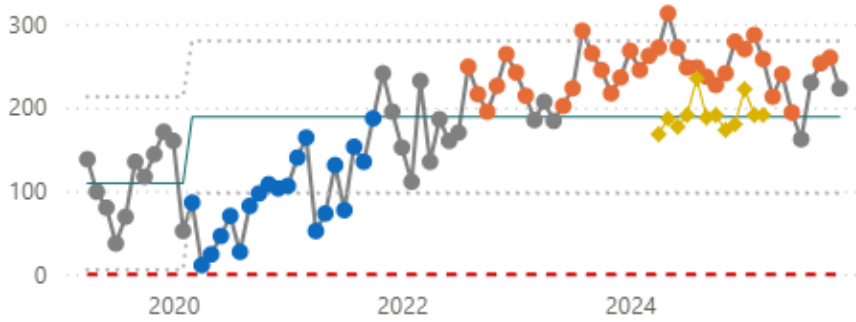
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E



66% reported for November, 844 breaches out of 2,462 new attendances. Chart is showing concerning variation.

Patients waiting over 12 hours in A&E



223 breaches out of 2,462 new attendances, 9%. The chart is showing usual variation

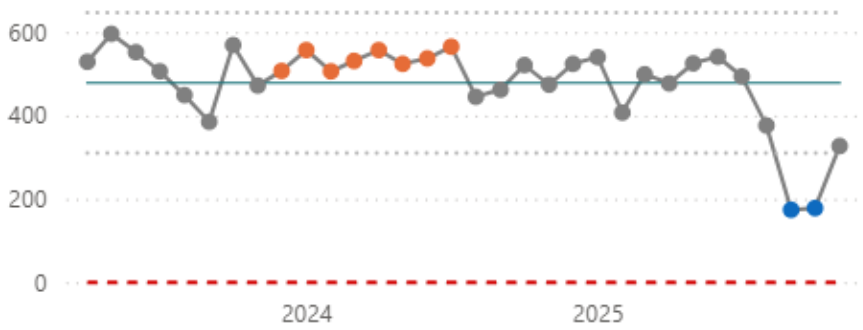
Key challenges / issues	Key actions / initiatives	Due date
• Staffing shortages - high number of consultant sickness between 4 and 6 off out of 13), an increase in junior doctor sickness	• Welsh Government initiative "Winter Sprint" commencing from 08.12.25 for two weeks with a focus on increased and earlier discharges, weekend discharges, strengthening of front door processes, enhanced community capacity and strong partnership between health and social care	08/12/25
• High infection rates with number of patients requiring side rooms/barrier nursing across the Emergency Department and wider site	• Safe alternatives to hospital - GP medical referrals to Clinical Streaming Hub will be streamed via the Clinical Streaming Hub to divert away from the front door as appropriate	08/12/25
• Continued demand on ambulance arrivals and walk ins	• Daily reviews of Top 20 clinically optimised patients and criteria led discharge	Active
• Limited discharges due to high sickness rates in clinicians have increased use of surge areas therefore reduced availability of beds	• Pilot fast track process when there is in house capacity	08/12/25
• Overcrowding and increase in corridor care within the department continues to disrupt the overarching flow	• Embed Home First Principles – discharge planning starts at admission	Active
• High number of clinical optimised patients across the acute site is impacting the timely ability to transfer patients out of hospital	• Aim to ensure Short Stay triage is not bedded to enable flow throughout the department	Active
	• Senior presence on Board Rounds	Active
	• Optimise use of interim care beds	Active

Urgent and Emergency Care – Ambulances - Glangwili Hospital

(Enhanced monitoring condition and Ministerial priority)

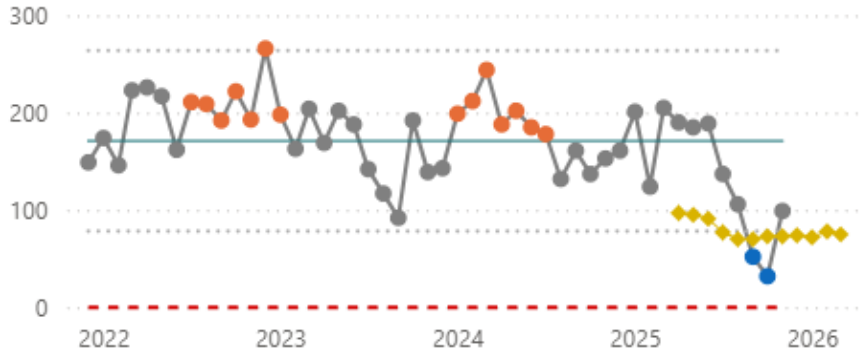
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



November data is showing usual variation. 327 handovers >45 minutes reported out of a total of 846 handovers, 39%.

Ambulance handovers taking over 4 hours



November data is showing usual variation. 99 handovers >4 hours reported out of a total of 846 handovers, 12%.

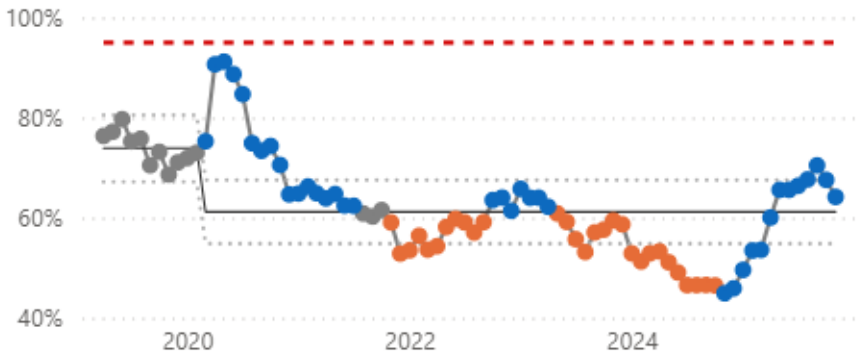
Key challenges / issues	Key actions / initiatives	Due date
• Sustained high volume of bed occupancy and surge across all ward areas. • Lack of physical space within the Emergency Department limits handover capacity. • Limited doctor deficits due to sickness within ED, which limits ability to provide senior decision maker within the rapid assessment and ambulance triage area (RAaT). • Early repatriation of pathway patients from referring hospitals continues to encounter delays. • High volume of clinically optimised patients across ward areas.	• Weekly deep dive and optimising board rounds with additional focus for "Winter Sprint Fortnight" • Continue with maximum utilisation of Llys Y Bryn assessment beds (x4) • Optimise use of GP beds at Amman Valley Hospital. • Address staffing deficits in ED. • Intermediate Care Multi- Disciplinary Team, Advanced Nurse Practitioner and Health Care Support Worker to be deployed to the front door.	31/12/25 Active Active 31/12/25 31/12/25

Urgent and Emergency Care – Emergency Departments - Glangwili Hospital

(Enhanced monitoring condition and Ministerial priority)

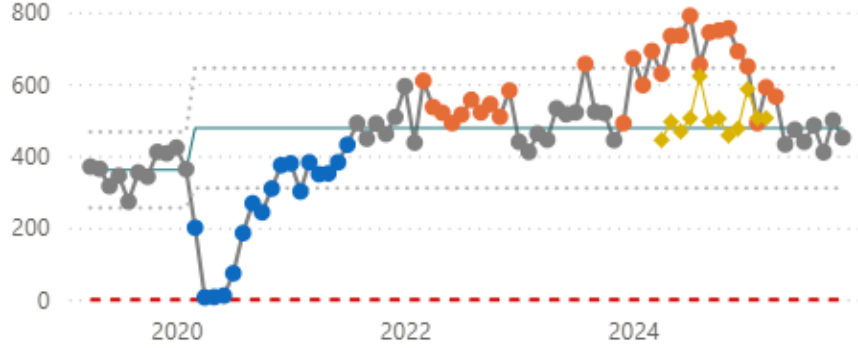
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E



64.2% reported for November, 1,647 breaches out of 4,598 new attendances. Chart is showing improving variation.

Patients waiting over 12 hours in A&E



451 breaches out of 4,598 new attendances, 9..8%. The chart is showing usual variation

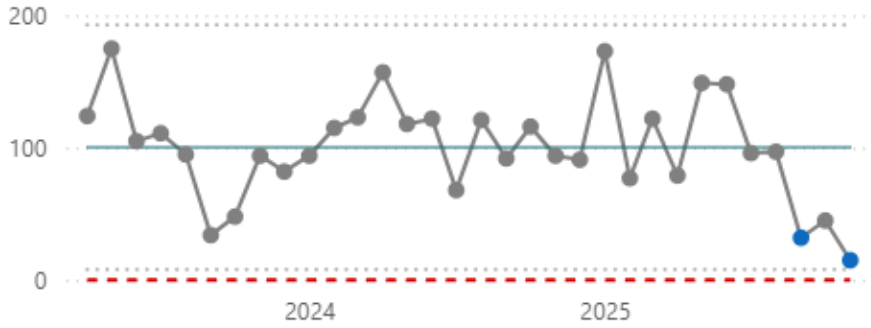
Key challenges / issues	Key actions / initiatives	Due date
• Front door demand has continued to be high with record number of daily presentations seen in November (202).	• GP triage x 4 days per week between hours of 6pm and 2am to review primary care presentations.	Active
• Increasing volume of patients presenting with non-urgent conditions has contributed to delays in 4 hour target.	• Re-direction policy being implemented at triage and rapid assessment.	31/12/25
• Senior ED Doctor deficits due to sickness absences.	• Capital refurbishment programme underway within Same Day Emergency Care (SDEC) footprint and relocation of service including Medical Day Unit, Discharge Lounge and GP Out of Hours (OOH) to ward area within hospital footprint. Space limitations temporarily until March 2026 when works will complete.	31/03/26
• Surge area around nursing bay in ED has been high occupancy due to acuity of presentations and demand to handover ambulances swiftly.	• Winter Sprint fortnight action plan to commence 8th December with focus on community capacity and early escalation in preparation for Christmas and New Year period.	8/12/25

Urgent and Emergency Care – Ambulances – Prince Philip Hospital

(Enhanced monitoring condition and Ministerial priority)

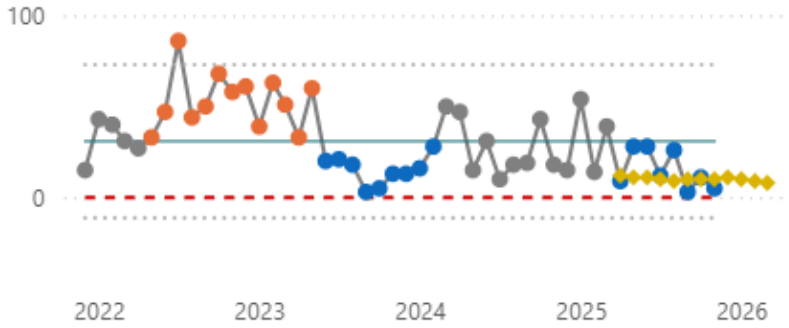
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



November data is showing improving variation. 15 handovers >45 minutes reported out of a total of 276 handovers, 5%.

Ambulance handovers taking over 4 hours



November data is showing improving variation. 5 handovers >4 hours reported out of a total of 276 handovers, 2%.

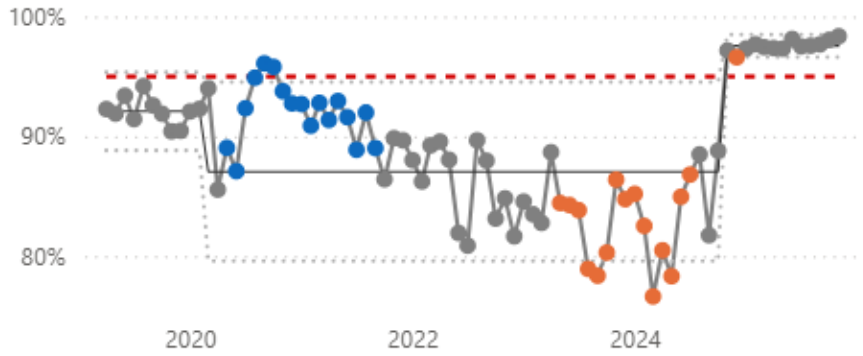
Key challenges / issues	Key actions / initiatives	Due date
• Continued front door pressure resulting in very limited capacity at point of handover. Area highly impacted with issues around IP&C (Infection Prevention and Control) issue continues to be present going into winter months. • Continuing to maintain Ambulance handover 45 minutes target which enabled us to handover ambulances within a timely manner however, this continues to add pressure internally on our ward areas where we surged as a result. • Prioritisation of medical patients in Minor Injury Unit (MIU) to come across to Acute Medical Assessment Unit (AMAU) remains. Meeting in relation to handover criteria to be discussed in December to support this pathway and enhance flow of patients. • Boarding protocol (Our next patient) where patients are moved early to areas where discharges or query discharges have been identified at escalation points via patient flow meetings and manager of the day escalation. This is proving to be more difficult as the internal surge continues to be present. However, we are still implementing this system where possible to further support flow in AMAU. • Clinical flow has been compromised through departments due to IPC issues on Ward 1 and Ward three resulting in 9 days of closure.	• Immediate ambulance release are almost always supported. • AMAU acute medical model is now functional (1st Sep) to support early discharge at the front door, this team is now also supported by Acute Response Team who attend weekly to support the medical team in identifying patients for community support which enables faster discharge. • Clear communication channels with the operational delivery unit (ODU) in WAST to support decision making with a view to minimise risk as part of hospital flow. • SDEC (Same Day Emergency Care) continue to support AMAU/MIU to reduce pressure at the front door. • Internal Operational Delivery Group support two calls per day on sites to monitor the development of patient flow outcomes. • Development and implementation of ‘Our next patient’ operation procedure now active in AMAU to ensure that each patient is assigned to the right ward in a timely manner under the care of the appropriate team.	31/12/25 Active Active 31/12/25 Active

Urgent and Emergency Care – Emergency Departments – Prince Philip Hospital

(Enhanced monitoring condition and Ministerial priority)

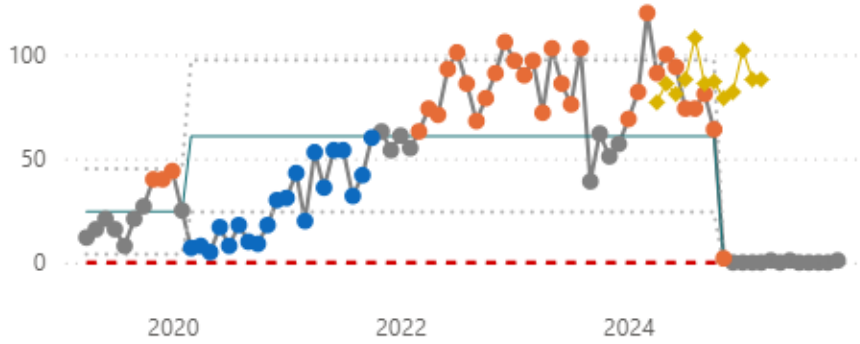
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in MIU



98.4% reported for November, 38 breaches out of 2,315 new attendances. Chart is showing usual variation performance trend. The control limits were adjusted from November 2024 due to change of front door model.

Patients waiting over 12 hours in MIU

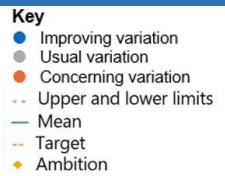


1 breach out of 2,315 new attendances. Chart is showing usual variation performance trend. The control limits were adjusted from November 2024 due to change of front door model

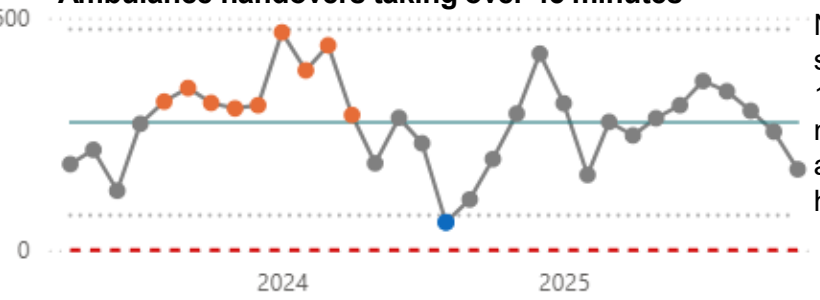
Key challenges / issues	Key actions / initiatives	Due date
• Our Minor Injury Unit (MIU) new patient attendance has returned to similar levels prior to closing overnight. (Since November 2024) there has been a significant decrease in the number of patients presenting with major complaints. This tread continues to be the case with a small number of medical patients presenting. Patient type is being motorized in our morning flow meetings.	• Locum consultant has created weekly hot clinics. These allow for prompt treatment of patients through SDEC that supports hospital flow and admission avoidance	Active
• Patients who are medically optimised, who are no longer requiring medical intervention, needing discharge support due to complex needs remain a challenge with around 40 patients a day. The level of patent group does have a negative effect on flow and impact the ability to create flow through the hospital resulting in delays for patients in MIU requiring a bed.	• Consultant connect went live on September the 1st awaiting first data pull due early 2026	01/01/26
• Medical Annual Leave has impacted on our ability to carry out all hot clinics in November	• Ongoing work with community colleagues in early discharge planning. The use of hospital at home to create a wrap around service enabling community GP's to refer into SDEC out of hours / weekends for SDEC to treat and refer back into the virtual ward.	01/01/26
	• Work to support the AMAU Medical Team staffing has began with contract reviews underway to secure the future of the team and continue its support in flow.	31/12/25

Urgent and Emergency Care – Ambulances - Withybush Hospital

(Enhanced monitoring condition and Ministerial priority)

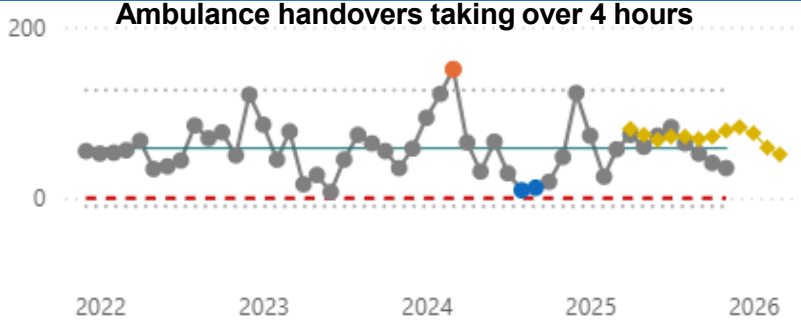


Ambulance handovers taking over 45 minutes



November data is showing usual variation. 174 handovers >45 minutes reported out of a total of 607 handovers, 29%.

Ambulance handovers taking over 4 hours



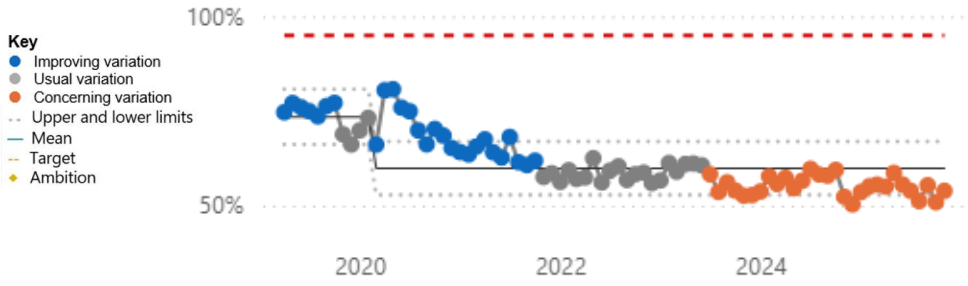
November data is showing usual variation. 35 handovers >4 hours reported out of a total of 609 handovers, 6%.

Key challenges / issues	Key actions / initiatives	Due date
Following the recent *Getting It Right First Time* (GIRFT) follow-up visit on 29th October 2025, best practice guidance emphasised maintaining the red line of a ringfenced resus area and ensuring that two RAT (Rapid Assessment and Treatment) beds remain unbedded to preserve ED flow and safety standards. During November, WGH faced significant operational constraints that impacted ambulance handover performance and ED throughput: • Middle grade and clinical fellow staffing shortages in ED, reducing capacity for timely assessment and decision-making. • Middle grade shortages on our medical wards, reducing capacity for timely assessment and decision-making. • IPC (Infection Prevention and Control) measures and roof leaks led to multiple bed closures across the site, further limiting inpatient capacity. • Healthcare Support Worker shortfalls compounded challenges in maintaining safe staffing ratios and supporting patient care.	**Workforce and Staffing:** • Developed business case for executive approval of an additional 3.4 WTE to meet Royal College of Emergency Medicine guidelines for ED medical staffing. • Submitted 4 requests for ED Middle Grades, with immediate vacancy request for 3 whole time equivalent (WTE). • Mitigation plans for Healthcare Support Worker shortfalls through bank and agency support. **ED Flow and Escalation:** • Implement clear escalation protocol for bed surging and boarding wards to de-escalate ED congestion. • Maintain ringfenced resus area and ensure two RAT beds remain unbedded as per GIRFT best practice. • Development of safe/unsafe/critically unsafe escalation protocol for ED which triggers additional levels of escalation • Conduct three times daily site position reviews focused on de-escalating ED and maintaining red lines. **Discharge and Bed Management:** • Every ward now has a “Fishbowl” review of the most complex patients weekly. • Introduced weekly Length of Stay (LOS) meeting with senior management to address discharge delays. • Broadened the scope of Martello ward beds to maximize utilisation for patient flow. • Continue opt-out discharge lounge with barrier tracking for pre-midday discharges. **Pathway Redesign:** • New Respiratory Pathway launched in November, supported by a weekly oversight group to monitor performance and drive continuous improvement. • Workforce planning for respiratory services, including 2 WTE respiratory posts and relocation of acute on invasive ventilation to intensive care unit. • *Reset* week 2 completed. Preparing for the two week *Winter Sprint*. **Performance Monitoring:** • Weekly reporting of ED and Acute Clinical Decisions Unit length of stay, ambulance handover breaches, and discharge performance to drive a d consultant engagement.	18/12/25 Completed Completed 18/12/25 Completed Completed Completed Completed Completed 01/12/25 Completed Started 11/25 Started 11/25 Completed Starting 08/12/25 Ongoing

Urgent and Emergency Care – Emergency Departments - Withybush Hospital

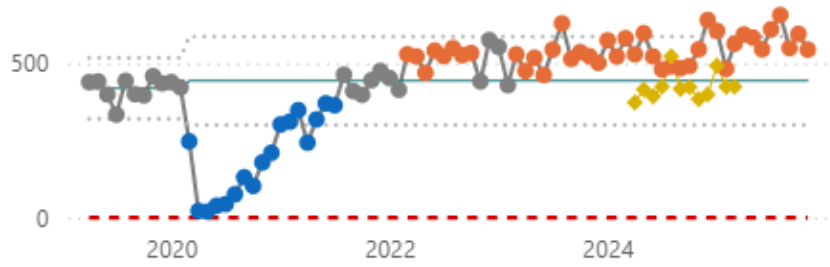
(Enhanced monitoring condition and Ministerial priority)

Patients waiting less than 4 hours in A&E



53.9% reported for November, 1,553 breaches out of 3,369 new attendances. Chart is showing concerning variation.

Patients waiting over 12 hours in A&E

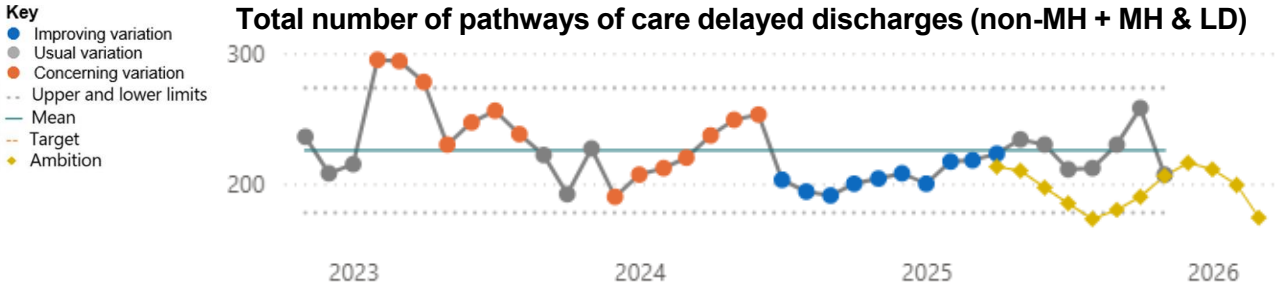


544 breaches out of 3,369 new attendances, 16.2%. Chart is showing concerning variation.

Key challenges / issues	Key actions / initiatives	Due date
Following the recent *Getting It Right First Time* (GIRFT) follow-up visit on 29th October 2025, best practice guidance emphasised maintaining the red line of a ringfenced resus area and ensuring that two RAT (Rapid Assessment and Treatment) beds remain unbedded to preserve ED flow and safety standards. During November, WGH faced significant operational constraints that impacted ambulance handover performance and ED throughput: • Middle grade and clinical fellow staffing shortages in ED, reducing capacity for timely assessment and decision-making. • Middle grade shortages on our medical wards, reducing capacity for timely assessment and decision-making. • IPC (Infection Prevention and Control) measures and roof leaks led to multiple bed closures across the site, further limiting inpatient capacity. • Healthcare Support Worker shortfalls compounded challenges in maintaining safe staffing ratios and supporting patient care.	**Workforce and Staffing:** • Developed business case for executive approval of an additional 3.4 WTE to meet Royal College of Emergency Medicine guidelines for ED medical staffing. • Submitted 4 requests for ED Middle Grades, with immediate vacancy request for 3 whole time equivalent (WTE). • Mitigation plans for Healthcare Support Worker shortfalls through bank and agency support. **ED Flow and Escalation:** • Implement clear escalation protocol for bed surging and boarding wards to de-escalate ED congestion. • Maintain ringfenced resus area and ensure two RAT beds remain unbedded as per GIRFT best practice. • Development of safe/unsafe/critically unsafe escalation protocol for ED which triggers additional levels of escalation. • Conduct three times daily site position reviews focused on de-escalating ED and maintaining red lines. **Discharge and Bed Management:** • Every ward now has a “Fishbowl” review of the most complex patients weekly. • Introduced weekly Length of Stay (LOS) meeting with senior management to address discharge delays. • Broadened the scope of Martello ward beds to maximize utilisation for patient flow. • Continue opt-out discharge lounge with barrier tracking for pre-midday discharges. **Pathway Redesign:** • New Respiratory Pathway launched in November, supported by a weekly oversight group to monitor performance and drive continuous improvement. • Workforce planning for respiratory services, including 2 WTE respiratory posts and relocation of acute on invasive ventilation to intensive care unit. • Reset week 2 completed. Preparing for the two week *Winter Sprint*. **Performance Monitoring:** • Weekly reporting of ED and Acute Clinical Decisions Unit length of stay, ambulance handover breaches, and discharge performance to drive accountability and consultant engagement.	18/12/25 Completed Completed 18/12/25 Completed Completed Completed Completed Completed 01/12/25 Completed Started 11/25 Started 11/25 Completed 08/12/25 Ongoing

Urgent and Emergency Care – Pathway of Care Delays (POCD)

(Ministerial priority)



- Number of census count in November is 207 patients and chart shows usual variation.
- The total days delayed for non-mental health decreased in November to 9,037 days.
- Mental health and learning disability delays also decreased in November to 987.
- Assessment delays remain the largest proportion of delays.
- The census count is based on any patient regardless of area of residency delayed within our hospitals and will include patients from outside of the 3 HDUHB Local Authority areas.

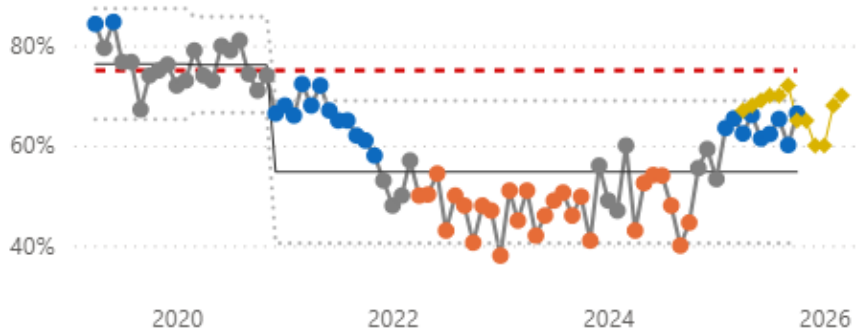
Key Challenges / Issues	Key actions / initiatives	Due date
Non-mental health: • Backlog for social care assessments within the Carmarthenshire acute and community system due to previous sickness and staffing challenges over the last few months (which has now resolved). • High levels of acuity and family/carers expectations are driving the need for nursing and continuing health care assessments within an already stretched system. • High levels of acuity, hospital-based deconditioning and limited access to appropriate rehabilitation due to the allied healthcare professions (AHP) workforce position contributing to the number of people requiring AHP assessments, reablement and new packages of care to support hospital discharge.	**Non-mental health:** • Overtime being offered to address backlog in social care assessments in Carmarthenshire. • Welsh Government monies being utilised to build additional social worker, domiciliary care and reablement capacity (staff recruitment and onboarding underway). • Embed and optimise trusted assessor (TA) models – especially around mental capacity assessments, • Task and finish group being set up to drive TA audit recommendations • Strengths-based collaborative communication training programme being rolled out across health and local authority • Regional focus on preventing deconditioning and Deconditioning Oversight Group established • Carmarthenshire rehabilitation pathway being developed • Regional Pathway of Care Action plan and regional steering group to monitor progress • *Winter Sprint* fortnight staring 8th December	31/12/25 31/12/25 Ongoing 31/01/26 31/03/26 Ongoing 31/3/26 Ongoing 22/12/25
Mental health & learning disability (MH&LD): The Mental Health & Learning Disability Clinical Care Group, Pathway of Care Delay (PoCD) census count for November 2025 is 12, this figure includes 5 discharges from last month, 8 who remain PoCD from the last count and 4 new patients identified as medically optimised. The patients are categorised as follows, older adult 9, a decrease of 1, adult 3 and 0 for learning disability, which are unchanged from last month.	**Mental health & learning disability (MH&LD):** The position in respect of patients who have a length of stay over the 90 and100 day threshold for Mental Health is 2 over 100, however, one older adult patient continues to have a delay exceeding 200 days. All patients are managed in accordance with the MH&LD PoCD action plan i.e. professional meetings have been undertaken and care plans are in place. In summary, there are 12 medically optimised patients which is an improved position. The count of 1 over 200 days is noted and assurance provided from the service that all options for disch[illegible] explored.	

Single Cancer Pathway

(Enhanced monitoring condition and Ministerial priority)

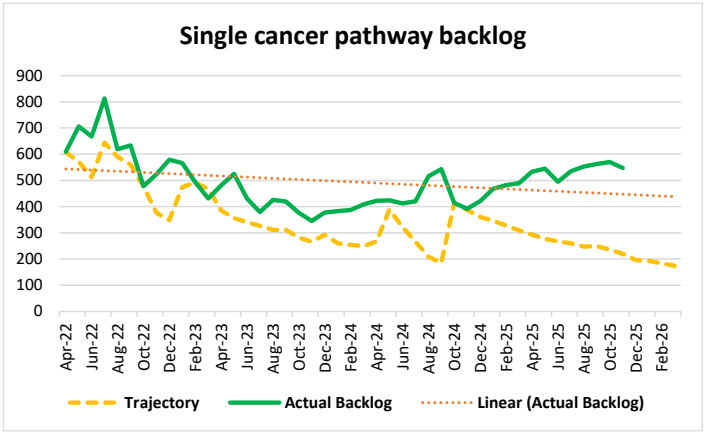
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% single cancer pathway patients starting treatment within 62 days



In October 2025, performance increased to 66.4%, exceeding the trajectory of 65%

Number of single cancer pathway patients waiting over 62 days



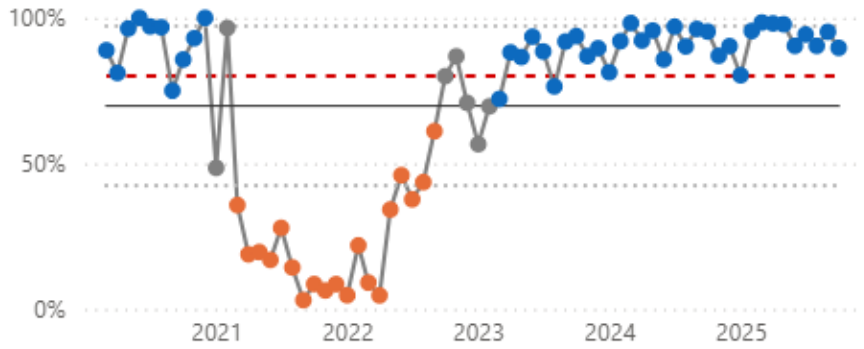
In November 2025, 548 patients were waiting over 62 days on the single cancer pathway.

Key challenges / issues	Key actions / initiatives	Due date
Single cancer pathway Treatment activity in October: 161 patients who were waiting over 62 days were treated, first treatment rates increased by 21 patients. 319 patients started treatment within 62 days. Fragility in Radiology remains a key risk to delivery. Recurrent investment in Radiology agreed for 2025/26.	Additional resources prioritised for 6 additional sessions per week for CT scanning and reporting, to remain in place for 2025/26.	31/03/26
Backlog Risks to meeting trajectory are predominantly associated with fragile service/workforce profile in key specialties (Radiology, Dermatology and Urology) which have limited resilience to sickness/absence.	Deep dives being undertaken per tumour site to inform improvement plans and trajectory for patients waiting in excess of 28 days for diagnostic tests.	31/12/25
	Robust improvement plans agreed for Urology prostate diagnostics for 2025/26.	31/03/26
Diagnostic Challenge To meet the 28-day diagnostic target requires the diagnostic component of the pathway to be provided within 7 days. The current position within Radiology is on average, 32 days from investigation to reporting, despite the additional sessions within CT. We are exploring opportunities to insource/outsource additional capacity to reduce the 32 day turnaround time for Radiology to within 7 days.	Piloting the use of the Galeas Bladder Test from January 2026 – 300 patients	31/01/26
	Faecal immunochemical test (FIT) pathway realigned to Primary Care, planned implementation November 2025. Being monitored until end December 2025.	31/12/25

Mental health assessments within 28 days

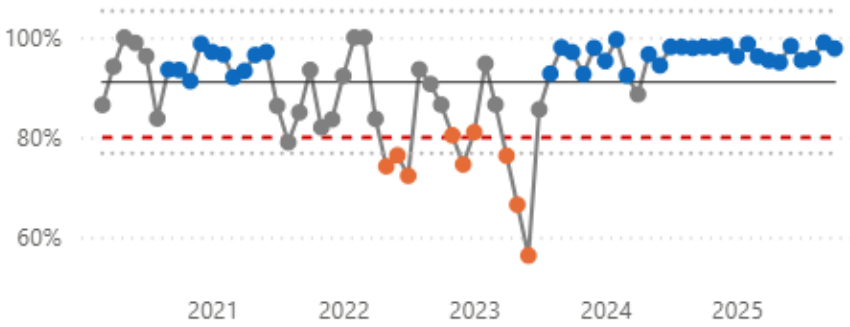
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% mental health assessments undertaken within 28 days (persons aged 0-17)



Latest performance of 89.7% is showing improving variation and the target of 80% was met.

% mental health assessments undertaken within 28 days (persons aged 18+)



Latest performance of 97.8% is showing improving variation and the target of 80% was met.

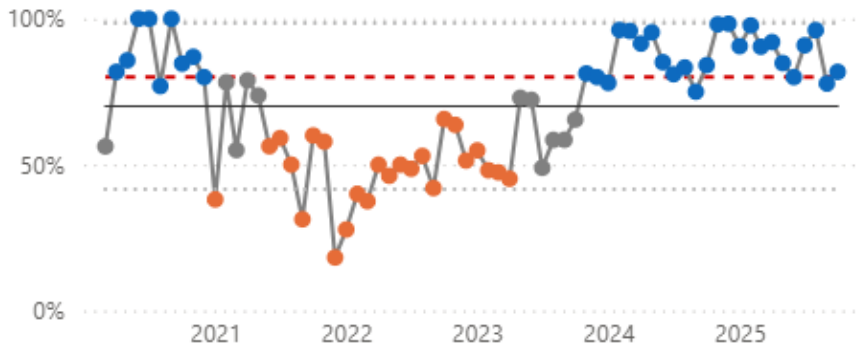
Key challenges / issues	Key actions / initiatives	Due date
% mental health assessments undertaken within 28 days (persons aged 0-17): 52 of 58 assessments were undertaken within target showing continued, and healthy, compliance.	**% mental health assessments undertaken within 28 days (persons aged 0-17):** Continued cross cover between county Local Primary Mental Health Support Service teams to balance capacity according to demand.	31/12/25
% mental health assessments undertaken within 28 days (persons aged 18+): Compliance remains above the required target, however, we have seen an increase in referrals across our Carmarthenshire and Ceredigion teams along with a more complex patient profile. This is increasing assessment time and/or the requirement for follow up assessment appointments. There is a vacancy in Ceredigion with long-term sickness in Carmarthenshire.	**% mental health assessments undertaken within 28 days (persons aged 18+):** Ensure effective administration processes and support are place so that the service remains compliant with the target, along with a review of assessment time slots to support complexities.	31/12/25

Therapeutic interventions following primary mental health assessment

(Enhanced monitoring condition)

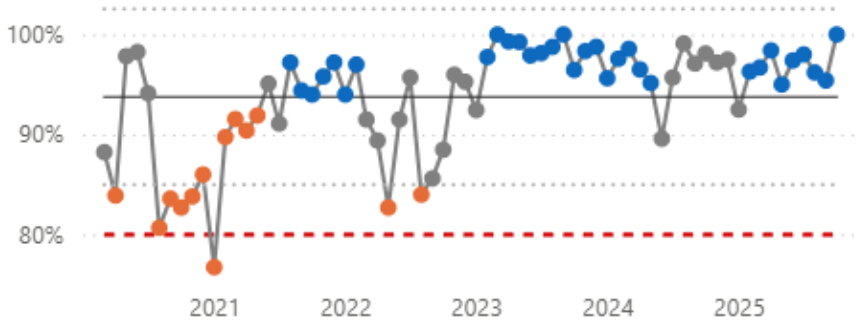
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17)



Latest performance of 81.8% is showing improving variation but the target of 80% was met.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+)



Latest performance of 100% is showing improving variation and the target of 80% was met.

Key challenges / issues	Key actions / initiatives	Due date
% therapeutic interventions started within 28 days following LPMHSS (Local Primary Mental Health Support Service) assessment (persons aged 0-17): 27 of 33 interventions commenced within target, showing a return to compliance for this metric following a brief dip the previous month.	**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17):** We are in discussions with NHS Performance and Improvement to pilot a 'One at a Time' approach to interventions in LPMHSS Carmarthenshire. We are rolling out SilverCloud digital therapies referrals for 11-15 year olds which will help manage demand and increase choice.	Live Live
% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+): Compliance remains above the required target. Increased referral numbers are limiting the number of available treatment sessions which potentially will impact on compliance over the next two months. Estates access continues to be challenging across the three counties.	**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):** Staff endeavour to ensure compliance with the measure by utilising supportive intervention options from third sector and SilverCloud digital options. Our Primary Care Liaison Service is operating across the three counties with positive outcomes of reducing potential referrals to LPMHSS, along with a focus on group interventions.	31/12/25 Live

Psychological Therapy Waits

(Enhanced monitoring condition and Ministerial priority)



Performance in October of 57.2% shows concerning variation and the target of 80% was not met.

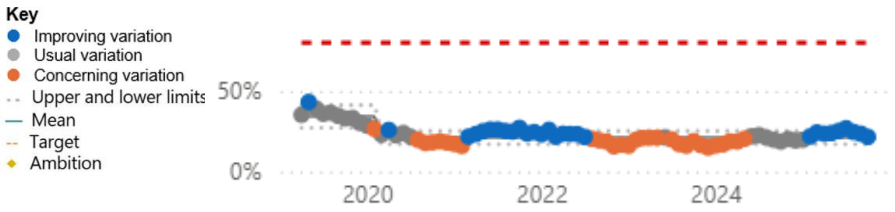
- 410 out of 733 (55.9%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 6 out of 13 (46.2%) were waiting <26 weeks to start an adult psychology assessment;
- 38 out of 63 (60.3%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

Key challenges / issues	Key actions / initiatives	Due date
Integrated Psychological Therapies Service (IPTS): We have seen an increase in compliance of 3.8%, however, the administration and processing of the group set up is labour intensive and is shouldered by clinical staff. The research team, who are leading on the patient-reported experience and outcome measures, are also experiencing challenges with two staff members successfully obtaining a PhD placement which has resulted in a heavy reliance on clinical staff to complete administration activity potentially reducing clinical activity.	**IPTS:** A number of high intensity evidence-based interventions are currently in place to increase capacity of service in attempts to minimise deterioration of position whilst the service model change towards groups and high-intensity interventions where needed takes effect.	31/12/25
Adult Psychology Mental Health (AMH): The waiting list position for AMH was steady in October, however, improvements in the coming months are expected following the recruitment of a Practitioner Psychologist. Additional capacity may also be possible with doctoral trainees on placement. A large geographical area can mean that access is limited in some areas particularly if a client requires face to face intervention. Additionally, given the limited number of staff in the community, any absence has a significant impact.	**AMH:** • All four clinicians are providing consultations to other services, decreasing referrals to AMH. • Grow Your Workforce plans are in place. • A whole-time equivalent vacancy for a Practitioner Psychologist has been recruited to and commenced on 6th October. This post is based in an area in Carmarthenshire where there is currently no community provision.	31/03/26 31/03/26 Complete
Learning disabilities (LDs): Long term sickness and vacancies in the team are affecting capacity and impact on waiting times, as well as intensive work and court reports required for the increasing complex Court of Protection (CoP) cases.	**LDs:** A project is underway to scope under 18s who potentially require a specialist LD service with pathways for earlier identification, education and engagement with families in children's services regarding the changes of legislation/transition from children to adult services including court of protection and the Best Interest process. The new service model includes a co-ordinator for CoP cases who can link in with legal services, to support writing court reports/managing cases to enable professionals to continue to effectively undertake their clinical roles. This will be recruited int rganisational change process from November 2025 to January 2026.	31/01/26

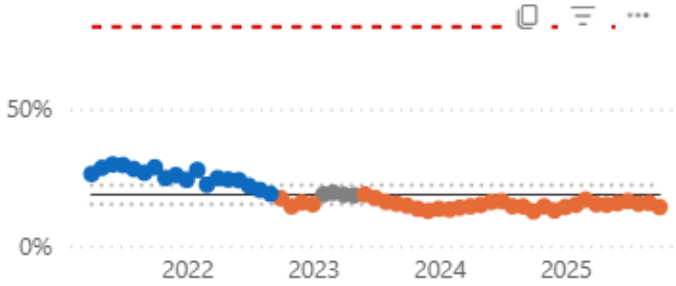
Neurodevelopmental Assessment Waits
(Enhanced monitoring condition and Ministerial priority)

Mental Health

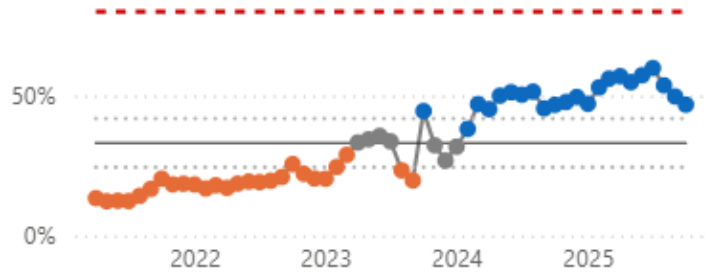
% children & young people waiting < 26 weeks to start a neurodevelopmental assessment



% children & young people waiting < 26 weeks: ASD



% children & young people waiting < 26 weeks: ADHD



The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position. Performance in October 2025 of 21.5% shows improving variation but the target of 80% was not met. Performance is driven by ASD, where 482 of 3,394 (14.2%) patients were waiting for an assessment <26 weeks. 462 of 987 (46.8%) were waiting for an ADHD assessment <26 weeks.

Key challenges / issues	Key actions / initiative	Due date
Autism Spectrum Disorder (ASD): As of October 2025, there are 2,912 children and young people waiting more than 26 weeks for an ASD assessment. Demand continues to outstrip capacity. The current waiting list for an ASD assessment stands at 3,394 with longest wait times 3 years, 6 months. Demand for assessment remains consistently high with referrals averaging 113 per month. This is approximately 3 times higher than current service capacity. Significant progress is being made internally to bring about more efficiencies, but key challenges include the absence of a regional strategic action plan around neurodivergence and whole system buy-in to bring about sustainable change. Current capacity does not allow for extensive regional stakeholder engagement and transformation.	**ASD:** • 3-year improvement plan and re-design of service underway. • Waiting list initiative commenced to bring about a more efficient, value-based approach to diagnostic assessment, starting with a review and stratification of the existing waiting list. Longest waits reduced from 3 years 9 months to 3 years 6 months since September. • Thematic analysis/service evaluation underway to understand drivers for diagnostic assessment. • Pending Welsh Government and Public Board approval, contracts to be awarded to two providers to eradicate >3 year waits by 2026. • Recruitment process to substantiate fixed term posts and recruit into additional posts. • Digital innovation - Support from digital services requested to maximise functionality of Welsh PAS, eradicating need for duplicate data systems; Pilot of AI scribe commences mid December. • Stakeholder mapping commenced and engagement plans with key stakeholders underway.	31/03/28 30/06/26 31/03/26 31/12/25 31/01/26 31/12/25 31/04/26
Attention Deficit Hyperactivity Disorder (ADHD): The longest wait for an ADHD assessment is currently 95 weeks with 159 waiting more than 52 weeks. The total ADHD waiting list is 987. The service has seen a 100% increase in referrals, resulting in a need to significantly increase core capacity where possible to achieve target. Despite this, demand continues to outweigh current core capacity even with a fully established medical workforce considered. Similarly, the demand for Quantitative Behavioural (QB) tests which forms part of the diagnostic pathway exceeds current capacity. Clinic room capacity across all sites remains a challenge.	**ADHD:** • Increase clinic room capacity through the Bandi appeal and reconfiguration of Puffin Ward. • Increase core capacity through provision of additional QB Tests and follow up sessions. Currently only one device is available to carry these out across the counties and a limited number of Healthcare Support Workers are trained to use these. Funding streams are being sought to support the purchase of additional devices. • There is a post to advert that, if successful, would see the recruitment of one whole time equivalent Community Paediatrician in Bronglais General Hospital. Interviews held last month unfortunately did not result in an appointment and the service are currently exploring alternative arrangements given the challenges in recruiting to this vacancy. • Continue to r[illegible]pacity flexibly and maximise through rigorous job planning.	31/03/27 31/12/25 31/03/26 31/02/26

Diagnostic waits over 8 weeks
(Ministerial priority)

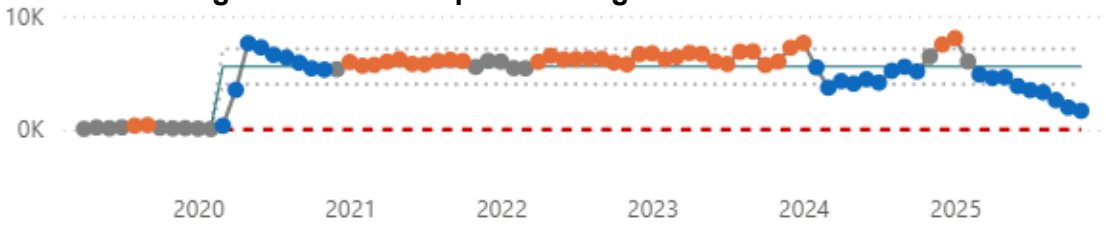
Key
- Upper and lower limits
- Mean
- Target
- Ambition

Variation - how are we doing over time
- Improving variation
- Usual variation
- Concerning variation

Assurance - performance against target
- Always hitting target
- Hit and miss target
- Always missing target

Trajectory - performance against our ambition
- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

Patients waiting >8 weeks for a specified diagnostic



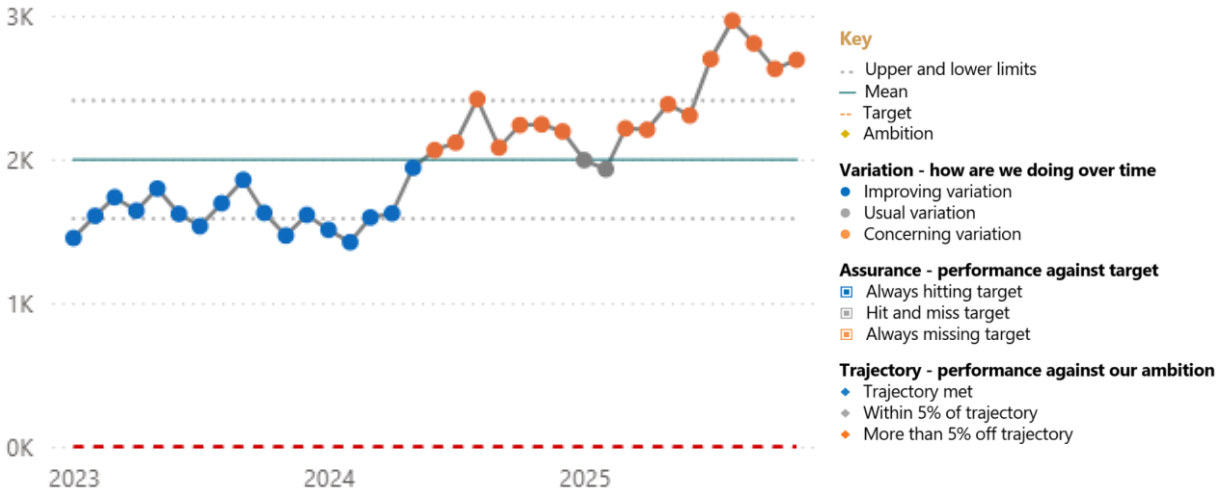
Performance is showing improving variation over the latest nine months with 1,656 breaches in November and recording the lowest result since March 2020.

Diagnostic	Latest period	Latest actual	Variation	Assurance	Trajectory
All	Nov 2025	1,656	●	▣	n/a
Radiology		1,432	●	▣	n/a
Endoscopy		154	●	▣	n/a
Phys measure		25	●	▣	n/a
Imaging		24	●	▣	n/a
Cardiology		20	●	▣	n/a
Neurophysiology		1	●	▣	n/a

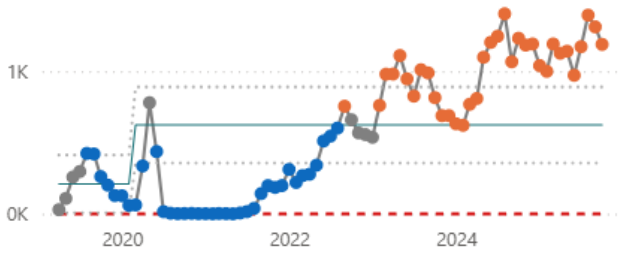
Key challenges / issues	Key actions / initiatives	Due date
Radiology • Demand exceeding capacity for timely investigations and reporting. Cancer and inpatient reporting is being prioritised. • There are currently 1,456 breaches in total [Computed Tomography 260, Magnetic Resonance Imaging 408 , Non Obstetric Ultrasound 761 which is a ddecrease of 256 breaches from November 2025.	• Ultrasound - Extension of Non Obstetric Ultrasound insourcing contract extended to November 2026 • Additional Obstetric sonography outsourcing/insourcing - obstetric added to current provider contract in Nov 2025. initial conversation with current insourcing provider for additional capacity commenced in Oct 2025 • Magnetic Resonance Imaging – 2 staffed scanners on site, one producing increased activity due to undertaking shorter, easier cases and one producing decreased activity due to performing complex, long scans. • Computed Tomography - Locum backfill out to advert to backfill staffing gaps. Computed Tomography Van procured and on site from 5/11/25 – 24/12/25 (looking to extend if required).	Completed 12/12/2025 Live 24/12/25
Endoscopy • Endoscopy theatre nursing staff fragility (particular to Glangwili and Prince Philip) due to short-term sickness and gaps in the nursing establishment. • Ongoing capital replacement programme for old/fragile endoscope equipment. • Additional demand created from Welsh Government Outpatient Initiative. • 20% Cystoscopy conversion rate from 1600 New appointments	• Endoscopy delivery plan in place to achieve zero breach performance by March 2026. • Investment uplift in endoscopy nursing establishment at Glangwili, New staff being onboarded. • Solutions currently being considered to address additional demand. • Working towards Service Evaluation on Urine tests used in place of Flexi Cystoscopy for Urgent Suspected Cancer/Non-visible hematuria. 300 patient assessment planned for January 2026 • Outsourcing/Insourcing underway with procurement as a secondary solution to the Urine test.	31/03/26 31/12/25 31/01/26 19/01/26 19/01/26
Cardiology: • Radiology Cardiac Myocardial Perfusion Imaging breaches at end of November decreased by 33 leaving just 7 patients waiting longer than 8 weeks.	• Significant improvement in breach performance, supported by a combination of core and additional outsourcing, which commenced on 18th September in partnership with Singleton. Re-triage of referrals enabled transfer of suitable patients to alternative diagnostic pathways. • Cancellations of scheduled list at Withybush hospital due to a leaking roof on site. To mitigate vacant post has been strategically utilised to offer overtime opportunities. • Dobutamine Stress Echocardiogram: Breaches decreased slightly. Transoesophageal Echocardiogram breaches increased. Primarily due to demand for inpatient procedures.	31/03/26 31/03/26 31/01/26

Therapy waits over 14 weeks
(Ministerial priority)

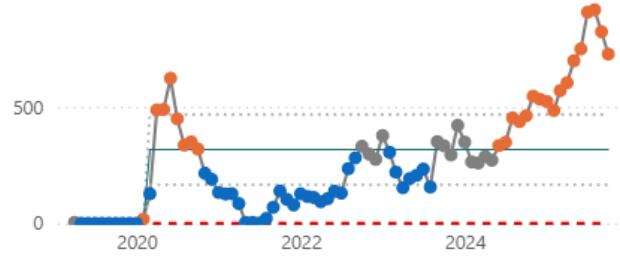
Patients waiting >14 weeks for a specified therapy



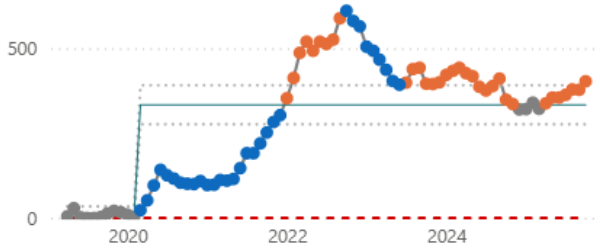
Number of patients waiting 14 weeks plus for Physiotherapy



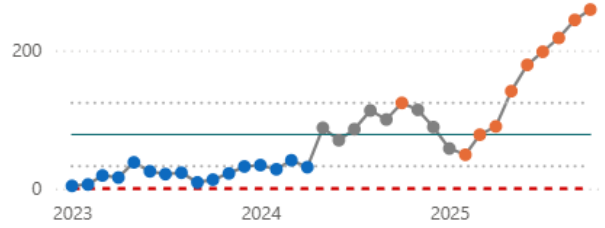
Number of patients waiting 14 weeks plus for Podiatry



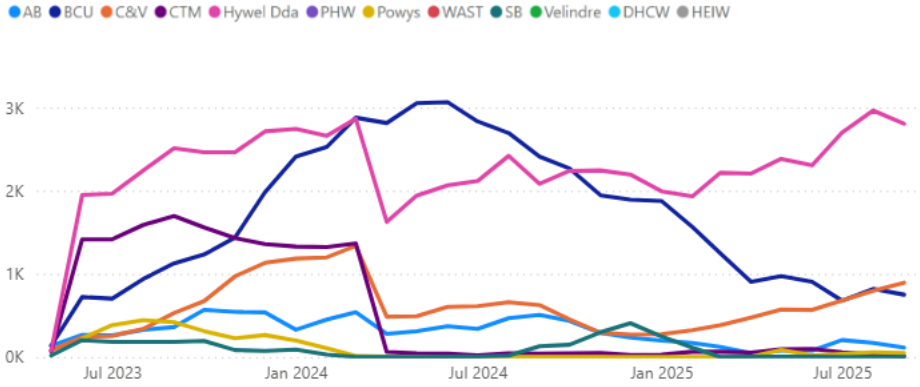
Number of patients waiting 14 weeks plus for Occupational Therapy



Dietetics: Number of patients waiting 14 weeks+ for Dietetics (excluding Weight Management)



Patients waiting 14 weeks or more for a specified therapy: Welsh Health Boards (September 2025)



Therapy	Latest period	Latest actual	Variation	Assurance	% children waiting < 14 weeks
All	Nov 2025	2,693	●	▣	62.6%
Physiotherapy		1,303	●	▣	97.6%
Podiatry		727	●	▣	91.9%
Occupational Therapy		407	●	▣	18.5%
Dietetics		216	●	▣	39.4%
Art therapy		35	●	▣	n/a
Speech & Language Therapy		5	●	▣	100%

Performance is showing concerning variation. Breaches in physiotherapy (1,303) and podiatry (727) remain high but both reduced breaches since August 2025. There is a widening gap between Hywel Dda and other Health Boards in Wales; Data as the end of September 2025 shows Hywel Dda with 2,807 breaches, with the next highest Cardiff and Vale at 894.

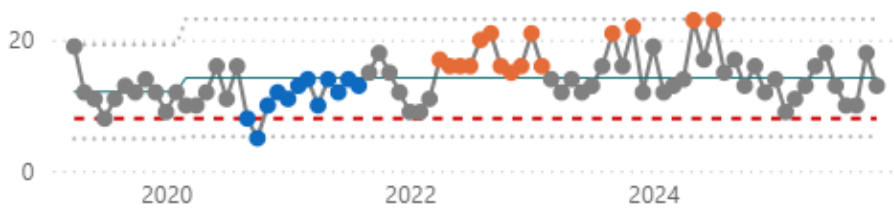
Therapy waits over 14 weeks (continued)
(Ministerial priority)

Key challenges / issues	Key actions / initiatives	Due date
Physiotherapy: 92% of breaches are within Musculoskeletal (MSK) specialty as demand is growing and is greater than capacity. Due to changes to Community Health Pathways and other national pathways (E.g. South Wales Spinal Network Guidance) are causing a shift of work from primary and secondary care towards community MSK Physiotherapy services. .	**Physiotherapy** • Development of a standard operating procedure for telephone triage initiative. Scope of project extended to include clinical risk stratification tool (Keele Start Back). This work is progressing, and a draft standard operating procedure (SOP) is in place. The deadline for completion of the SOP has been extended due to other priorities and service pressures. • Financial Control Group approval given to actively recruit Band 4 bank staff. Pending approval to advertise. Aim to complete recruitment cycle by 15th February 2026. • Full MSK service review being undertaken in collaboration with National MSK Network. Draft report has been received by Health Board on 3rd November, with a request from Health Board to review and comment. Deadline for response extended to 5th Jan 2025. • Scope feasibility for Health Board validation team to review and validate MSK and community routine waiting lists. Initial meeting scheduled 8th December 2025.	31/12/25 Live 05/01/26 31/12/25
Podiatry As of November 2025, waiting times reduced to 725 due to actions taken. Over last 5 years demand increases noted with new referral growth (9,000 to 14,500 annually) - despite mitigation efforts, nearly 3,000 new referrals waiting. Changes to the vascular pathway contributed to a rise in referrals, validation work continues of the waiting list. Patient contacts have reduced from 60,000 - 45,000 annually due to increased patient complexity. Lower clinic throughput: Patients seen in clinics decreased from 18-10 per day, reflecting increased complexity and time per case. Lower-risk cases now discharged to private sector, narrowing scope of patients seen.	**Podiatry** • Three Whole Time Equivalent (WTE) Band 5 staff recruited, replacing leavers. These staff commenced in September 2025 and increasing capacity by 1,200 patients annually. • Skill mixing for efficiency: 6 administration staff (Bands 3 & 4) undergoing Agored training to become podiatry assistants, enabling task redistribution, backfilling with new admin recruits. • Plans to establish a consultant podiatrist role to manage complex cases more efficiently. • Application of strict eligibility criteria and robust discharge processes in place and ongoing. • A demand and capacity deep dive and service review completed in September 2025, indicated a shortfall of three WTE staffing needed. • Innovative practice rollout: Ongoing implementation of phone triage, skill mixing, and pathway redesign to improve service efficiency.	Complete 01/09/26 01/03/26 Complete Complete 01/09/26
Occupational therapy (Paediatrics): Increases in new referrals over the last 3 months contributing to ongoing challenges in addressing the current backlog. Our focus remains on prioritising urgent and non-urgent cases. We are assessing our current capacity and are working with recruitment team to manage current vacancies.	**Occupational therapy (Paediatrics):** • Advert out to recruit maternity backfill • Advert being prepared to replace Neonates Clinical Lead who leaves post at the end of January • Continuing to explore any further additional capacity internally to manage current waiting list • Demand and capacity modelling has been completed in October 2025 and action plans being developed.	30/01/26 30/01/26 31/03/26 30/01/26
Dietetics: Paediatric selective eating increased referral demand. Vacancies being recruited with fixed term agency starting to have impact and Paed Lead now in post. Diabetes recruitment now complete and expected to be in post end if Jan 2026.	**Dietetics:** • Paediatric service lead in post, induction complete. Work to commence to develop recommendations improve access and service sustainability. Fixed term agency starting to have impact . • Diabetes recruitment complete, expect all in post by end January 2026	28/02/26 31/01/26

C.difficile and E.coli cases
(Enhanced monitoring)

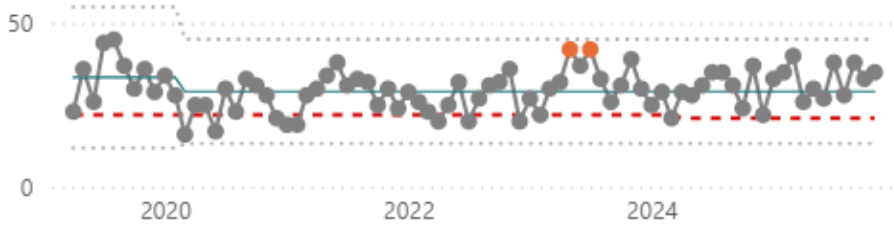
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Number of laboratory confirmed C.difficile cases (in-month)



Performance is showing usual variation with 13 cases in November.

Number of laboratory confirmed E.coli bacteraemia cases (in-month)



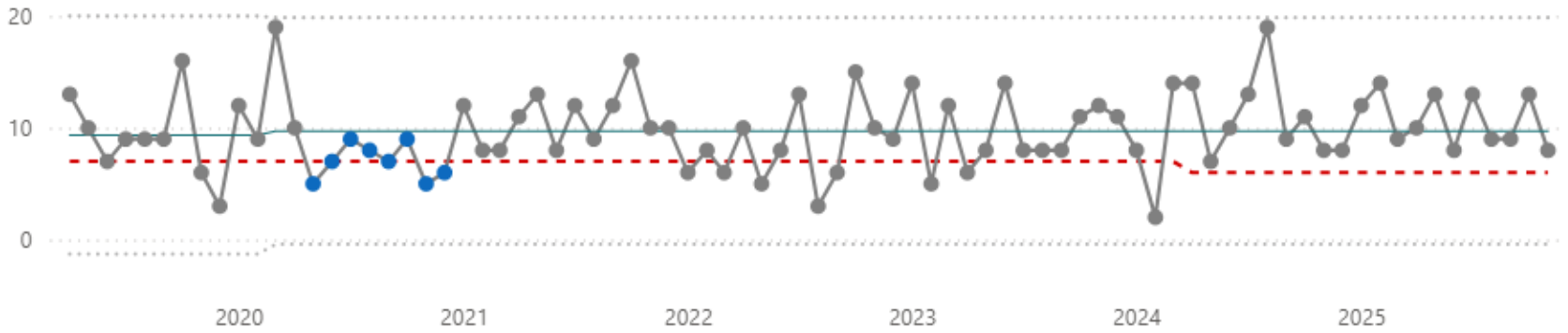
Performance is showing usual variation with 35 cases in November.

Key challenges / issues	Key actions / initiatives	Due date
C. difficile: • Increased testing in November due to Norovirus prevalence may have led to an increase in C. difficile diagnosis. • Start Smart and Then Focus (SSTF) audits for antibiotic prescribing not consistently completed. • Environmental cleaning and deep cleaning challenges relating to staffing and surge capacity in ward areas. • Lapses in compliance to hand hygiene practices and bare below the elbow across all staff disciplines. • Level 2 mandatory compliance for Infection, Prevention and Control is at 75.36% as a Health Board below expected 85% target. • There is a risk due to vacancies in the Antimicrobial Pharmacy team that Antimicrobial stewardship will be negatively impacted.	• The SSTF audits have been scrutinised in terms of completion and prescribing, tazocin and cotrimoxazole most prescribed antibiotics. Around two thirds of C. difficile patients (67%) had a Proton Pump Inhibitor prescribed, quality improvement projects linked to C.difficile collaborative discussed at C. difficile Improvement Group. • Environmental audits and observational audits continue, Audit and management tracking for infection prevention control will be piloted in the next month. • Healthcare-Associated Infection (HCAI) cases discussed monthly at the HCAI Assurance Group meeting for each site and learning disseminated through Clinical Care Groups (CCG). • Hydrogen Peroxide Vapor (HPV) available on 3 acute sites currently, with the 4th site coming online in coming months.	31/12/25 31/01/25 31/12/25 31/01/25
E. coli: • Burden of infection remains community-onset; cases are linked to urinary tract infections and some catheter device related infections. • Cases are predominantly in the 80 to 89 age demographic. • Lapses in compliance to hand hygiene practices and bare below the elbow across all staff disciplines. • Aseptic Non-Technique (ANTT) compliance for the Health Board is at 83.35%.	• Health and Wellbeing Booklet for Hywel Dda University Health Board population in review status and to be published following presentation at the Readers' Panel. • Healthcare Associated Infections (HCAI) cases discussed monthly at the Assurance Group meeting for each site and learning disseminated through Clinical Care Groups. • Hand Hygiene audits completed by Ward Managers monthly, these are reviewed and monitored.	31/01/25 31/12/25 31/12/25

S.aureus
(Enhanced monitoring condition)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Number of laboratory confirmed S. aureus bacteraemia cases (in-month)



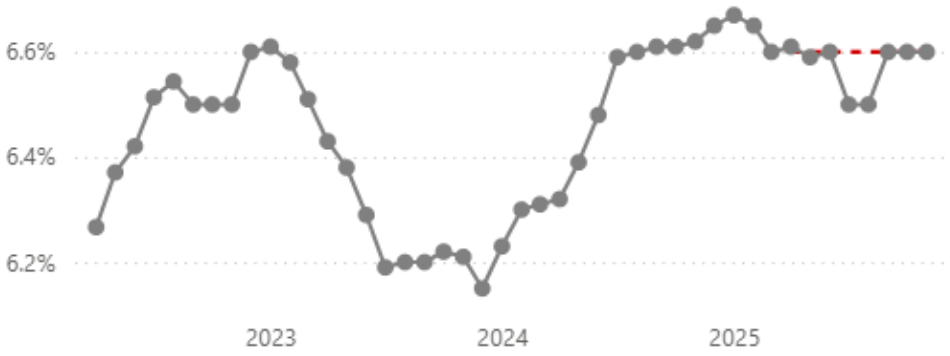
Performance is showing usual variation with 8 cases in November.

Key challenges / issues	Key actions / initiatives	Due date
S. aureus: • Inconsistent compliance with aseptic non-touch technique (ANTT), 83.35% for E-learning. • Environmental or equipment contamination contributing to transmission, linked to challenges around environmental cleaning and surge. • Greater burden of infection remains to be in community, with wounds being the primary source of infection. • Lapses in compliance to hand hygiene practices and bare below the elbow across all staff disciplines. • Inconsistent use of cannula bundles for peripheral venous catheters.	• ANTT compliance and competency assessments for clinical staff shared via Clinical Care Groups (CCG) meetings .Request to place competency assessments as mandatory on Electronic Staff Record tool sitting with Mandatory Training Group • Healthcare-Associated Infection (HCAI) cases discussed monthly at the HCAI Assurance Group meeting for each site and learning disseminated through CCGs . Review of areas with highest rates in CCG to be shared • Hand hygiene validation audits and observational audits in wards and departments as indicated from monthly senior nurse audits.	31/12/25 31/12/25 31/12/25

Staff sickness
(Delivery framework)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% staff sickness rate (12 months rolling)



In November 2025, 12 rolling staff sickness was 6.6%

Services with 60+ staff with the highest levels of in-month sickness rates in October 2025

Team	Staff	In-month %	R12m %
Glangwili Hotel Services	135 staff	**12.4%**	14%
Sunderland Ward	71 staff	**12.1%**	11.9%
Prince Philip AMAU	74 staff	**12.3%**	11.4%
Withybush Hotel Services	137 staff	**9.5%**	11.2%
Glangwili Theatres	85 staff	**10.3%**	11%
Prince Philip Acute Response	65 staff	**10%**	11%

Key challenges / issues

Conditions impacting absence rates include:
As per the NHS Performance Framework 2025-26, the Health Board sickness absence target is a reduction on the 2024-25 outturn of 6.60%. Figures are indicative of a small upward trend in absence, but the Health Board is still within the target of 6.60%.

Absence rates attributed to anxiety, stress and depression (35.1%) continues to account for the highest reasons for absences across the Health Board. Absence attributed to cold, cough, flu is increasing (8%) and is now the third highest reason for absence.

Estates and Facilities sickness rates continue to be the highest across the Health Board but are showing signs of improvement with ongoing focused.

Key actions / initiatives

Work continues with temporary redeployment guidance, bite sized training sessions, Occupational Health referral how to guide, passport for reasonable adjustments, collaboration with HEIW, learning from Occupational Health data.
The annual staff flu vaccination programme began on 1st October, supported by peer vaccinators.
First meeting of the Heath Boards Health & Wellbeing Group has taken place with terms of reference and objectives to be agreed.

Targeted support for sickness absence:
- Posts for 2/3 sickness absence advisors are due to go out to advert to help facilitate more focused support for managers from the Workforce team.
- Ongoing focused support from the Workforce teams continues in collaboration with Senior Managers with a focus on hot spots across all Clinical Care Groups.
- Designated support from Workforce continues to be utilised to help address sickness absence aligned [illegible]ations matters

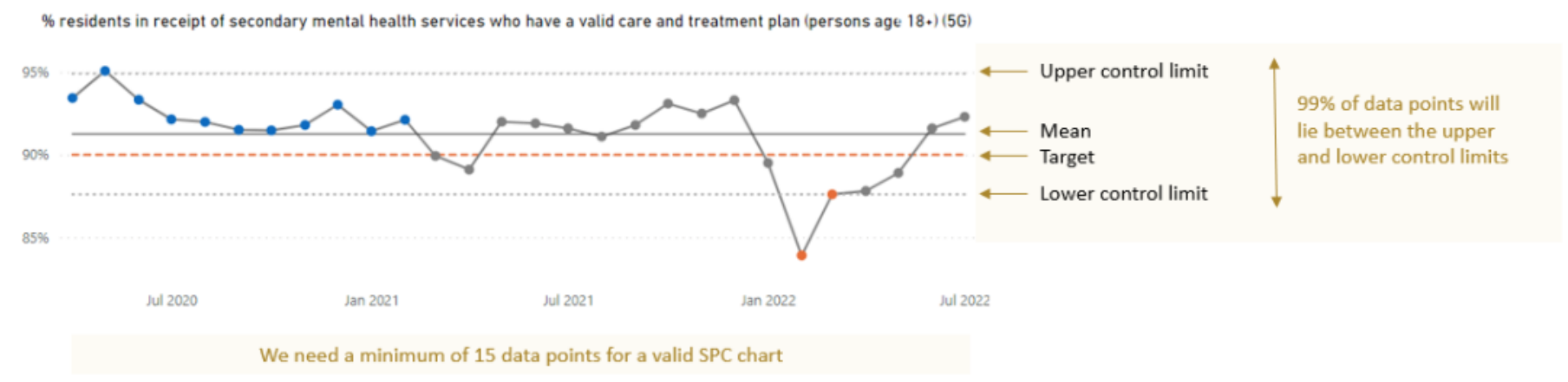
Due date

Live

Why use SPC charts?

- Plotting data over time can inform better decision-making
- There are many factors that impact our performance and therefore month-on-month variation is to be expected
- RAG data in a table can hide what is happening
- SPC charts enable us to determine if changes are showing special cause variation (concerning or indeed improving) or if the changes are within our expected performance range. They also help us easily compare our performance against target.
- There is a strong evidence base to support the use of SPC charts to inform NHS improvement.
- We started using SPC charts for performance reporting to Board and Committee in March 2021. The feedback has been very positive, with SPC charts helping to change the conversation to focus on improvement.

Anatomy of a SPC chart



Rules for special variation within SPC charts

Special variation is change that is unlikely to have happened by chance.

We are using the Making Data Count approach for SPC charts. There are 4 rules:



A single data point outside the process limits



Two out of three points close to the process limit



Shift of 7* or more points above or below the mean line



Run of 7* or more points in ascending/descending order

* A pattern of 7 has a 1 in 128 (0.8%) probability of occurring by chance.

Understanding the SPC icons

Each SPC chart produces 2 types of icons i.e.. one for variation and another for assurance.

Variation How are we doing over time	●	Concerning trend = a decline that is unlikely to have happened by chance
	●	Usual trend = common cause variation / a change that is within our usual limits
	●	Improving trend = an improvement that is unlikely to have happened by chance
Assurance Performance against target	▣	Missing target = will consistently fail target without a service review
	▣	Hit and miss target = Indicates that the Board cannot have sufficient assurance that the target can be consistently achieved over time, and the delivery of the target is particularly sensitive to external factors
	▣	Hitting target = will consistently meet target
Note: remember **blue** is good, orange is **bad**		

5.2

12:35 PM, 5 Mins

5.2 - NWSSP PERFORMANCE REPORT QUARTER 2 2025/26

Huw Thomas (Hywel Dda UHB - Director of Finance)

For assurance

Attachments

NWSSP Performance Report Quarter 2 2025-26 FPC 16 December 2025.pdf

HDdUHB NWSSP Summary Performance Report Quarter 2 2025-26.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Performance Report Quarter 2 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Rhian Davies, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Finance and Performance Committee (FPC) with summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30 September 2025 (Quarter 2 2025/26).

The Finance and Performance Committee is requested to receive an assurance from the content of the NWSSP Performance Report for Quarter 2 2025/26.

Cefndir / Background

The NWSSP is hosted and governed by Velindre University NHS Trust Shared Services Regulations and the Shared Services Partnership Committee (SSPC). The SSPC is hosted by Velindre University NHS Trust on behalf of the seven Health Boards, three Trusts and two Special Health Authorities within NHS Wales (the partners) and is responsible for monitoring governance and performance.

The required standards for effective governance are outlined within the SSPC's Standing Orders, Values and Standards of Behaviours framework, and associated policies. The partners participate in the SSPC and take collective responsibility for the delivery of the services through a hosting agreement between the partners.

The purpose of the SSPC is to:

- Set the policy and strategy for NWSSP;
- Monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- Seek to improve the approach to delivering Shared Services which are effective, efficient and provide value for money for partners;
- Ensure the efficient and effective leadership direction and control of NWSSP; and
- Ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The Board has approved Standing Orders in relation to the establishment of joint committees. In line with these Standing Orders, Hywel Dda University Health Board (HDdUHB) has established a NWSSP Committee as a joint committee of the Board, the activities of which require reporting to the Board.

Asesiad / Assessment

As part of the approval of Year 1 of the SSPC Integrated Medium Term Plan (IMTP) for 2025-26, the SSPC reviewed its Key Performance Indicators. A number of Lead indicators were identified for each division. There are 21 Lead indicators in total.

Full details of the performance against all Wales agreed KPIs for services provided to HDdUHB are attached (**Appendix 1-3**) with comparison data for the rolling twelve-month period to 30 September 2025.

HDdUHB Specific Key Performance Indicators

In summary, of the 21 Lead indicators for Quarter 2 the performance is as follows:

	Green	Amber	Red	Not Applicable
Quarter 2 2025/26	20	-	1	-
Quarter 1 2025/26	17	-	1	3

By exception, the area where performance is not on target is highlighted below:

Accounts Payable – NHS Public Sector Prompt Payment (PSPP)[1]

Performance driven by both HDdUHB and NWSSP shows the organisation missing the following KPI:

PSPP Compliance NHS: **Target** **95%**
Performance: **85.8%**

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 2 reporting 85.8%

[1] Definition of the CBI Prompt Payment Code financial target for NHS bodies:
Payment of at least 95% of non-NHS invoices within 30 calendar days from the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. NHS bodies must disclosure in their financial statements performance against the measure set out above and also performance on the same basis for NHS invoices (although the latter is not a financial target).

What is NWSSP doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice hold data to help address the performance.

The Finance team within the Health Board work with NWSSP colleagues to improve performance in this area but it continues to be challenging as this is an area where more intervention is required as there are low numbers of Purchase Orders raised (as NHS organisations are on the Purchase Orders exemption list) and authorised signatories frequently need a number of reminders before invoices are approved for payment.

This area was highlighted in the Finance and Digital *Executive Improving Together Session* (EITs) in November where the Finance Team sought Executive Team support to raise the importance of compliance with their respective teams as part of the organisational financial oversight agenda.

The Health Board continues to meet the non-NHS PSPP target which is the required financial target.

All Wales Key Performance Indicators

Performance is reported on an all Wales basis for KPIs that cannot be attributed to a specific health organisation, with comparative data for the rolling twelve-month period to 30 September 2025.

Summary Assessment by NWSSP

The Quarter 2 performance for the organisation was good with 20 out of 21 KPIs showing as green. The time to hire target was achieved in September.

Further action will continue to be taken forward to address the performance in areas of underperformance.

1 KPI did not achieve the targets - this is a combination of NWSSP and Health Board responsibility. NWSSP continues to support the organisation in relation to accounts payable performance.

Appendix 4 shows the Outcome measures that NWSSP has been working on at the end of September 2025 to highlight and report the impact and importance of what it does.

Extra tables and charts have been included by NWSSP this quarter, their inclusion aims to provide additional detailed insights gathered from feedback from health organisations performance meetings. These tables have been headed as ‘For Information’ within the various appendices. Accounts Payable and Payroll Overpayments are routinely monitored via the Financial Assurance paper presented to Audit and Risk Assurance Committee (ARAC).

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

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

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.11 Commission regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30 June 2025.

Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad: Parties / Committees consulted prior to Finance and Performance Committee:	Shared Services Partnership Committee (SSPC)

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	NWSSP was established to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	NWSSP has a remit to focus on delivering savings that can be re-invested in direct patient care.
Gweithlu: **Workforce:**	NWSSP is hosted by Velindre NHS Trust and any workforce implications are dealt with by the Trust.
Risg: **Risk:**	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Cyfreithiol: **Legal:**	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

NWSSP
SUMMARY PERFORMANCE REPORT

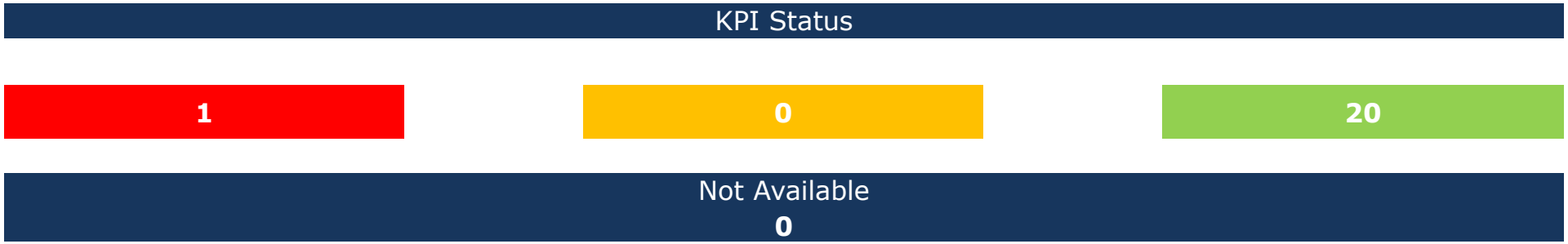
HYWEL DDA
UNIVERSITY HEALTH BOARD

Period 1st July 2025– 30th September 2025

Delivering Value, Innovation and Excellence through Partnership

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Overview



Points of Contact

Rebecca Nelson – Director of Planning, Performance & Informatics (Rebecca.Nelson2@wales.nhs.uk)
Richard Phillips – Assistant Director of Planning & Performance (Richard.phillips@wales.nhs.uk)

Key Messages

The purpose of this report is to provide summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 30th September 2025.

As part of the approval of our Year 1 of our IMTP for 2025-26, the Shared Services Partnership Committee (the Committee) reviewed our Key Performance Indicators. We then identified a number of Lead indicators for each division. There are 21 Lead indicators in total.

The Quarter 2 performance for the organisation was good with 20 out of 21 KPIs showing as green.

The time to hire target was achieved in September.

Further action will continue to be taken forward to address the performance in areas of underperformance.

Of the 1 KPI that did not achieve the targets:

- 1 is a combination of NWSSP and Health Board responsibility.

NWSSP continue to support the organisation in relation to accounts payable performance.

Professional Influence Benefits

The main financial benefits accruing from NWSSP relate to professional influence benefits derived from NWSSP working in partnership with Health Boards and Trusts. These benefits relate to savings and cost avoidance.

- Legal Services – Settled Claims savings, damages and cost savings.
- Procurement Services – Cost reduction, catalogue management etc. (Heads of Procurement discuss with Director of Finance of Health Orgs)
- Specialist Estates Services – Property management/lease/rates negotiated reductions and Build for Wales framework savings.
- Counter Fraud Services – Financial Recoveries and prevention.
- Accounts Payable - statement reconciliation, priority supplier programme (PSP) and the prevention of duplicate payments.

The indicative financial benefits arising in the period April – September 2025 for the organisation is £4.4M with the breakdown in the following table.

Service	YTD Benefit £m
Specialist Estates Services	0.12
Procurement Services	3.97
Legal & Risk Services*	-
Accounts Payable	0.26
Oxygen Finance – PSP	0.02
Counter Fraud Services**	0.02
Total	**4.4**

* Not available at the time of writing
** Q1 only

Explanation of Appendices

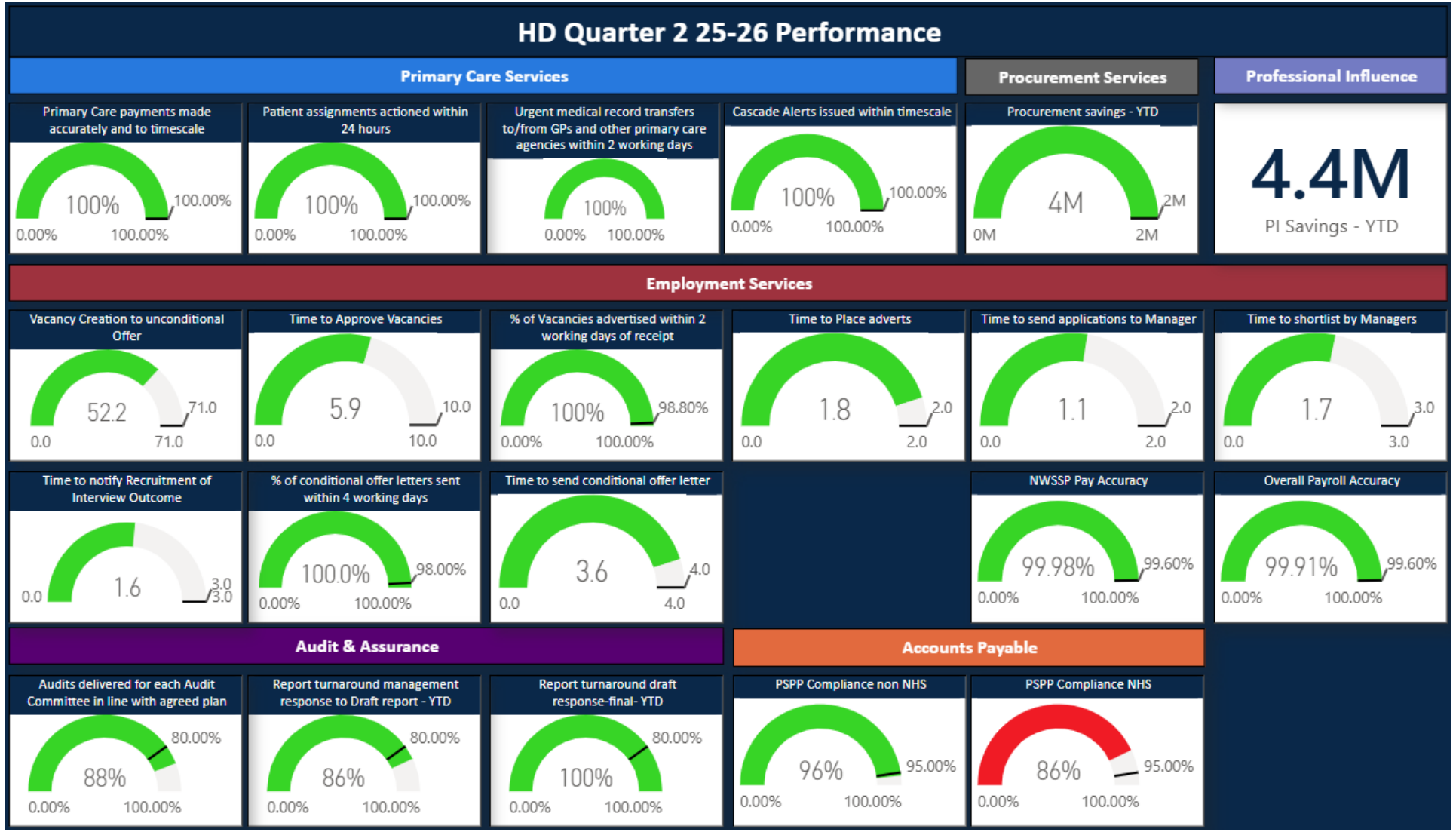
Appendix 1 to this report provides the September performance for your health organisation against the Lead indicators with comparison data for the rolling twelve-month period to 30th September 2025.

Appendix 2 provides September performance against All Wales KPIs which cannot be attributed to a specific health organisation but report an All-Wales position with comparison data for the rolling twelve-month period to 30th September 2025.

Appendix 3 then highlights the position for all health organisations at the end of September 2025.

Appendix 4 highlights the Outcome measures reporting we have been working on at the end of September 2025.

Summary Performance

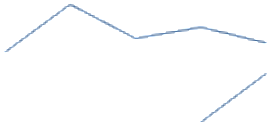


Action Plan for Lead Indicators

There was one KPI showing as red for the in-month September position.

There were no KPIs showing as amber for the in-month September position.

Accounts Payable - NHS PSPP

HD High Level - KPIs Sep 2025	Target	31/12/2024	31/03/2025	30/06/2025	30/09/2025	Trend
		Accounts Payable				
PSPP Compliance non NHS	95%	97.8%	96.4%	96.8%	96.2%	
PSPP Compliance NHS	95%			80.2%	85.8%	

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 2 reporting 85.8%

What are we doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice on hold data to help address the performance.

Accounts Payable

For information - All Wales performance in relation to P2P as at the end of September 2025.

All Wales Accounts Payable data @ end September 2025	AB	BCU	C&V	CTM	DHCW	HEIW	HD	POWYS	PHW	SBU	VEL	WAST	TOTAL
Number of Invoices on Hold	6,317	7,825	7,641	6,742	219	518	2,833	693	1,171	5,719	2,538	695	**42,911**
Value of Invoices on Hold £m	9.690	15.486	25.796	12.788	2.285	5.166	8.427	10.400	6.836	17.821	6.605	2.736	**124.036**
Number of Invoices on hold, older than 30 days	4,406	5,166	5,042	4,613	86	105	1,647	428	731	3,641	1,664	360	**27,889**
Number of invoices on No PO No Pay Hold	1,037	820	297	770	12	13	145	85	115	1,152	99	101	**4,646**
Number of invoices - Top 15 suppliers for NPNP	522	300	68	337	3	1	29	15	23	618	14	12	**1,942**
Number of invoice lines on a Receipting hold	4,502	5,003	5,704	4,911	102	77	2,649	554	415	3,929	1,956	426	**30,228**
Priority Supplier Programme - Rebate income to date	£20,951	£57,651	£26,313	£56,444	£2,511	£526	£15,578	£2,574	£2,239	£48,643	£30,483	£25,510	**£289,423**
Agreed Invoice Exception approval implementation	Mar-26	No	No	Sep-25	Live	No	No	No	Jan-26	Oct-25	Live from Jun 25	No	
Reviewed governance of data load submissions	No	No	No	No	No	No	No	Yes	Yes	Yes	No	Yes	

Whilst there has been a slight deterioration from the previous month, performance continues to be the best of the larger Health Boards

Since the preparation of this report, implementation date of February 2026 has been agreed. Data load governance has also been reviewed.

Key

- Deterioration on Previous Month
- Same as Previous Month
- Improvement on Previous Month

Appendix 1 – Performance for the period to 30th September 2025

HD High Level - KPIs Sep 2025	Target	31/12/2024	31/03/2025	30/06/2025	30/09/2025	Trend
Financial Information						
Professional Influence Savings - YTD		£16.173 m	£18.171 m	£2.217 m	£4.398 m	
Employment Services Payroll Services						
NWSSP Pay Accuracy	99.6%	99.95%	99.96%	99.98%	99.98%	
Overall Pay Accuracy	99.6%	99.86%	99.89%	99.93%	99.91%	
Organisation KPIs Recruitment						
% of vacancy creation to unconditional offer within 71 days		86.3%	80.0%	92.4%	86.6%	
Vacancy creation to unconditional offer	71	50.0	50.8	49.6	52.2	
% of vacancies approved within 10 working		80.2%	79.5%	81.5%	91.5%	
Time to Approve Vacancies	10	8.0	7.4	9.0	5.9	
% of vacancies shortlisted within 3 working		94.8%	92.5%	95.1%	90.4%	
Time to Shortlist by Managers	3	3.3	1.2	1.1	1.7	
% of interview outcomes notified within 3 working		85.8%	91.3%	80.9%	88.5%	
Time to notify Recruitment of Interview Outcome	3	1.5	1.6	2.3	1.6	
NWSSP KPIs Recruitment						
% of Vacancies advertised within 2 working of receipt	95.00%	98.9%	100.0%	100.0%	100.0%	
Time to Place Adverts	2	1.6	1.8	1.6	1.8	
% of applications moved to shortlisting within 2 working of vacancy closing		100.0%	100.0%	100.0%	100.0%	
Time to Send Applications to Manager	2	1.0	1.1	1.2	1.1	
% of conditional offer letters sent within 4 working	95.00%	94.5%	100.0%	100.0%	100.0%	
Time to send Conditional Offer Letter	4	4.0	3.8	3.2	3.6	
Procurement Services						
Procurement savings - YTD		Target £2.751m Actual £4.676m	Target £3.012m Actual £4.784m	Target £0.983m Actual £1.983m	Target £2.046m Actual £3.973m	
Accounts Payable						
PSPP Compliance non NHS	95%	97.8%	96.4%	96.8%	96.2%	
PSPP Compliance NHS	95%			80.2%	85.8%	
Primary Care Services						
Primary Care payments made accurately and to timescale	100%	100%	100%	100%	100%	
Patient assignments actioned within 24 hours	100%	100%	100%	100%	100%	
Urgent medical record transfers to/from GPs and other Primary Care agencies within 2 working days	100%	100%	100%	100%	100%	
Cascade Alerts issued within timescale	100%	100%	100%	100%	100%	
Audit & Assurance						
Audits reported to agreed Audit Committee (Excluding External Factors)	80%	50%	74%	Not Applicable	88%	
% of audit outputs in progress		19%	13%	16%	27%	
Report turnaround management response to Draft report - YTD	80%	82%	81%	Not Applicable	86%	
Report turnaround draft response-final- YTD	80%	100%	100%	Not Applicable	100%	

Appendix 2 – All Wales Performance for the period to 30th September 2025

ALL WALES KPIs		31/12/2024	31/03/2025	30/06/2025	30/09/2025	Trend
Primry Care Services						
Prescription - Payment Month keying Accuracy rates	99%	99.77%	99.84%	99.69%	99.81%	
Prescriptions processed (Apr - Sept)		43.2m	73.1m	7.03m	42m	
Welsh Risk Pool						
Time from submission to consideration by the Learning Advisory Panel	95%	100%	100%	100%	100%	
Time from consideration by the Learning Advisory Panel to presentation to the Welsh Risk Pool Committee	100%	100%	100%	100%	100%	
Holding sufficient Learning Advisory Panel meetings	90%	100%	100%	100%	100%	
Legal and risk						
Advice acknowledgement- 24hrs	90%	100%	100%	100%	100%	
Advice response – within 3 days	90%	100%	100%	100%	100%	
Student Awards						
% of NHS Bursary Applications processed within 20 days	100%	100%	100%	100%	100%	
Student Awards % Calls Handled	95%	97.7%	98.9%	98.9%	98.4%	
CTeS						
P1 incidents raised with the Central Team are responded to within 20 minutes	80%	100%	100%	100%	Not Applicable	
BACS Service Point tickets received before 14.00 will be processed the same working day	92%	100%	100%	100%	99%	
Digital Workforce						
DWS % Calls Handled	85%	91%	96%	96%	98%	
SMTL						
% of Monitoring reports completed within 14 days from receipt into the laboratory	91%	100%	100%	100%	100%	
% of Monitoring reports completed within 40 days from receipt into the laboratory	91%	100%	100%	100%	100%	
% delivery of Audited reports on time (NHS)	92%	Not Applicable	100%	100%	100%	
Pharmacy Technical Services						
Complaints	0	0	0	0	0	
Medical Examiner						
Deaths Scrutinised		100%	100%	100%	100%	
All Wales Laundry						
Orders dispatched meeting customer standing orders	90%	95%	94%	94%	97%	
Microbiological contact failure points	85%	100%	97%	97%	95%	
Number of pieces of returned linen by customer not meeting quality standards	<100	1	0	0	0	

Appendix 3 – Health Org Performance comparison 30th September 2025

KPIs Sep 25	KFA	Target	SB	AB	BCU	C&V	CTM	HD	PHW	PTHB	VEL	WAST	HEIW	DHCW
HEALTH ORG KPIs Financial Information														
Professional Influence Savings- YTD	Our Value		£5.669 m	£8.284 m	£8.249 m	£7.443 m	£5.684 m	£4.398 m	£0.743 m	£0.548 m	£1.787 m	£0.338 m	£0.014 m	£0.173 m
Employment Services														
Payroll Services														
NWSSP Pay Accuracy	Our Services	99.6%	99.98%	99.99%	99.96%	99.90%	99.95%	99.98%	99.81%	99.90%	100.00%	99.94%	99.72%	99.92%
Overall Pay Accuracy	Our Services	99.6%	99.81%	99.81%	99.81%	99.78%	99.66%	99.91%	99.72%	99.79%	99.78%	99.77%	99.37%	99.84%
Calls Handling % Quarterly Average	Our Services	95%						98.8%						
Orgalisation KPIs Recruitment														
Vacancy creation to unconditional offer	Our Services	71 days	73.2	59.6	64.5	98.2	69.4	52.2	52.8	64.4	47.9	71.6	49.1	57.0
Time to Approve Vacancies	Our Services	10 days	19.7	9.2	4.7	20.6	22.5	5.9	10.6	9.7	0.9	8.7	3.6	0.0
Time to Shortlist by Managers	Our Services	3 days	7.3	6.1	6.2	7.5	5.1	1.7	8.3	7.2	10.8	6.5	3.8	11.3
Time to notify Recruitment of Interview Outcome	Our Services	3 days	4.5	2.8	1.8	2.4	3.1	1.6	5.4	1.9	2.3	6.9	4.1	4.2
NWSSP KPIs Recruitment														
Time to Place Adverts	Our Services	2 days	1.4	1.5	1.6	1.4	1.4	1.8	1.9	2.0	1.3	1.3	1.3	1.6
Time to Send Applications to Manager	Our Services	2 days	1.0	1.1	1.0	0.9	0.8	1.1	1.0	1.0	1.0	1.0	1.1	1.0
Time to send Conditional Offer Letter	Our Services	4 days	3.7	3.5	3.7	3.5	3.7	3.6	3.6	3.8	3.4	4.0	3.7	3.4
Calls Handling % Quarterly Average	Our Services	95%						98.9%						
Procurement Services														
Procurement Savings- YTD	Our Value		Target £2.815m Actual £4.204m	Target £5.061m Actual £7.569m	Target £3.339m Actual £6.522m	Target £4.291m Actual £6.396m	Target £2.913m Actual £4.564m	Target £2.046m Actual £3.973m	Target £0.409m Actual £0.536m	Target £0.128m Actual £0.511m	Target £0.255m Actual £1.406m	Target £0.005m Actual £0.055m	Target £0.001m Actual £0.000m	Target £0.000m Actual £0.000m
Accounts Payable														
Call Handling% - Quarterly Average	Our Services	95%						98.6%						
PSPP Compliance non NHS	Our Services	95%	96.7%	96.9%	96.9%	96.6%	96.2%	96.2%	97.8%	91.5%	96.4%	98.8%	98.3%	99.0%
PSPP Compliance NHS	Our Services	95%	94.4%	91.5%	87.8%	76.4%	86.8%	85.8%	93.6%	86.3%	81.7%	91.0%	95.5%	95.4%
Audit & Assurance														
Audits reported to Agreed Audit Committee (Excluding External Factors)	Our Services	80%	100%	89%	78%	100%	100%	88%	100%	33%	100%	100%	86%	100%
% of Audit outputs in progress	Our Services		26%	29%	18%	20%	16%	27%	33%	13%	18%	35%	36%	23%
Report turnaround (15 days) management response to Draft report - YTD	Our Services	80%	0%	Not Applicable	60%	100%	100%	86%	100%	100%	100%	100%	100%	67%
Report turnaround (10 days) draft response-final- YTD	Our Services	80%	100%	Not Applicable	100%	100%	100%	100%	100%	100%	Not Applicable	100%	100%	100%
Primary Care Services														
Primary Care payments made accurately and to timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Patient assignments actioned within 24 hours	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Urgent medical record tralsfers to/from GPs and other Primary Care Agencies within 2 working days	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Cascade Alerts Issued within timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A

Appendix 4 – Outcome Reporting (Our Services)



GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

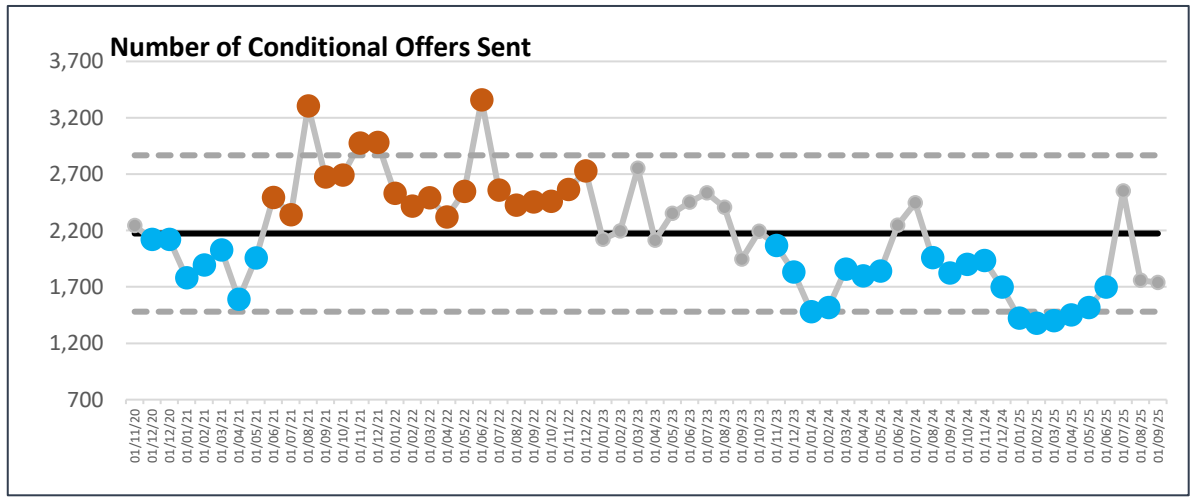
For information - All Wales Audit & Assurance performance at end of September 25.

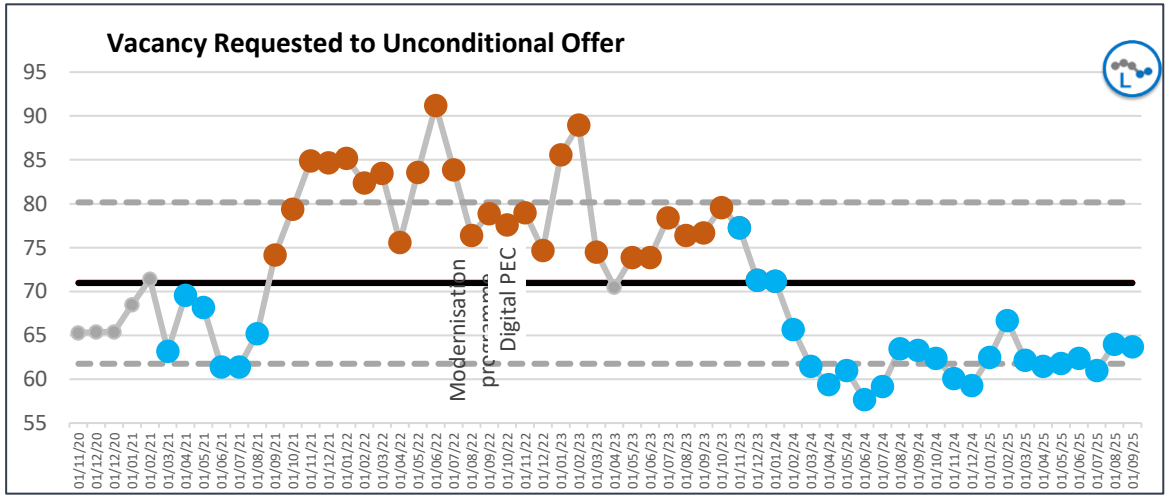
Client	Total Reviews Planned	Audits Reported (Draft / Final)	Audits in Progress	On Track/ Achieved Proposed Audit Committee	Report turnaround fieldwork to draft reporting [10 days]	Report turnaround management response to draft report [15 days]	Report turnaround draft response to final reporting [10 days]
Aneurin Bevan	28	14.3%	28.6%	88.89%	100.0%		
Betsi Cadwaladr	33	27.3%	18.2%	77.78%	100.0%	60.0%	100.0%
Cardiff & Vale	35	11.4%	20.0%	100.00%	100.0%	100.0%	100.0%
Cwm Taf Morgannwg	32	9.4%	15.6%	100.00%	100.0%	100.0%	100.0%
DHCW	13	30.8%	23.1%	100.00%	100.0%	66.7%	100.0%
HEIW	11	27.3%	36.4%	85.71%	100.0%	100.0%	100.0%
Hywel Dda	30	23.3%	26.7%	87.50%	100.0%	85.7%	100.0%
Joint Commissioning Committee	4	0%	0%				
NHS Wales Performance & Improvement	4	25.0%	0%	100.00%	100.0%		
NWSSP	19	15.8%	15.8%	100.00%	100.0%	100.0%	100.0%
PHW	12	25.0%	33.3%	100.00%	100.0%	100.0%	100.0%
Powys THB	24	16.7%	12.5%	33.33%	100.0%	100.0%	100.0%
Swansea Bay	27	18.5%	25.9%	100.00%	100.0%	0%	100.0%
Velindre	17	23.5%	17.6%	100.00%	100.0%	100.0%	
WAST	20	15.0%	35.0%	100.00%	100.0%	100.0%	100.0%
Total	**309**	**18.4%**	**22.0%**	**91.76%**	**100.0%**	**79.4%**	**100.0%**

Employment Services – Recruitment

For information - All Wales performance in relation to recruitment time to hire for the last 12 months ending September 25.

Recruitment Org	Target	Vacancy Creation to Unconditional Offer												Trend
		Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	
AB	71	67	76	68	70	64	64	58	59	61	58	62	60	
BCU	71	66	61	57	58	58	56	60	58	63	68	64	65	
CV	71	87	82	75	81	88	95	88	86	94	102	104	98	
CTM	71	72	72	75	74	76	74	70	68	70	71	70	69	
HD	71	52	55	50	56	48	51	48	49	50	49	55	52	
HEIW	71	62	53	44	61	66	47	60	48	58	63	55	49	
DHCW	71	46	39	45	57	53	32	34	58	46	48	59	57	
NWSSP	71	60	49	50	61	56	61	58	54	58	42	52	57	
PTHB	71	72	70	70	76	70	81	65	68	71	58	68	64	
PHW	71	58	52	55	52	59	63	55	59	58	59	55	53	
SBU	71	65	65	63	68	71	72	76	73	70	70	80	73	
VEL	71	51	50	55	49	67	54	55	50	54	50	57	63	
WAST	71	76	79	72	77	76	76	84	96	76	78	63	72	
All Wales	71	62	60	59	63	67	62	62	62	62	61	64	64	





Employment Services – Recruitment

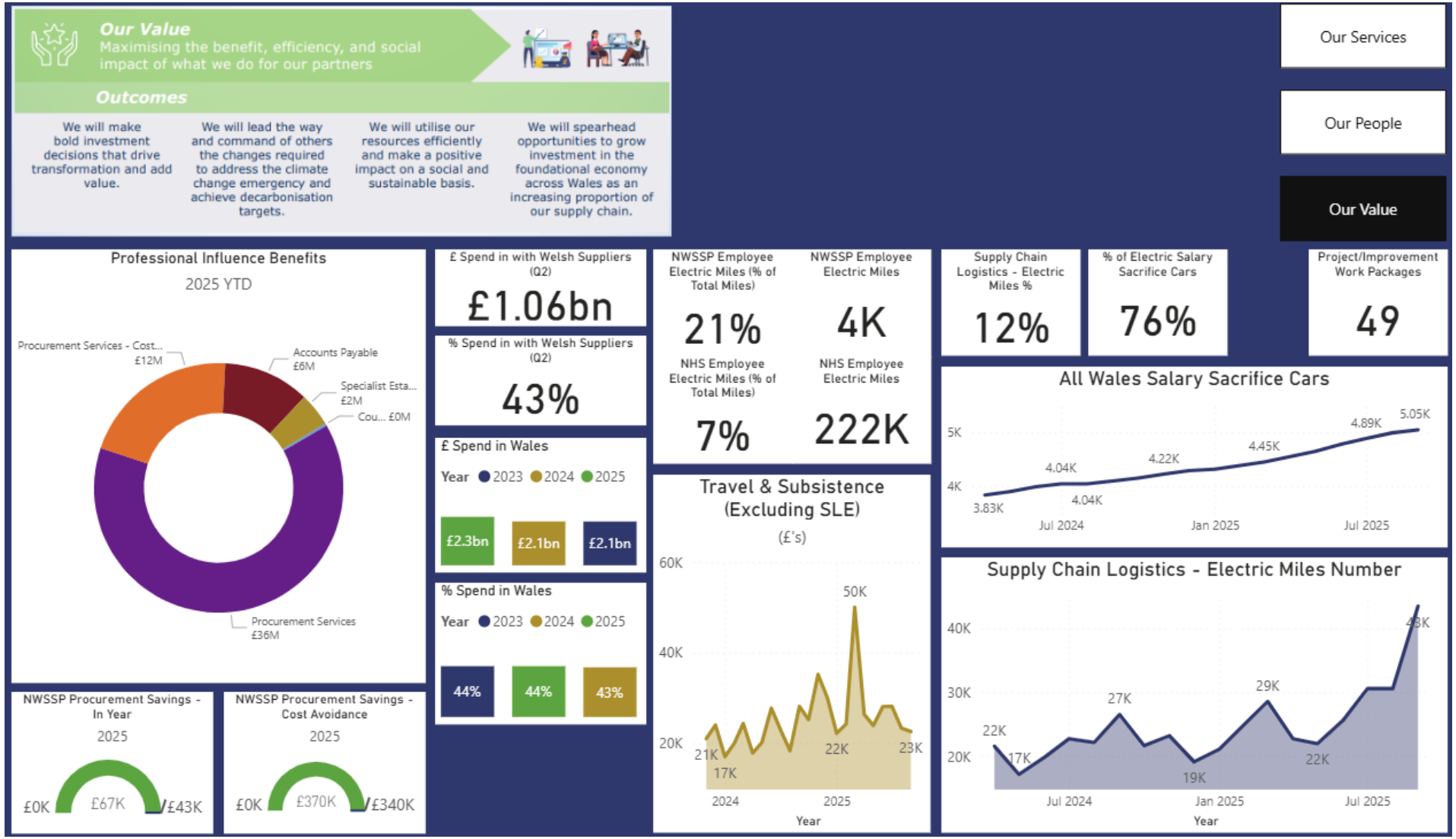
For information - The charts below show the time to hire performance for the individual organisations April – September 25.



Appendix 4 – Outcome Reporting (Our People)



Appendix 4 – Outcome Reporting (Our Value)



Mileage Claims

For information - The table below provides an overview of the total mileage claims by organisation, along with the proportion that are electric miles in September 25.

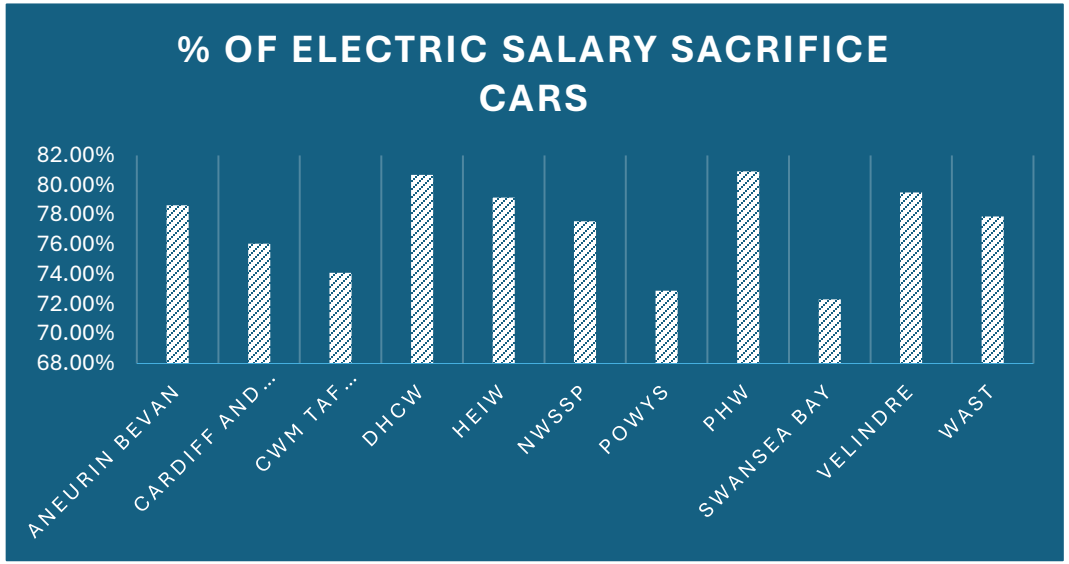
Organisation	Total Miles Claimed	Electric Miles Claimed	Electric Miles %
Cardiff & Vale	190,700	9,434	5%
WAST	137,695	15,218	11%
DHCW	10,282	2,087	20%
CVB	8,124	0	0%
Public Health	72,845	6,403	9%
AB	410,869	28,742	7%
NWSSP SLE	286,670	16,864	6%
NWSSP exc SLE	18,246	3,894	21%
BCU	569,107	51,029	9%
Powys	157,527	6,134	4%
HEIW	12,228	1,264	10%
Hywel Dda	434,042	32,642	8%
Cwm Taf	398,693	27,707	7%
Velindre	16,180	702	4%
Swansea Bay	352,847	19,625	6%
Total	3,076,054	221,747	7%

Salary Sacrifice Cars

For information - The table and chart below provide an overview of the total number of vehicles managed under the NWSSP scheme, along with the proportion that are electric as of September 25.

Hywel Dda currently manages its own scheme but has agreed to move to the NWSSP.

Organisation	Total Cars	Live Electric	Live Hybrid	Live Petrol	% Electric
Aneurin Bevan	932	733	172	27	**78.65%**
Cardiff and Vale	990	753	192	45	**76.06%**
Cwm Taf Morgannwg	857	635	182	39	**74.10%**
DHCW	145	117	24	4	**80.69%**
HEIW	72	57	13	2	**79.17%**
NWSSP	312	242	68	2	**77.56%**
Powys	107	78	24	5	**72.90%**
PHW	152	123	26	3	**80.92%**
Swansea Bay	943	682	209	52	**72.32%**
Velindre	122	97	22	3	**79.51%**
WAST	416	324	81	11	**77.88%**
TOTAL	5,048	3,841	1,013	193	**76.09%**

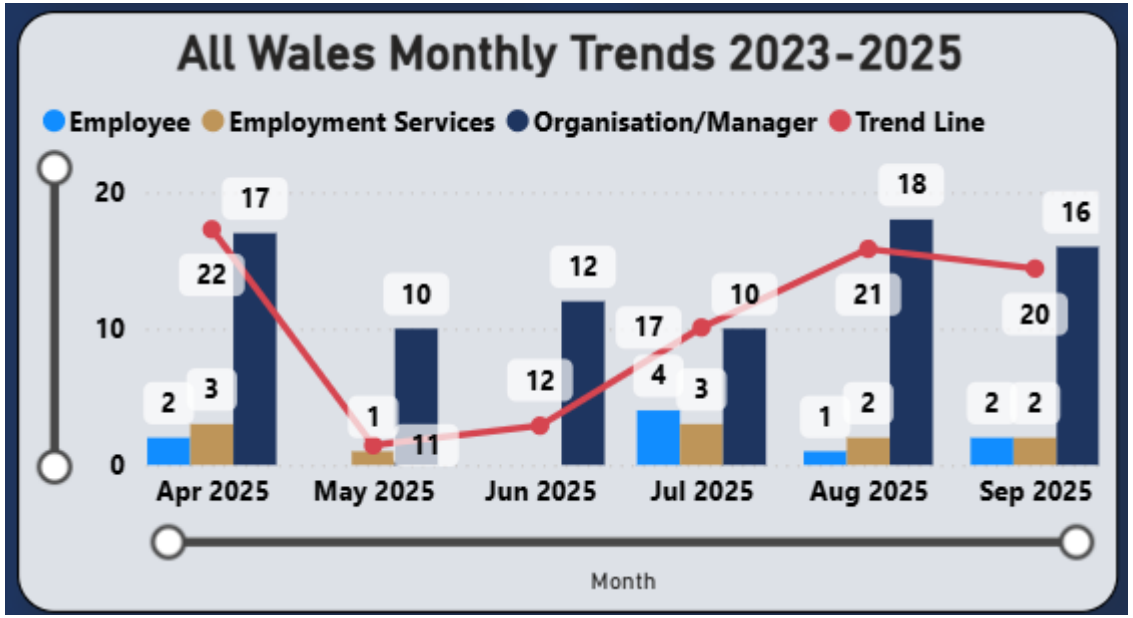


Procurement Savings

Supporting information for the Procurement savings - The table below provides an overview of the identified cash releasing procurement savings by procurement team for April – September 25.

HB	HDT	
TEAM DELIVERING SAVINGS	Target	Actual
HYWEL DDA PROCUREMENT TEAM	£328,955	£560,182
NATIONAL - CLINICAL	£0	£191,381
NATIONAL - COMMISSIONING	£0	£12,443
NATIONAL - ENERGY	£1,179	£625
NATIONAL - HOTEL SERVICES AND TEXTILES	£0	£52,812
NATIONAL - ICT & OFFICE EQUIPMENT	£61,383	£104,459
NATIONAL - MAINTENANCE	£7,768	£51,114
NATIONAL - MEDICAL	£244,885	£331,427
NATIONAL - PHARMACY	£1,364,457	£2,668,781
NATIONAL - PROVISIONS	£37,714	£1
	£2,046,341	**£3,973,226**

For information - The chart below provides a summary of the payroll overpayment volumes for the organisation, based on data from the overpayments dashboard covering the period from April to September 25.



Note: The data was recorded as at the end of September.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership



Delivering Value, Innovation and Excellence through Partnership

6

12:40 PM, 0 Mins

---

6 - FOR APPROVAL

6.1

12:40 PM, 5 Mins

6.1 - FINANCIAL PROCEDURES

Huw Thomas (Hywel Dda UHB - Director of Finance)

For approval

Attachments

Financial Procedures FPC 16 December 2025.pdf

FP1049 Use of Consultancy.pdf

FP1049 EqIA Screening Tool.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Procedures
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Tim John, Head of Accounting and Statutory Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Each year planned reviews are undertaken of the financial procedures operated by Hywel Dda University Health Board (HDdUHB). The procedures, which set out the main financial system controls, are reviewed in terms of:

- Relevance
- Best practice
- Audit recommendations
- System change
- Health Board policy

The Finance and Performance Committee can take assurance that there is a robust review process in place in respect of financial procedures.

Cefndir / Background

The following procedures have been reviewed and are presented to the Finance and Performance Committee for approval:

- **Financial Procedure 1049** – Use of Consultancy

The purpose of these documents is to outline the key processes to be followed by Health Board staff in connection with the above-named financial procedures and to set out associated roles and responsibilities.

Asesiad / Assessment

- **Financial Procedure 1049** – Use of Consultancy

The financial procedures are covered by a specific Financial Procedures Equality Impact Assessment (EqIA) with no negative impact.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **APPROVE** the following updated financial procedures:

- **Financial Procedure 1049** – Use of Consultancy

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.13 Review and approve financial procedures on behalf of the Health Board
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Previous procedures, internal audit report recommendations, standing financial instructions.

Rhestr Termau: Glossary of Terms:	Included within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	HDdUHB Finance HDdUHB Local Counter Fraud Service NWSSP – Procurement Services

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial procedures are required to ensure sound financial control.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Financial procedures are required to ensure good governance and therefore minimise risk.
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Financial procedures are required to ensure good governance and sound financial control.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	EqIA has been undertaken with no negative impacts on those with protected characteristics.

Use of Consultancy

Procedure information

Procedure number: 1049

Classification: Financial

Supersedes: 2.0

Version number: 3.0

Date of Equality Impact Assessment: *Detail date of EqIA*

Approval information

Approved by: Finance and Performance Committee

Date of approval: *Enter approval date*

Date made active: *Enter date made active (completion by policy team)*

Review date: Enter review date (normally three years from approval date)

Summary of document:
This document provides details of the process to be followed when considering using the services of management consultants.

Scope:
Hywel Dda University Health Board wide

To be read in conjunction with:
Standing Orders Hywel Dda University Local Health Board (opens in a new tab)
Standing Financial Instructions (opens in a new tab)
Counter Fraud, Bribery and Corruption Policy (opens in a new tab)
Purchase to Pay Procedure (opens in a new tab)
Financial Procedures (opens in a new tab)

Patient information:
N/A

Owning group:
Finance Directorate
Date signed off by owning group

Executive Director job title:
Director of Finance

Reviews and updates:
1.0 – New Procedure – 28/10/2021
2.0 – Clarified definition of consultancy and included flowchart for assurance and approval process to be followed – 22/12/2022
3.0 – Review – *Enter approval date*

Keywords
Use of consultancy

Glossary of terms
HDdUHB - Hywel Dda University Health Board
SFIs - Standing Financial Instructions
FPC – Finance and Performance Committee
ARAC - Audit and Risk Assurance Committee
CEO - Chief Executive Officer
DoF - Director of Finance
ET - Executive Team

FRAUD, BRIBERY AND CORRUPTION

All staff are required to comply with the Health Board's policies and procedures and apply best practice in order to prevent Fraud, Bribery and Corruption. Staff should be made aware of their own responsibilities in protecting the Health Board from these crimes.

All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud or inappropriate actions and are protected by the All Wales Procedure for NHS Staff to Raise Concerns Policy (opens in a new tab). Anyone who suspects fraud or has any concerns reference Fraud Bribery and Corruption can make a referral by contacting the Counter Fraud Department by any of the following methods:

- Telephoning the office on 01267 266268,
- Emailing HDUHB.CounterFraudTeam.HDD@wales.nhs.uk,
- Making an online referral at https://reportfraud.cfa.nhs.uk or
- Making an anonymous referral by telephoning Crimestoppers on 0800 028 40 60.

Staff should refer to the Counter Fraud, Bribery and Corruption Policy (opens in a new tab) for further information.

Table of Contents

Introduction 5
Scope 5
Aim 5
Objectives 5
Roles and Responsibilities 5
Principles 5
Definition 5
Why appoint Consultants? 6
Alternatives 6
When not to use Consultants 6
Making the Case 7
Procedure to follow when considering Consultancy 7
Procurement process 7
Approval limits 8
Reporting 9
Post review and value for money 9
Monitoring 9
Appendix A – Definition of Consultancy and Professional Services 10
Appendix B - Flowchart 13

Introduction

This procedure details the guidelines set for the application and approval process for use of Consultancy services within Hywel Dda University Health Board (HDdUHB).

Scope

The procedure is applicable across the whole of Hywel Dda University Health Board (HDdUHB). It applies to all employees and Independent Members. The term “employees” includes all those who have a contract of employment or honorary contract with the HDdUHB, including volunteers and bank workers.

Aim

The aim of this document is to:

- Provide guidance for the use of Consultancy within Hywel Dda University Health Board (HDdUHB). This is to minimise the risk of incurring expenditure inappropriately and ensuring best value for money is achieved.

Objectives

The aim of this document will be achieved by the following objectives:

- Confirming the principles around definition of consultancy and when the Health Board would use Consultancy
- Providing clear procedures to follow when the decision has been made to use Consultancy
- Identifying the delegated limits for Consultancy spend
- Providing the reporting mechanism for Consultancy spend
- Review of outcomes

Roles and Responsibilities

Any Manager using Consultancy needs to undertake the actions outlined within this procedure. Approval needs to follow delegated limits which is outlined in ‘Approval limits’. The manager, with support from Procurement, will need to ensure there is a post project review as outlined in ‘Post review and value for money’.

Principles

Definition

Consultancy seeks to fill a knowledge gap. It is defined as **the provision to management of objective advice relating to strategy, structure, management or operations of an organisation**. It will usually be related to business change or transformation. Such advice will be provided outside the ‘business as usual’ environment when in-house skills are not available and will be time-limited. The consultants

delivering the service will operate outside of the client organisation's structure and staffing establishment, with payment based on the delivery of a defined service or output.

Consultancy often includes the identification of options with recommendations, or assistance with the implementation of solutions but typically not the delivery of business as usual activity (e.g. advising on legal risk or technical matters). Such contracts should usually be categorised as professional services, rather than consultancy services

The limits and processes set out in this procedure relate to Consultancy services. The use of professional services falls under the standard guidelines for non-pay expenditure set out in 1054 - Purchase to Pay procedure (opens in a new tab)

Areas where the need for Consultancy may arise, together with definition of Consultancy and Professional services, as identified by the Government guidance of 'Consultancy and Professional Services spend control' is included in Appendix 1.

Why appoint Consultants?

Typically, there are 3 main reasons why you may want to use consultants:

- the expertise the consultant offers
- their independent viewpoint
- the resources they provide

Alternatives

There are alternatives to using consultants and these should be tested before the commencement of any appointments process. These can be best summarised as follows:

- Use your own personnel: quite often over-looked but there may be capacity within the organisation in its broadest sense who could undertake an assignment particularly if an independent view is not required. This could be supplemented with some additional training but could be beneficial to the organisation and to the development of the individual.
- Secondments: the requirement may be suited to a short-term secondment opportunity through an individual[s] with some specific experience.
- University/Colleges: college placements might be a lower cost solution
- Recruitment Agencies: although sometimes costly the rates for appointing through an employment agency are invariably more cost effective than consultancy rates. There are however factors to consider such as term of employment and termination fees.

Before commencing with a consultancy arrangement, a full options appraisal should be carried out and the decision to proceed, if this is the chosen option, signed off by the senior responsible officer.

When not to use Consultants

Consultants should always be appointed for the right reasons particularly when the costs can sometimes be prohibitive. Consultants should not be used in some of the following circumstances:

- There is no clarity on what is required, they need to have a specific set of tasks and deliverables otherwise the potential for wasting money is significant
- Previous use of consultants has not yielded benefits expected. This will flag up issues with approach and involvement.
- Requiring consultants to perform tasks which are dependent upon factors and decisions outside their control
- Buying their name to give some credibility to a flawed or unfeasible project
- Using them as scapegoats to take the blame for unpopular actions
- Imagining they are miracle workers who can solve all organisational problems
- Believing they can save you the time and trouble of defining policies and objectives

Making the Case

Serious consideration should be given to appointing consultants in the first place and some thoughtful analysis up front is always good practice. Such information analysis might include:

- The purpose and scope of the work
- The results and outputs expected
- The proposed contract basis
- Estimated cost of the work
- Benefits to be derived and likelihood of being achieved
- Propose management arrangements for managing the work
- Assessment of the alternatives to the use of consultants
- An indication of any implementation consequences of the consultants' work
- Assess and declare any conflicts of interest, including any association with interested parties.

Procedure to follow when considering Consultancy

Procurement process

Procurement rules must be followed when considering Consultancy. You will need to contact the local Procurement department in the first instance to gain advice whether selection can be made from an existing Framework.

The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out in UK Regulations.

Contract Value (excluding VAT)	Minimum Competition*
< £5,000	At discretion of DoF
£5,000 - £25,000	3 written quotations

£25,000 - Procurement Act 2023 threshold and/or the Health Service Procurement (Provider Selection Regime Wales) 2023	4 tenders
Above Procurement Act 2023 threshold and/or the Health Service Procurement (Provider Selection Regime Wales) 2023	5 tenders
Contracts above £1m	WG approval required

*subject to existence of suitable suppliers

Approval limits

Approval requirements for consultancy expenditure are set within the Health Board Scheme of Delegation and somewhat differ to general non-pay expenditure:

	Consultancy	**General Non-Pay**
Executive Directors	≤ £25,000	≤ £100,000
Chief Executive Officer/ Director of Finnace	≤ £25,000	≤ £500,000
CEO & DoF	-	£500,000 < X ≤ £1,000,000
CEO and Executive Team	£25,000 < X ≤ £1,000,000	£500,000 < X ≤ £1,000,000
Board (following CEO/ ET approval)	£25,000 < X ≤ £1,000,000	> £1,000,000
Welsh Government	> £1,000,000	> £1,000,000

Each Executive Director can approve Consultancy up to £25,000. Anything over £25,000 needs approval by the Board. The first step is agreement by the CEO and Executive Team. This is discharged by the Financial Control Sub Group.

In addition, scrutiny in the use of consultancy is undertaken by the Finance and Performance Committee (FPC), prior to consideration for approval by the Board.

The flowchart in Appendix B sets out the correct process to be followed.

Managers requesting the use of consultancy should plan ahead and be aware of the timescale required for approval before they can engage a consultant.

Reporting

Consultancy spend is reported annually as a matter of course through the Statutory Annual Accounts, in addition Procurement will maintain a central record of consultancy engagements which will be reported through the Finance Assurance report at the Audit and Risk Assurance Committee (ARAC).

Post review and value for money

Once the assignment is completed it is also good practice to have an exit meeting to identify issues, lessons learnt, were objectives met, what aspects were good and which bad or can be done better. This should be recorded and kept as a reference point for any future assignments with that supplier.

The project lead should ensure this is completed within 4 weeks of the end of the assignment and made available to Finance/Procurement to be reported at the next FPC meeting. The project lead should use the post project evaluation template provided by Procurement.

Monitoring

The monitoring and review of this procedure is the responsibility of the Finance Department. Reviews will be undertaken in line with the Health Board's review policy, which is every 3 years, or when changes are identified prior to the required review date.

Appendix A – Definition of Consultancy and Professional Services

Extract from the Gov.co.uk website 'Consultancy and professional services spend controls'

Consultancy services

These are services:

- that provide advice to fill a knowledge gap. This can be to identify options and recommendations, or advice to assist with implementing solutions; it will usually be related to business change or transformation, so will be time-limited
- where the individuals (consultants) delivering the service (output) will operate outside of the client organisation's structure and staffing establishment
- where payment is based on the delivery of a defined service (output). This may require a team of consultants working for an extended period of time, or could require a single consultant whose fee will be calculated based on the time taken to deliver the output
- that should not involve the individuals (consultants) working in a Business as Usual (BAU) environment (e.g. advising on legal risk or technical matters). Such contracts should usually be categorised as professional services, rather than consultancy services

Professional Services

These are services:

- that are not defined as consultancy
- that are not purely or mostly advisory (unless the advice is part of a formal report that is required to undertake business as usual activities e.g. a legal opinion or technical report)
- where the individuals delivering the service (output) will operate outside the client organisation's structure and staffing establishment
- where payment is generally based on the delivery of defined outputs or outcomes (e.g. task and finish work)
- that, as with consultancy, deliver a service (output) that may require a team working for an extended period of time, or may be provided by an individual whose fee will be calculated based on the time taken to deliver the service
- that are often delivered in a BAU environment but may relate to the delivery of a project or programme. They can be responsible for a non-BAU output (e.g. legal advisers recruited to provide advice on a specific issue)
- that seek to fill gaps to assist the procuring organisation to deliver or implement an operational service, including those that are BAU. As such, professional services should not be purely (or mostly) advisory and contracts should be defined according to the delivery of outputs and deliverables rather than the number of days of effort utilised
- where for the purposes of the control there is no need for individuals to demonstrate any specific skills, qualifications or experience
- where contractors can be paid according to time worked or for delivery of a defined output or service. This can include Managed Services

Areas where consultancy/professional services may be required

Strategy and Organisation and Change Management are likely to be consultancy but reference to the definitions should be made on a case by case basis when deciding which process to follow and advice sought from Procurement if there is any doubt.

Strategy

The provision of strategic objective advice including advice relating to corporate strategies, appraising business structures, Value for Money reviews, business performance measurement, management services, product or service design, and process and production management.

Organisation and Change Management

Provision of objective advice relating to the strategy, structure management and operations of an organisation in pursuit of its purposes and objectives. Advice related to long range planning, organisation restructure, rationalisation of services, and general business appraisal of organisations.

Finance/Audit

The provision of objective finance advice including advice relating to corporate financing structures, accountancy, control mechanisms and systems. This includes both strategic and operational finance.

Information Technology/Information Systems

The provision of objective IT/IS advice including that relating to IT/IS systems and concepts, strategic IT/IS studies and development of specific IT/IS projects. Also includes advice related to defining information needs, computer feasibility studies, making computer hardware evaluations and to e-business.

Legal

The provision of external legal advice and opinion including advice insofar as it relates to the policy formulation and strategy development particularly on commercial and contractual matters.

Property & Construction

Provision of specialist advice relating to property services and estates including portfolio management, design, planning and construction, tenure, holding and disposal strategies.

Human Resources

The provision of objective HR advice including advice on the formulation of recruitment, retention, manpower planning and HR strategies, and advice and assistance relating to the development of training and education strategies.

Technical

The provision of technical advice including the provision of technical studies, prototyping and technical demonstrators, concept development, project and task based technical advice.

Marketing & Communications

The provision of objective marketing and communications advice including advice on the development of publicising and the promotion of the Department's Business Support programmes, including advice on design, programme branding, media handling, and advertising.

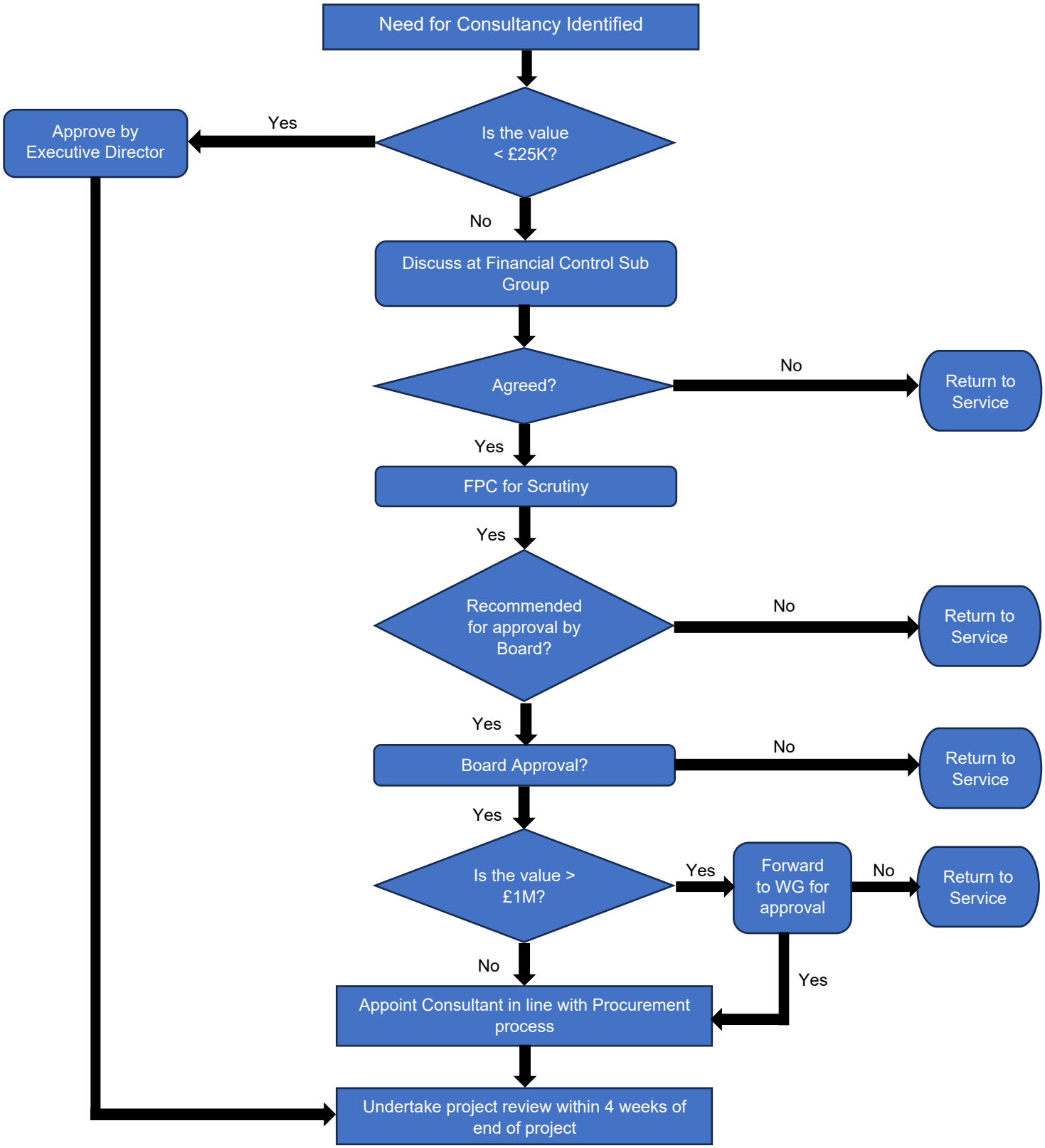
Procurement

The provision of objective procurement advice including advice in establishing procurement strategies.

Project and Programme Management (PPM)

The provision of advice relating to ongoing programmes and one-off projects. Advisory support in assessing, managing and/or mitigating the potential risks involved in a specific initiative; work to ensure benefits realisation.

Appendix B - Flowchart



Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full EqIA.

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Director and Directorate	Hywel Dda University Health Board wide
Service Area	Hywel Dda University Health Board wide

Title of Procedure, Project, Proposal, Policy being screened:	1049 – Use of Consultancy

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The aim of this document is to provide guidance for the use of Consultancy within the Health Board. This is to minimise the risk of incurring expenditure inappropriately and ensuring best value for money is achieved.

The aim of this document will be achieved by the following objectives:

- Confirming the principles around definition of consultancy and when the Health Board would use Consultancy
- Providing clear procedures to follow when the decision has been made to use Consultancy
- Identifying the delegated limits for Consultancy spend
- Providing the reporting mechanism for Consultancy spend
- Review of outcomes

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

- Standing Orders Hywel Dda University Local Health
- Standing Financial Instructions
- Counter Fraud, Bribery and Corruption Policy
- Purchase to Pay Procedure
- Financial Procedures

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact)**.**

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqIA must be undertaken: Equality Impact Assessments (EqIAs) (sharepoint.com)

Age Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on people of different age groups.					
Disability Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will not have an impact on those with a disability.					
Gender Reassignment Is it likely to affect those who either: • Have undergone, intend to undergo or are currently undergoing gender reassignment. • Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no effect on individuals who have undergone gender reassignment.					
Marriage / Civil Partnership Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment. Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: This group is in relation to workplace and employment only and is therefore not relevant for this policy.					
Pregnancy and Maternity Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on those who are pregnant or are on maternity.					
Race / Ethnicity Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?					
Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on people of different race or ethnicity.

Religion or Belief
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on people who have a religion or belief.

Sex
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on one sex more than the other.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on individuals regardless of their sexual orientation.

Armed Forces Community
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified:
The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on members of the Armed Forces and their families.

Socio Economic Duty
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.

For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see:
more-equal-wales-socio-economic-duty

Positive Impact		Negative Impact		No Impact	✓

Justification of impact identified: The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on individuals of different socio economic groups.					
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.					
Positive Impact		Negative Impact		No Impact	✓
Justification of impact identified: The aim of this document is to provide guidance for the use of Consultancy within the Health Board. It will have no impact on opportunities for people to use the Welsh language.					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: Equality Impact Assessments (EqIAs) (sharepoint.com)

Screening Completed by:	Name	Sarah Morgan
	Title	Finance Analyst
	Contact details	sarah.morgan16@wales.nhs.uk
	Date	25/11/2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Timothy John
	Title	Head of Accounting & Statutory Reporting
	Contact details	Timothy.john@wales.nhs.uk
	Date	25.11.25
Guidance has been provided by Diversity & Inclusion Team:	Name	Kylie Daniels
	Title	Senior Diversity and Inclusion Officer
	Contact details	Kylie.daniels@Wales.nhs.uk
	Date	05/12/2025
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

6.2

12:45 PM, 15 Mins

6.2 - BUSINESS CASE: 7-DAY CLINICAL STREAMING AND SDEC BUSINESS CASE SUMMARY

Huw Thomas (Hywel Dda UHB - Director of Finance)

For approval

Attachments

7-Day Clinical Streaming and SDEC Business Case Summary FPC 16 December 2025.pdf



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

7 Day Clinical Streaming, Hospital@Home and Same Day Emergency Care Business Case

Finance and Performance Committee, 16 December 2025

Introduction

- The Clinical Streaming Services (CSS), Hospital@Home and Same Day Emergency Care (SDEC) Business Case proposes moving from the existing five-day to a seven-day model for Hywel Dda University Health Board.

- The proposal is based on detailed financial analysis, national recommendations and findings, and the evaluation of a pilot weekend undertaken in March 2025.

- As such the Business Case contains inherent complexity, relating to the consultation, stakeholder engagement, interdependencies, failure demand and the ‘how’ of realising the ambition to overlay fiscal responsibility in a way that integrates and enables the preventive operational ‘shift left’

- The aim is to improve urgent and emergency care performance, patient outcomes, and align with national priorities.

Strategic Fit

- Aligns with the National Six Goals Programme for Urgent and Emergency Care (UEC) and Single Point of Access Framework.

- Supports Ministerial Priorities for UEC

    - *UEC1: Implement effective Community Based Falls Response Services. To enhance outcomes and experience for those who fall by improving initial response times, reducing the risk of long lies and ensuring service users access community falls pathways when appropriate*

    - *UEC2: Implement a robust 'Single Point of Access' (SPOA) for UEC. Create in each health board area that simplifies access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, to improve patient outcomes regardless of where they present*

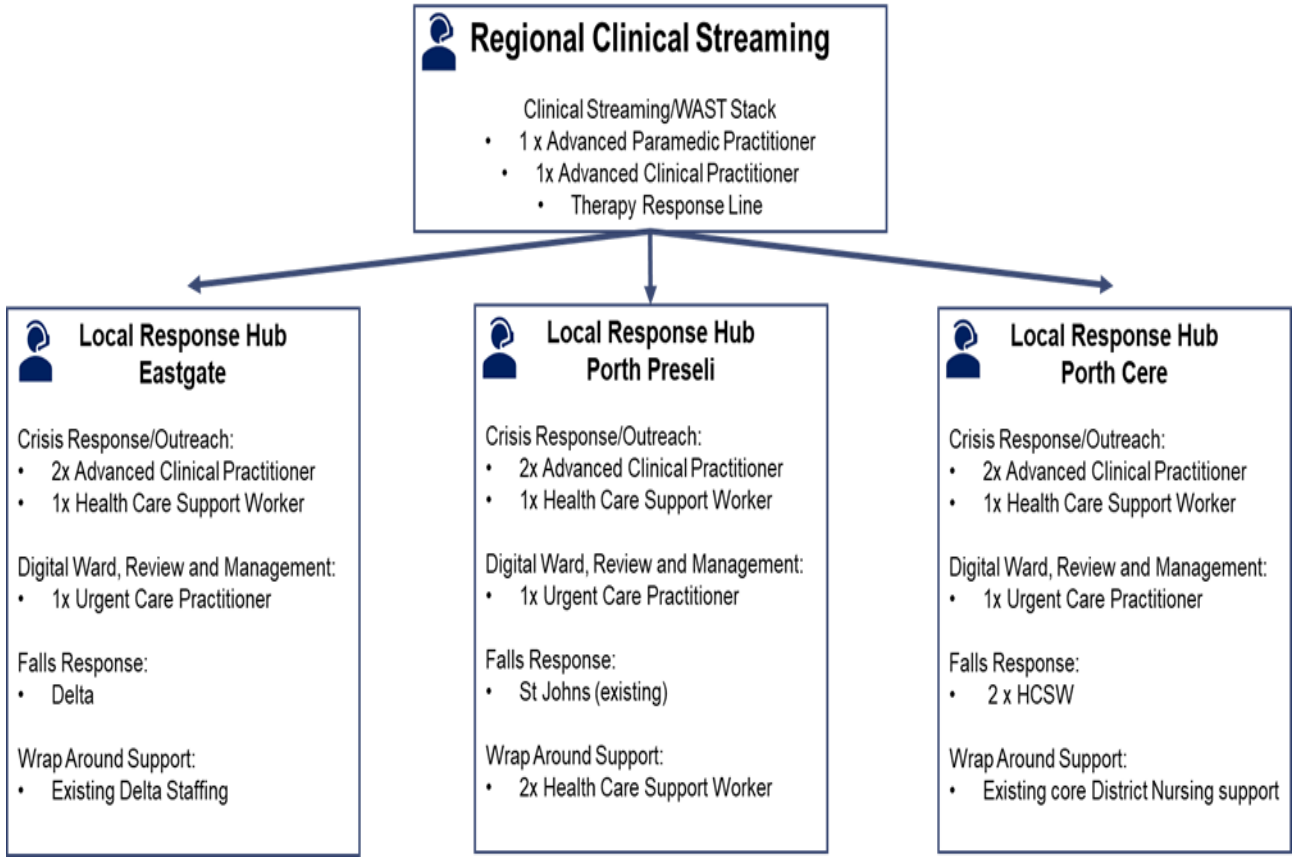
- Alignment with the Health Board's UEC Accelerated Transformation Programme and Heath Board's Emergency Department's Get It Right First-Time (GIRFT) recommendations.

- Promotes integrated, community-based care and reduces reliance on Emergency Departments

Case for Change

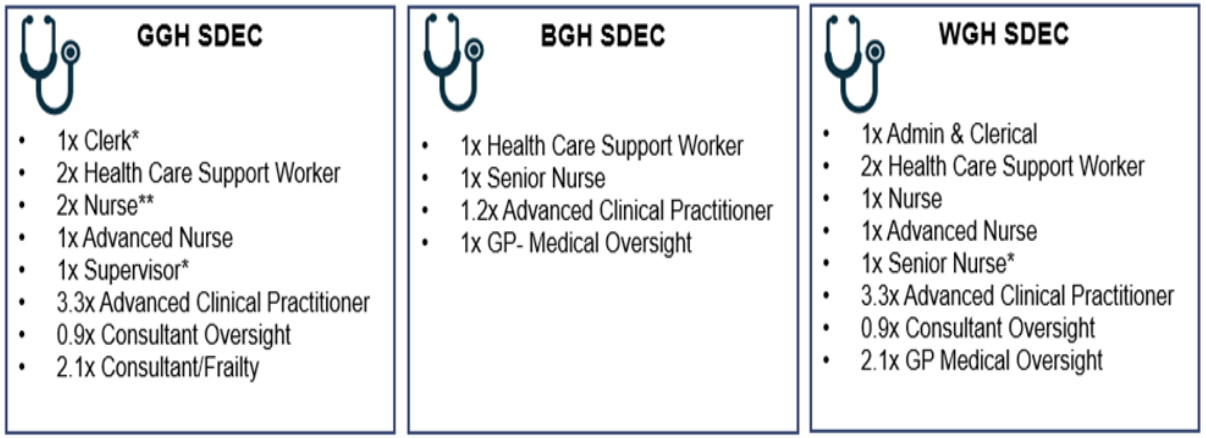
- Weekend care delays and poorer outcomes for patients.
- Increased ED attendances and ambulance handover delays.
- Limited access to alternative care pathways on weekends.
- Hospital@Home currently lacks weekend cover.
- The Health Board is in Targeted Intervention for UEC, opportunity to improve performance.
- The local Weekend Pilot showed significant potential benefits in terms of cost avoidance and patient outcomes
- The proposed models have been Clinically led, developed and unanimously agreed with Clinicians and Operational staff over the last year
- Current sustainability of UEC model, no change was not seen as an option.

Proposed Model: Clinical Streaming and Hospital@Home



- Please note this is based on per day basis, Saturday and Sunday, 8am – 8pm basis (please refer to appendices for costings). Pharmacy is not included for Weekend working but will provide 3x senior pharmacy support, one per County, Monday to Friday, 9am-5pm, to support the model
- The model is inclusive to the population crisis needs with a particular focus on frailty, falls, complex respiratory and an alternative to admission option where safe and appropriate for our most vulnerable citizens. This clearly aligns with the UEC Ministerial priorities.
- This model enables 7-day virtual ward functionality through Hospital@Home. Currently this is only 4 days a week as patients have to be discharged every weekend as a streaming hub is not operating to monitor.
- Therapy funding in the Clinical Streaming Model will be used to support a Therapy Response Line at weekends
- There is direct access for Care and Nursing Homes alongside other clinical professionals
- Integrated Level one, Level two and Level three falls response, seven days a week
- Local response teams (ACPs, Out of Hours (OOHs), Pharmacy, Therapies, District Nurses).
- Regional Clinical triage with cross-hub coordination.
- Integration with Out of Hours, Therapies, and Intermediate Care teams. Pathways have already been built up over the week working between the CSS which have shown positive results, this will be continued in to the weekend.
- Engagement through a number of key stakeholder workshops, inclusive of Primary Care, Secondary Care, Local Authority and Llais representatives has led to the consensus on the staffing model put forward.

Proposed Model: SDEC



- Please note that this is based on Whole Time Equivalent (WTE) on a per day basis
- The Optimal SDEC model refers to implementing a model which strengthens the current weekday services and provides cover for weekend working.
- The Optimal SDEC model will enable partnership working with Clinical Streaming Services and Virtual Wards across 7-days, enabling direct referrals from WAST (ambulance service) and Out-of-Hours GP services. This integration will allow rapid discharge and admission avoidance
- Will enable the stream of patients from CSS to SDEC and back to the community to support improvement of A&E and hospital flow at weekends

Clinical Streaming and Hospital@Home Benefits

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Clinical Streaming

Local pilot evaluation demonstrated:

- Cost avoidance and improved patient experience.
- Faster discharge and reduced hospital admissions
- Enhanced staff collaboration and morale, with positive patient and staff stories.

National/International evidence from similar models (e.g., Clinical Streaming Hospital at Home, Virtual Wards) shows:

- Denmark - Pre-ED Clinical Streaming Hubs:
  - Decreased emergency department overcrowding by diverting low-acuity cases early.
  - Increased patient safety through the use of validated triage and symptom-based protocols.
  - Demonstrated more efficient use of resources such as ambulances, ED personnel, and beds.
  - Improved system performance via digital integration and coordinated care pathways.
  - Enhanced patient experience by reducing unnecessary hospital visits.
- Nationally Streaming and Hospital@Home model has shown to produce significant savings, with high patient satisfaction and safety.
- Community-based interventions are found to reduce unnecessary admissions and follow-ups, saving thousands of pounds per patient.
- Evidence indicates Hospital@Home services led to major reductions in 111 calls, ambulance incidents, ED attendances, and emergency admissions.
- These models are especially effective for complex and frail patients, improving outcomes and experiences.

Overall, evidence strongly supports investing in seven-day clinig hubs for cost savings and better care.

Same Day Emergency Care Benefits

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Health Board Pilot Weekend:

- SDEC 91% same-day discharge rate, reducing unnecessary admissions and improving patient flow.
- SDEC absorbed 56% of all ED medical takes during the pilot, easing pressure on Emergency Departments.

National Data:

- SDEC can discharge 38%–92% of patients the same day, reducing risks of hospital-acquired infections and deconditioning.
- SDEC supports improved patient flow, reduces Monday backlogs, and aligns with NHS Long Term Plan requirements.
- Financially, avoiding unnecessary admissions generates cost savings and optimizes resource use.
- Case studies reinforce that seven-day services improve safety, hospital flow, and system efficiency.

Overall, the implementation of a 7-day SDEC service represents a high-impact intervention that improves patient safety, enhances hospital flow, and delivers measurable cost efficiencies while meeting national policy requirements.

Clinical Streaming Financial Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Service	Band/Grade	Values	
		Establishment (WTE)	Estimated Cost (£)
CSH - Weekend		16.49	£1,373,802.81
Pharmacists		3.80	£309,798.67
Grand Total		20.29	£1,683,601.48

	Hospital Admission	ED attendance	LOS	Potential Cost Avoidance	Bed Saving
Weekend Pilot	19	34	5.75	4,154,318	16
Data Review	8	7	15.13	4,049,856	17

- The weekend Clinical Streaming (CS) model costs £1.7m per year.
- Two cost-benefit reviews were conducted, with Cost avoidance based on potential costs from hospital admissions and ED attendances:
  - Local pilot weekend data.
  - Three-Year inpatient data review for potential Clinical Streaming/Hospital@Home patients whose admissions could be avoided.
- Both evaluations suggest a potential bed saving of 16–17 beds per year (non-surge).
- Assumptions include; average length of stay, resource release complexity, and pharmacy intervention savings.
- The main benefit is identified was a reduction in variable pay spend on surge within hospitals.
- The model's financial sustainability depends on ongoing recruitment and operational efficiency.

SDEC Financial Analysis: Costs

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Service	Band/Grade	Values Establishment (WTE)	Estimated Cost (£)
SDEC BGH - 7-Day		10.99	£972,796.57
SDEC GGH - 7-Day SP Roster 3		35.70	£3,801,176.03
SDEC WGH - 7-Day		32.61	£3,164,235.39
Grand Total		79.30	£7,938,207.99

			Day Values								
			Monday			Saturday			Total Headcount	Total Hours	Total Calculated WTE
Service	Band/Grade	Role	Headcount	Hours	Calculated WTE	Headcount	Hours	Calculated WTE			
SDEC BGH - 7-Day	Band 3	Support Worker	1.00	11.50	0.39	1.00	11.50	0.39	2.00	23.00	0.78
	Band 7	Senior Nurse	1.00	11.50	0.39	1.00	11.50	0.39	2.00	23.00	0.78
	Band 8A	ACP	1.20	13.80	0.47	1.20	13.80	0.47	2.40	27.60	0.94
	GP	Medical Oversight	1.00	9.38	0.32	1.00	9.38	0.32	2.00	18.75	0.64
SDEC BGH - 7-Day Total			***4.20***	***46.18***	***1.57***	***4.20***	***46.18***	***1.57***	***8.40***	***92.35***	***3.14***
SDEC GGH - 7-Day SP Roste	Band 2	Clerk	1.00	7.50	0.25	0.00	0.00	0.00	1.00	7.50	0.25
	Band 3	HCSW	2.00	23.00	0.78	2.00	23.00	0.78	4.00	46.00	1.56
	Band 5	Nursing	2.00	23.00	0.78	1.00	11.50	0.39	3.00	34.50	1.17
	Band 6	Advanced Nursing	1.00	11.50	0.39	1.00	11.50	0.39	2.00	23.00	0.78
	Band 7	Supervisor	1.00	7.50	0.20	0.00	0.00	0.00	1.00	7.50	0.20
	Band 8A	ACP	3.30	45.38	1.54	3.30	45.38	1.54	6.60	90.75	3.08
	Consultant	Consultant Oversight	0.90	12.38	0.42	0.90	12.38	0.42	1.80	24.75	0.84
		Consultant/Frailty	2.10	28.88	0.98	2.10	28.88	0.98	4.20	57.75	1.96
SDEC GGH - 7-Day SP Roster 3 Total			***13.30***	***159.13***	***5.34***	***10.30***	***132.63***	***4.50***	***23.60***	***291.75***	***9.84***
SDEC WGH - 7-Day	Band 2	Admin & Clerical	1.00	11.00	0.37	1.00	11.00	0.37	2.00	22.00	0.74
	Band 3	Support Worker	2.00	22.00	0.74	2.00	22.00	0.74	4.00	44.00	1.48
	Band 5	Nursing	1.00	11.00	0.37	1.00	11.00	0.37	2.00	22.00	0.74
	Band 6	Advanced Nursing	1.00	11.00	0.37	1.00	11.00	0.37	2.00	22.00	0.74
	Band 7	Senior Nurse	1.00	7.50	0.25	0.00	0.00	0.00	1.00	7.50	0.25
	Band 8A	ACP	3.30	36.30	1.23	3.30	36.30	1.23	6.60	72.60	2.46
	Consultant	Consultant Oversight	0.90	12.38	0.42	0.90	12.38	0.42	1.80	24.75	0.84
	GP	Medical Oversight	2.10	28.88	0.98	2.10	28.88	0.98	4.20	57.75	1.96
SDEC WGH - 7-Day Total			***12.30***	***140.05***	***4.73***	***11.30***	***132.55***	***4.48***	***23.60***	***272.60***	***9.21***
Grand Total			29.80	345.35	11.64	25.80	311.35	10.55	55.60	656.70	22.19

SDEC Financial Analysis

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Site	Cost	LOS	Cost Bed day	Patients a year	Patients a week
WGH	£3,200,000	7.14	£527	851	16
BGH	£1,000,000	10.90	£527	174	3
GGH	£3,800,000	7.23	£527	997	19
	£8,000,000				39

	Prevention rate		
Site	100% surge reduction	50% surge reduction	Difference
WGH	80%	49%	32%
BGH	46%	23%	23%
GGH	80%	51%	30%

	Total Patients per week		
Site	100% surge reduction	50% surge reduction	Difference
WGH	62	38	25
BGH	18	9	9
GGH	66	41	24
Total	146	88	58

	Prevention rate		
Site	100% surge reduction	50% surge reduction	Difference
WGH	80%	49%	32%
BGH	46%	23%	23%
GGH	80%	51%	30%

- Traditionally productivity savings are calculated using a standard bed day cost. If the number of bed days equals the extra cost of the resource required, then in theory the service is sustainable. In the SDEC case, if the extra resource required is £8m, then the number of additional patients that SDECs would need discharge on a weekly basis, at the current length of stay per site, would be 39.
- This assumes that every patient care is equal, in an established bed with approved staffing model. It does not account for the costs of Boarding and Surge beds which are significantly less costly. This has been accounted for in the cost value calculations, as well as the likely demand cohort over weekends.
- Additionally, calculations were made on the basis that SDEC solely would have impact on reducing and eliminating Surge/Boarding beds. This has been adjusted in calculations
- It has been found that if Surge and Board beds were to be reduced by Urgent and Emergency Care ‘Back door’ programmes by 50% and the SDEC model ‘Front Door’ only had to account for the other 50%, then the number of patients that SDEC would have to prevent being admitted would be an additional 88 per week across all SDEC sites. The prevention rate of Medical patients would drop to a maximum of 51% rather than 80%.

Workforce Analysis (with Staffing Models and Opportunities)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Significant recruitment challenges for all models, especially senior and specialist roles.

- SDEC Bronglais Hospital: High WTE requirements for Bands 3, 7, 8A, and GP roles; timelines exceed 6–12 months for senior roles.
- SDEC Glangwili Hospital: High WTE requirements for Bands 2–8A and Consultant roles; timelines extend beyond 12–18 months for advanced practice and consultant posts.
- SDEC Withybush Hospital: High WTE requirements for Bands 2–8A, GP, and Consultant roles; timelines exceed 12–18 months for senior roles.
- Clinical Streaming Hub: High WTE requirements for Bands 3–8A, Band 6–7, and Pharmacist roles; timelines exceed 12 months for advanced practice and pharmacy roles.

Recruitment risks are high due to limited internal talent pipeline and candidate diversity.

Failure to recruit will destabilise teams and jeopardise implementation. Mitigations include phased recruitment, international sourcing, talent development, and trainee roles (Annex 21). Opportunities exist for portfolio working and internal talent development.

Options Appraisal

Option A: Implement seven-day Clinical Streaming and Hospital@Home services across Hywel Dda University Health Board.

Option A	Cost per year	Estimated cost avoidance per year
Optimal 7-day Clinical Streaming Model	£1.7m	£4m

Option B: Implement seven-day Clinical Streaming, Hospital@Home, and phased rollout of SDEC services by site, with annual reviews and potential expansion or discontinuation. Phased introduction allows for operational embedding, benefit realisation, and scheduled review points. This option assumes that SDECs are able to meet the value threshold required for continuation of service (please see SDEC Financial Analysis).

Option B	Cost Optimal 7-day Clinical Streaming Model	Cost Avoidance Optimal 7-day Clinical Streaming Model	Cost Optimal 7-day SDEC model, phased implementation.	Cost Avoidance Optimal 7-day SDEC model, phased implementation	Total Cost	Total Cost Avoidance
Year One. ***CSS Model and WGH SDEC***	**£1.7m**	**£4m**	**£3.2m**	£3.2m	**£4.9m**	**£7.2m**
Year Two. ***CSS Model and WGH and BGH SDEC***	**£1.7m**	£4m	**£4.2m** WGH £3.2m BGH £1m	£4.2m	**£5.9m**	**£8.2m**
Year Three. ***CSS Model and WGH, BGH and GGH SDEC***	**£1.7m**	£4m	**£8m** WGH £3.2m BGH £1m GGH £3.8m	£8m	**£9.7m**	**£12m**

Implementation Plan

- **Option B** implementation suggested to be full seven-day Clinical Streaming, Hospital@Home, and a phased rollout of Same Day Emergency Care (SDEC) across Hywel Dda University Health Board.

- Proposed roll out for SDECs (sequencing based on current SWOT analysis):
  - Withybush Hospital in Financial Year-One (2026-27)
  - Bronglais Hospital in Year-Two (2027-28)
  - Glangwili Hospital in Year-Three (2028-29)

- Withybush Hospital was chosen as the initial pilot site for the following reasons:
  - Withybush Hospital currently provides significant boarding and surge care, so piloting here could help stabilise current pressures and test the model's effectiveness in a high-demand environment.
  - Mature and established SDEC, with links across Streaming and Out-of-Hours services, increasing the likelihood of successful delivery and measurable benefits.

- Annual phasing allows time for operational embedding and benefit realisation at each site.

- Scheduled review points each year assess impact and inform a comprehensive year-end evaluation.

- Continuation or expansion depends on achieving costed cash savings (see financial analysis).

- If cash savings are not realised, the service will be discontinued and the Exit Plan enacted.

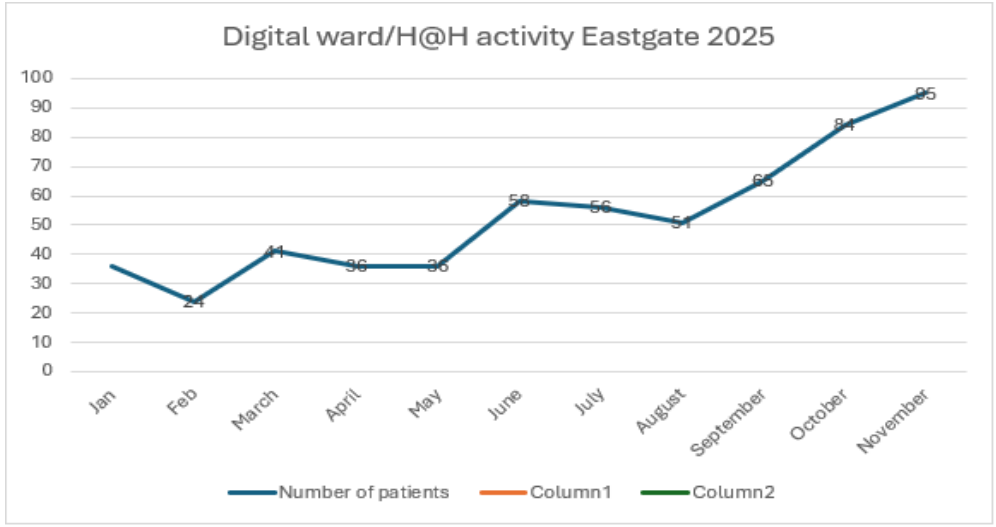
- Exit Plan developed with Workforce and Finance to ensure substantively appointed staff can be redeployed across the organisation through Organisational Change Processes.

Key Risks and Mitigations

Risk	Mitigation
No guarantee for Advanced Paramedic Practitioners to work in weekend due to current APP resource within WAST.	Will need to utilise Advanced Clinical Practitioners in the Navigator role if APP's are not available over the weekend. Ongoing meetings with WAST to understand position further and to try and build more APP resource in Hywel Dda to support the Weekend working.
Workforce fatigue	Need to recruit staff to substantive/permanent positions, as a temporary or bank cover is not sustainable over a long-period of time.
Recruitment. Significant recruitment challenges listed as part of the Workforce analysis	Each Response Hub has recently attracted interest from both internal and external candidates for Clinical Streaming roles. It is anticipated that this interest will continue to grow, driven by the demand for and appeal of portfolio working across disciplines, a key benefit of operating within a Clinical Streaming environment. In addition, the service is considering the introduction of Annex 21 trainee roles. This strategy would allow senior ACPs/APPs to provide weekend coverage while trainees support weekday operations. It also strengthens workforce sustainability by developing future ACPs who are internally trained to meet the required risk appetite and experience standards.
Communication and Engagement	To date no engagement with the public has been done on the model. Comms and engagement advice is to develop public focus groups to engage on model before launch. Llais and other key stakeholders such as Local Authorities and WAST have been engaged with on the model to date.
Benefits Realisation	The benefits of the service may take six months to a year to fully realise. New staff will need time to be trained to effectively work in a Clinical Streaming Environment, and services need to adapt to work with the hubs effectively over weekends. The programme group will need to ensure ongoing data analysis There is a risk that the service will not realise the required benefits/cash savings. The benefits realisation will be monitored through the Six Goals Integrated Operational Group, and formally reviewed Finance and Performance Committee and Formal Executive Team each year for decision.
Exit Plan	As staff will be employed on a permanent basis a workforce plan will need to be developed to ensure that all staff will be able to be re-deployed through OCP processes

Expected Benefits

- In addition to the financial and quality of care benefits demonstrated it is expected to see that following implementation of the 7-day model the following performance related benefits for UEC in the Health Board:
    - Reduced attendances
    - Reduced admissions
    - Less conveyances
    - Reduced length of stay
- Both the learning from the Enhanced Weekend Pilot, National and International evidence, and data from a recent increase in hours in the Eastgate Local response Hub:



- Hours increased from 9am - 5pm to 8am - 8pm at the end of October 2025. This patient data represents patients the hub is supporting at home with regular medical monitoring that would otherwise need hospital admission. This does not represent the totality of activity, only those that are ‘admitted’ to the Hospital@Home or digital ward.
- All performance metrics will be tracked as part of ongoing monitoring and review process.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

7

1:00 PM, 0 Mins

7 - FOR INFORMATION

7.1

1:00 PM, 0 Mins

7.1 - ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

Capital Update FPC 16 December 2025.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	16 December 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	All-Wales Capital Programme 2025/26, Capital Resource Limit and Capital Financial Management
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Welsby, Senior Finance Business Partner Planning and Major Projects

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This update report is presented to the Finance and Performance Committee to:

- Note the 2025/26 Capital Resource Limit (CRL)
- Note the current risk associated with delivery of 2025/26 CRL
- Note the project updates

Cefndir / Background

This report provides an update on the CRL for 2025/26.

Asesiad / Assessment

Capital Resource Limit 2025/26

The CRL for 2025/26 has been issued with the following allocations:

Allocation	£'m
All Wales Capital Programme (AWCP)	28.838
Discretionary Programme* (DCP)	6.850
IFRS 16 Leases	1.027
Total	**36.715**

***The Health Board received DCP of £10m in 2025/26. A contribution of £2.205m has been made towards the Targeted Estates Fund schemes within AWCP. A further £0.945m has been paid back to the AWCP to account for capital scheme slippages in 2024/25.**

Since the last report the following amendments have been made to the CRL:

Scheme	£m	Description
Adjustments as part of the October CRL fixing exercise:		
Backlog Maintenance - 2024-25	(0.110)	Funding returned to WG due to underspend
Aberystwyth Sexual Assault Referral Centre	(0.130)	Funding returned to WG due to underspend
Year end funding – October 2024	(0.250)	Deferral of funding to align with current project expected timeline (Pentre Awel)
Targeted Estates Fund (TEF)	(2.586)	Deferral of funding to align with current project expected timelines and to reflect reprioritisation of expenditure plans (several projects within TEF)
Mental Health Quality and Safety Schemes	(0.064)	Funding returned to WG due to forecast underspend
Carmarthen Hwb - Equipment and Fit-out costs	(1.200)	Deferral of funding to align with current project expected timeline
Subtotal	(4.340)	
New allocations:		
WGH – RAAC VAT recovery	(0.900)	Recovery of VAT on the completed RAAC works returned to WG
EFAB VAT recovery	(0.394)	Recovery of VAT on completed EFAB projects returned to WG
Front Door Project, GGH	2.096	New capital funding for the GGH Same Day Emergency Care Front Door project
Fire Enforcement Works, WGH – Phase 2	0.912	Funding for the construction phase of the WGH Fire Enforcement Works following approval of the business case by WG
Decarbonisation Project	2.231	New funding allocation for energy performance improvements at several sites
Digital Priorities Investment Fund (DPIF) - Connecting Care	0.653	New funding allocation for community hardware in respect of the Connecting Care project
End of Year Digital Funding 2025-26	0.630	Funding for replacement of end of life wifi access points
IFRS16 – Leica Managed Service Contract	0.746	Lease funding allocation in respect of new Managed Service Contract with Leica
Subtotal	**5.974**	
Total	**1.634**	

Capital Expenditure Plan

The following table shows the capital expenditure plan for 2025/26 with expenditure incurred to date.

Scheme	Planned Spend 2025/26 £m	Cumulative Spend Apr-Nov £m	Spend Nov £m	Remaining balance £m
AWCP				

Glangwili - Fire Enforcement works - Phase 2 - Fees	0.779	0.719	0.013	0.060
Backlog Maintenance – (slippage from 2024-25)	1.214	0.528	0.046	0.686
Aberystwyth Sexual Assault Referral Centre	1.875	1.674	0.009	0.201
Block C, Picton Terrace, Carmarthenshire	2.488	1.418	0.170	1.070
Diagnostic Equipment - WGH Fluro & Chilled Water Plant	2.570	1.052	0.666	1.518
EFAB - Infrastructure	0.127	0.004	0.000	0.123
EOY Funding 24/25 – (Pentre Awel)	0.150	0.121	0.002	0.029
Targeted Estates Fund (TEF) - Fire	0.570	0.000	0.000	0.570
TEF - Infrastructure	2.294	0.147	0.070	2.147
TEF - Decarbonisation	0.050	0.000	0.000	0.050
TEF - Mental Health	1.684	0.003	0.000	1.681
TEF - Infection Prevention Control	0.569	0.297	0.000	0.272
TEF - Decontamination	0.426	0.197	0.021	0.229
Carmarthen Hwb - Equipment and Fit-out costs	2.318	0.012	0.009	2.306
Fishguard Health and Wellbeing Centre	0.067	0.038	0.005	0.029
DPIF - Digital Maternity Cymru System Programme 2025/26	0.100	0.001	0.000	0.099
Non-Radiology Ultrasound Replacement	0.761	0.000	0.000	0.761
DPIF – (RISP)	0.429	0.000	0.000	0.429
Aseptic Unit, Withybush Hospital	1.753	0.229	0.219	1.524
Gamma Camera Upgrade, WGH	0.481	0.008	0.001	0.473
Mental Health Quality and Safety Schemes	1.317	0.030	0.000	1.287
MRI Upgrade, GGH	1.324	0.017	0.003	1.307
Radiology Ultrasound Replacement, PPH	0.138	0.000	0.000	0.138
Hospital Helicopter Landing Sites	0.030	0.010	0.000	0.020
WGH - RAAC VAT Recovery	-0.900	0.000	0.000	-0.900
EFAB VAT Recovery	-0.394	0.000	0.000	-0.394
SDEC Front Door Project, GGH	2.096	0.120	0.072	1.976
Fire Enforcement WGH - Phase 2	0.912	0.251	0.021	0.661
Decarbonisation Project	2.231	0.000	0.000	2.231
DPIF - Connecting Care	0.653	0.000	0.000	0.653
End of Year Digital Funding 2025-26	0.630	0.000	0.000	0.630
Sub-total AWCP	**28.742**	**6.876**	**1.327**	**21.866**
Discretionary				
IT	2.847	0.436	0.100	2.411
Equipment	1.593	0.660	0.003	0.933
Estates – Statutory	0.450	0.177	0.035	0.273

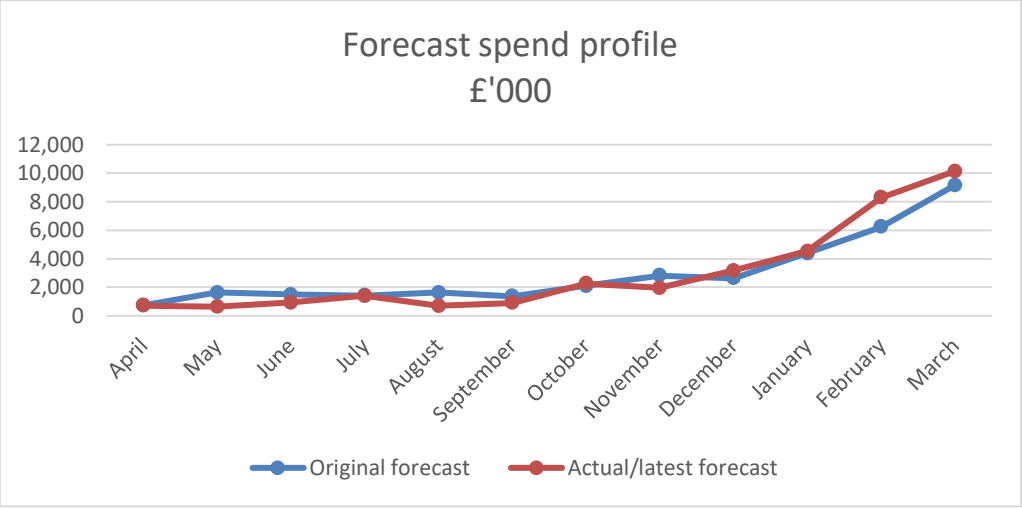
Estates Infrastructure	1.792	1.212	0.445	0.580
Mental Health	0.000	0.000	0.000	0.000
Other	0.264	0.172	0.052	0.092
Sub-total Discretionary	**6.946**	**2.657**	**0.635**	**4.289**
IFRS 16	**1.027**	**0.281**	**0.281**	**0.746**
TOTAL expenditure	**36.715**	**9.814**	**2.243**	**26.901**

Further details on the revenue consequences of these schemes are noted in **Appendix 1**.

Expenditure Profile Forecast

The below chart shows current forecast expenditure compared with the original forecast. Expenditure for November was lower than forecast due to:

- RISP – (£0.429m) – Project delayed but "go live" has now occurred on 1 December therefore no risk to delivery. These costs will be invoiced as a single up-front cost, relating to the provision of hardware, and are therefore liable now the project is live.
- Picton Terrace – (£0.383m) - no risks to delivery by year end flagged at this point
- Backlog Maintenance – (£0.161m) - no risks to delivery by year end flagged at this point
- TEF schemes – (£0.197m) – funding has been reprofiled in November due to delays in programme for the Generators schemes



FINANCIAL RISKS ASSOCIATED WITH CAPITAL SCHEMES IN 2025/26

Significant spend profiled in period February and March 2026

The above graph highlights total spend of circa £18m is currently forecast for the period February to March 2026. This could be further exacerbated with the receipt of any additional funding prior to the 31 March leading to increased levels of spend in the latter months of the financial year.

Close monitoring will occur to ensure that if there are any risks identified, mitigating measures are put in place to ensure that capital spend is maximised.

CAPITAL SCHEME UPDATES (SCHEMES GREATER THAN £1M)

Withybush Fluoroscopy and Chiller

Works to replace the Fluoroscopy scanner and chilled water plant started in September 2025. No risks identified at this stage and is expected to complete by the end of the Financial year.

Aberystwyth Sexual Assault Referral Centre (SARC)

The project has achieved completion and unspent funds returned to WG.

Cross Hands Health and Wellbeing Centre

Discussions are on-going with Welsh Government (WG) to review the scope of the project to ensure that it is deliverable within the budgetary envelope available.

Picton Terrace

Funding has been provided by WG to develop Corporate Headquarters within Carmarthen which is expected to be in occupation by the end of the financial year. This will rationalise the Health Board estate by reducing a number of freehold and leasehold properties which are currently being occupied. Scheme is progressing well and is expected to be completed in December 2025.

Carmarthen Hwb

This project is led by Carmarthenshire County Council, in partnership with the Health Board and University of Wales Trinity St David. A number of services will be co-located within the building which are currently being delivered across a number of different locations.
Funding has been provided to the Health Board for equipment and digital.

Aseptic Unit Withybush

A sustainable compliant Aseptic Unit will be built at Withybush Hospital in advance of the development of a South-West Regional Aseptic Unit. This will ensure that the facilities and delivery of aseptic services within Hywel Dda University Health Board will meet the required regulatory standards. Progress has been delayed due to a requirement to re-design the aseptic demountable unit to ensure compliance with relevant building standards.

Same Day Emergency Care (SDEC), Glangwili Hospital

Works to increase capacity in the SDEC service at Glangwili Hospital commenced in November 2025 and are scheduled to complete in March 2026.

Decarbonisation Project

Funding has been provided towards several energy performance improvements across Health Board sites.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

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

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 1196 - not be able to provide safe, sustainable, accessible and kind services. This is caused by insufficient investment to ensure we have appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. Score 16
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 6. Sustainable use of resources

Amcanion Cynllunio Planning Objectives	7 Primary and community strategic plan 8 Estates plans 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Capital Allocation and prioritisation process. Capital Investment procedure and all relevant Welsh Government guidance.
Rhestr Termau: Glossary of Terms:	Explanation of terms is included in the main body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Capital Monitoring Forum Capital Planning Group Individual Project Boards of Capital Schemes Welsh Government Capital Review Meeting Capital Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Included within individual business cases and Capital prioritisation process
Gweithlu: **Workforce:**	Included within individual business cases and Capital prioritisation process
Risg: **Risk:**	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within HDdUHB
Cyfreithiol: **Legal:**	Included within individual business cases and Capital prioritisation process

Enw Da: **Reputational:**	Included within individual business cases and Capital prioritisation process
Gyfrinachedd: **Privacy:**	Included within individual business cases and Capital prioritisation process
Cydraddoldeb: **Equality:**	Included within individual business cases and Capital prioritisation process

APPENDIX 1

REVENUE CONSEQUENCES OF CAPITAL SCHEMES

The below table summarises the revenue consequences of capital schemes of which funding has been received in 2025/26:

Scheme	Total £'m	Additional £'m	Costs included in current budgets (replacements) £'m
AWCP			
Glangwili - Fire Enforcement works - Phase 2 - Fees	0.00	0.00	0.00
Backlog Maintenance - 2024-25	0.00	0.00	0.00
Diagnostic Equipment - WBH Fluro & Chilled Water Plant	0.00	0.00	0.00
Aberystwyth Sexual Assault Referral Centre	0.00	0.00	0.00
Block C, Picton Terrace, Carmarthenshire	Occupation expected to generate efficiencies of at least £100k through rationalisation of freehold and leasehold estate.		
Efab - Infrastructure	0.00	0.00	0.00
EOY Funding 24/25 - Pentre Awel	0.48	0.48	0.00
TEF - Fire	0.00	0.00	0.00
TEF - Infrastructure	0.00	0.00	0.00
TEF - Decarbonisation	0.00	0.00	0.00
TEF - Mental Health	0.00	0.00	0.00
TEF - Infection Prevention Control	0.00	0.00	0.00
TEF - Decontamination	0.00	0.00	0.00
DPIF (Digital Priorities Investment Fund) - RISP	Business Case approved by Board in 2023. Minimal additional revenue costs expected over the life of the contract.		
Digital Maternity Cymru System Programme 2025/26	Business Case approved by March '2025 Board. Project expected to generate a net revenue saving through cost avoidance / efficiency.		
Non-Radiology Ultrasound Replacement	0.08	0.00	0.08
Aseptic Unit, Withybush Hospital	Efficiencies of at least £0.033m will be generated		
Carmarthen Hwb - Equipment and Fit-out costs	0.45	0.45	0.00
Fishguard Health and Wellbeing Centre	Business case under development – revenue consequences of project not yet known		
Non-Radiology Ultrasound Replacement	0.00	0.00	0.00
Gamma Camera Upgrade, WGH	0.00	0.00	0.00
Mental Health Quality and Safety Schemes	0.00	0.00	0.00
MRI Upgrade, GGH	0.00	0.00	0.00
Radiology Ultrasound Replacement, PPH	0.00	0.00	0.00
Hospital Helicopter Landing Sites	0.00	0.00	0.00
SDEC Front Door Project, GGH	0.00	0.00	0.00

Fire Enforcement WGH – Phase 2	0.00	0.00	0.00
Decarbonisation Project	Spend to save project. Revenue savings will be utilised to repay capital costs.		
DPIF – Connecting Care	0.00	0.00	0.00
End of Year Digital Funding 2025/26	0.00	0.00	0.00
Sub-total AWCP	**1.01**	**0.93**	**0.08**
Discretionary			
IT	0.00	0.00	0.00
Equipment	0.18	0.00	0.18
Estates – Statutory	0.00	0.00	0.00
Estates Infrastructure	0.00	0.00	0.00
Other	0.00	0.00	0.00
Sub-total Discretionary	**0.18**	**0.00**	**0.18**
TOTAL	**1.19**	**0.93**	**0.26**

The above table shows the total revenue costs as a consequence of capital expenditure in 2025-26 as £1.19m. Total additional costs are estimated at £0.93m and costs assumed to be included in current revenue budgets, as they are equipment replacements, totals £0.26m.

The following assumptions were made: -

- Medical Equipment replacement assumed at 10% of capital cost.
- Any Estates work to existing buildings are assumed to be revenue neutral unless the building footprint increases or changes significantly.
- Some capital investments will lead to longer term revenue savings (such as decarbonisation initiatives and digital investment); however, it has been assumed that these will be included as a part of directorate savings plans.

7.2

1:00 PM, 0 Mins

7.2 - JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

JCC PPF Sub-Committee Highlight Report 23 October 2025.pdf

Cyd-bwyllgor Comisiynu Joint Commissioning Committee

Planning, Performance and Finance

Highlight Report from the Planning, Performance and Finance Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	23/10/2025
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Gareth Mitchell, Corporate Governance Manager, NWJCC
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, PPF Chair and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Stacey Taylor, Director of Finance and Value, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Health Boards		Noted

1. SITUATION/BACKGROUND

This report had been prepared to provide Health Board Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered by the NHS Wales Planning, Performance and Finance (PPF) Sub-Committee at its meeting in public on 23 October 2025.

Key highlights from the meeting are reported in Section 3.

2. PURPOSE

The Purpose and Role of the JC is set out in Paragraphs 2.18 and 2.20 of the NWJCC Standing Orders (SOs).

3. HIGHLIGHT REPORT

(Links to reports highlighted - October 2025 - NHS Wales Joint Commissioning Committee)

Status	Update
Alert / Escalate	The NWJCC Financial Report – Month 6 2025-26 was received. 3 proposals for savings were agreed to be discussed at November's JC meeting, these included savings in medium secure services, potential savings in ambulance services and the capping of specialised services activity for the last quarter of the financial year.
Advise	The NWJCC Operational Performance Report was received. Discussions noted continuing issues with data quality and system integration. Attendees were given a demonstration of a dashboard and received an update on a rapid review of performance reporting with the intention of using a newly designed report from March 2026. The PPF Risk Register was noted during the meeting. Attendees noted that risk reporting would be on a bi-monthly basis to ensure that the reporting of risks is relevant and to ensure that the Sub-Committees are providing onward assurance to the JC. Attendees further noted the work being undertaken to improve the differentiation of commissioning and provider risks.
Assure	The Implementation of NWJCC Foundation Plan 25-26 - Q2 Progress Update report was received. Attendees noted that the majority of areas detailed were on track or had slipped slightly. Attendees further noted that the Auditory Implant Device Service remained in escalation.
Inform	The Development of the NWJCC Integrated Medium Term Plan (IMTP) was received. Attendees noted that a workshop was being arranged for early December to engage stakeholders in the IMTP process. This engagement would then inform the clinically-led prioritisation process. Attendees discussed the changing financial picture and how this may affect the process in the near future. Members further discussed inequity in relation to cross-border services and the disproportionate impact for Betsi Cadwaladr University Health Board and Powys Teaching Health Board.

Status	Update
Appendices	None.

4. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC **Link to JCC Strategic Objectives(s)**	Maximise Value Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Leadership Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** (Duty of Quality Statutory Guidance (gov.wales))	Effective Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐ Outcome:	No: ☒ If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb	Yes: ☒	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*		
	Outcome for Equality (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~ Outcome for Welsh Language (delete as appropriate): ~~POSITIVE~~/NEUTRAL/~~NEGATIVE~~	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

5. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 3 of this report.

7.3

1:00 PM, 0 Mins

7.3 - NHS PRODUCTIVITY COMMISSION 'FROM DIAGNOSIS TO DELIVERY'

Huw Thomas (Hywel Dda UHB - Director of Finance)

For information

Attachments

NHS Productivity Commission From Diagnosis to Delivery Report.pdf

The Health Foundation | NHS Productivity Commission

From diagnosis to delivery

A framework for accelerating NHS productivity growth

Tera Allas | Anita Charlesworth | Hannah Chhoa-Howard | Katie Fozzard | Alison Moulds | Stephen Rocks

November 2025



The NHS Productivity Commission

The Health Foundation has launched the NHS Productivity Commission to provide evidence and identify solutions that can drive productivity growth in the NHS in England over the next decade.

The Commission is co-chaired by Anita Charlesworth, Senior Economic Adviser at the Health Foundation, and Tera Allas, a leading expert on economic growth, productivity and public policy.

Our eight commissioners – Richard Murray, John Hall, Habib Naqvi, Jim Buchan, Catherine Davies, Matthew Bell, Rachel Wolf and Ben Gershlick – bring expertise from policy, economics and the front-line workforce. They are supported by a secretariat, based at the Health Foundation, and an Expert Advisory Panel, whose role is to provide challenge and support for each of the productivity drivers, working with the commissioners and secretariat to develop policy solutions (see Who we are).

Acknowledgements

We are grateful to all our co-chairs, commissioners and Expert Advisory Panel members, whose views and comments informed this report.

We would also like to thank colleagues from the Health Foundation for their contributions. We received insightful comments from Hugh Alderwick, Patrick South, Peter Stilwell and Charles Tallack. The report was improved markedly thanks to the support of our communications team: Kate Addison, Tatjana Cvijanovic, Lisa Hornung and Stephen Robinson. Finally, all the secretariat's work is ably supported by Juney De Aguilar.

Errors or omissions remain the sole responsibility of the authors.

Cite this publication

Allas T, Charlesworth A, Chhoa-Howard H, Fozzard K, Moulds A, Rocks S. *From diagnosis to delivery: a framework for accelerating NHS productivity growth.* Health Foundation; 2025 (www.health.org.uk/reports-and-analysis/reports/from-diagnosis-to-delivery).

The Health Foundation
8 Salisbury Square, London EC4Y 8AP
020 7257 8000
info@health.org.uk

ISBN: 978-1-918254-00-6
Registered charity number: 286967
Registered company number: 01714937
© 2025 The Health Foundation

Contents

Foreword	4
Key points	7
Introduction	10
What is system productivity?	13
NHS productivity landscape	16
Diagnosing the problem	31
A framework for improving productivity	37
From problems to solutions	50
Who we are	53
References	55
Appendix	63

Foreword

Spending our careers in and around the NHS, wider public sector and private sector – often working directly on productivity – has taught us a simple truth: productivity is not an abstract statistic. Sometimes referred to as the economy's 'speed limit', productivity underpins rising living standards and provides the headroom for improved public services.

Since 2007, UK productivity growth has been weak, and communities have felt the effects through stagnant living standards and austerity. The same is true in health: a fall in NHS productivity growth means fewer people have accessed timely, high-quality care, with consequences for both their quality of life as well as the economy.

It is no surprise that NHS productivity fell during the COVID-19 pandemic. While there are now signs of recovery, experiences after past economic shocks show recovery cannot be taken for granted. Nor is recovery enough. Sustained improvement is essential to the NHS's long-term sustainability: an extra one percentage point of productivity growth each year over the next decade could free up around £20bn for improving care, but failing to do so would leave a big dent in the public finances.

Our aim in the NHS Productivity Commission is to bring together evidence from the NHS, other countries and the wider UK economy to help policymakers and leaders unlock that potential.

These are simultaneously exciting and worrying times for the NHS. The goals of the government's recent 10-Year Health Plan – a shift to prevention, community care and digital – are welcome. But after years of tight funding and the pandemic, the pressures are intense and the NHS has struggled with these shifts before. Technology represents a big opportunity, but one that most organisations across the economy find difficult to capitalise on.

We do not expect to find silver bullets. In a system with more than 1.5 million staff seeing around 2 million patients each day, change cannot be mandated from the centre. Opportunities will shift as technology expands what is possible. Local organisations and teams need to keep finding, testing and scaling improvements, and they need the time, support and autonomy to turn opportunities into results.

That requires trust. We know 'productivity' can sound threatening: in the wider economy it is often linked with job losses or fears of de-skilling. In the NHS, it can be heard as a criticism of staff or as money placed before quality. Change is hard, and while productivity brings collective benefits, leaders must consider carefully how productivity gains are experienced and shared among staff, patients and taxpayers.

Government and national bodies have a critical role. The government has set a productivity growth target more than double the pre-pandemic rate. That ambition is welcome. But goals are not enough – the conditions for success, including the practical tools, must be created.

This Commission will propose how to build those conditions. We are focusing on the foundations of productivity growth: workforce, capital, technology and innovation, and transformation. This report outlines our early thinking about why productivity matters, trends in productivity and what explains the recent downturn. Going forward, we are working with our fellow commissioners, secretariat and an Expert Advisory Panel to develop a roadmap for long-term, sustained NHS productivity growth. In doing so, we want to move from describing the problem to identifying solutions.

We cannot do this alone. We want to engage widely throughout this Commission. Alongside this report, we are launching a call for evidence. If you have practical ideas for change and improvement, please share them with us.

Tera Allas and Anita Charlesworth
Co-chairs, NHS Productivity Commission

Key points

- Productivity is about delivering the best health care from the available resources. This has always been important for the NHS but became even more so after the onset of the COVID-19 pandemic.
- NHS productivity rose for decades but fell sharply in 2020 and, despite improvements since, has not returned to its original path. The health service has lost around a decade of productivity growth, according to the latest official data for 2022/23. If pre-pandemic trends had continued, the NHS would have been around 14% more productive in 2022/23 – equivalent to roughly £20bn of additional care.
- International comparisons should be made with caution, but the NHS appears to have experienced a steeper and more prolonged productivity decline than many peer countries' health services.
- Recovering this lost productivity matters for patients and public finances. But recovery alone is not enough: population ageing, rising illness and a weak economic outlook mean the NHS must deliver sustained productivity growth.
- The NHS has achieved gains before, averaging around 1% per year pre-pandemic. Shorter hospital stays contributed significantly: we estimate it explains around half of pre-pandemic gains in productivity (non-quality-adjusted). Advances in treatments and changes to payment systems supported this shift, which shows what is possible when policy levers are aligned.
- Much of the NHS's productivity shock is structural and linked to long-term policy decisions. The health service entered the pandemic with a hospital-centric system but with little spare capacity. Hospital staff numbers grew even as there were constraints on other resources, such as available beds.
- The government has ambitious plans for improving NHS productivity. But experts recently convened by the Health Foundation judged there is only a 1 in 6 chance of achieving the government's 2% annual productivity growth target – which is more than double the historical rate – under current conditions.
- There is also a risk that a short-term target crowds out longer term priorities. Successful technology adoption could raise growth, but the NHS has an uneven track record of scaling digital tools and faces a legacy of underinvestment in capital.

- To avoid a ‘diagnosis without delivery’ cycle, the NHS Productivity Commission will focus on four drivers where national policy can unlock gains: workforce, capital, technology and innovation, and transformation.
- By spring 2026, expert commissioners will co-author four policy options papers (one per driver) proposing solutions to increase NHS productivity. From spring to autumn 2026, we will integrate these into a coherent roadmap for raising productivity.

Introduction

Improving productivity is integral to creating a high-performing and sustainable health service. Amid tight public finances and stalled progress in improving the nation's health, the NHS in England needs to seize opportunities over the next decade to deliver more and better care to patients for every pound spent. To assist, the Health Foundation has launched the NHS Productivity Commission to develop practical, evidence-based and ambitious solutions to improve productivity.[1]

NHS productivity increased for decades before the COVID-19 pandemic but reversed at its onset. Had pre-pandemic trends continued, the NHS in England would have been 14% more productive in 2022/23 – equivalent to around £20bn of the NHS budget. That is enough for millions more outpatient appointments or tens of thousands of extra major operations.

Unlike the UK economy, NHS productivity remains stubbornly below pre-pandemic levels.[2] Since 2019, activity has not kept pace with funding increases and performance is poor.[3] Public satisfaction with the NHS is at a record low, and waste is a growing concern.[4,5] Meanwhile, public spending pressures are mounting. Recovering the fall in productivity is crucial.

But recovery alone will not be enough. Demographic change, rising illness and a weak economic outlook mean continued productivity growth is essential for improving outcomes and protecting public finances.[6,7,8,9] Our projections show that sustained productivity growth could free up tens of billions of pounds for the NHS.[10]

Had pre-pandemic trends continued, the NHS in England would have been 14% more productive in 2022/23 – equivalent to around £20bn of the NHS budget.

Fortunately, this is also a moment of real opportunity. Breakthroughs in technology, including artificial intelligence (AI), are starting to show genuine promise.[11,12] Just as productivity growth has been the long-term driver of rising living standards in the wider economy, health care could be similarly transformed, offering better patient outcomes at lower cost.[13]

The 10-Year Health Plan is ambitious. The government has also set a target of 2% annual NHS productivity growth to the end of this parliament – more than double the long-term average.[14] However, while there are many promising initiatives across the system, experts convened by the Health Foundation were not confident this target will be met without further action.[15]

We will support efforts to boost productivity by looking carefully at the foundations. We have developed a framework based on what matters most:

1. having the right staff to deliver care (workforce)
2. fit-for-purpose equipment and buildings for staff (capital)
3. the right digital tools and new ways of working (technology and innovation)
4. the leadership, objectives, accountability and resources to drive forward change (transformation).

Over the course of this Commission, we will build an evidence-based understanding of how each driver can be strengthened and the policy reforms needed to get there. We will learn from best practice in health care, internationally and from other sectors. Our recommendations will be brought together in a series of policy options papers for each driver and, finally, an overall roadmap for the system that sets out priorities for change.

This report lays the groundwork. To begin, we set out our understanding of NHS system productivity. We look at trends in key measures over the past two decades and diagnose the reasons for the NHS's recent stalling productivity. Then, we introduce our four-driver framework, which will guide future recommendations. And finally, we explain how you can get involved.

What is system productivity?

Though productivity can be defined and measured in many ways, this Commission will take the broadest view: system productivity means the health care value created for every pound invested.

This definition reflects the NHS Constitution's principle of making 'the most effective, fair and sustainable use of finite resources' and aligns with duties in the Health and Care Act 2022.[16,17] It applies at every level of the system, from the whole NHS, down to a single operating theatre. In every case the question is the same: **are resources being used to create the greatest value**?

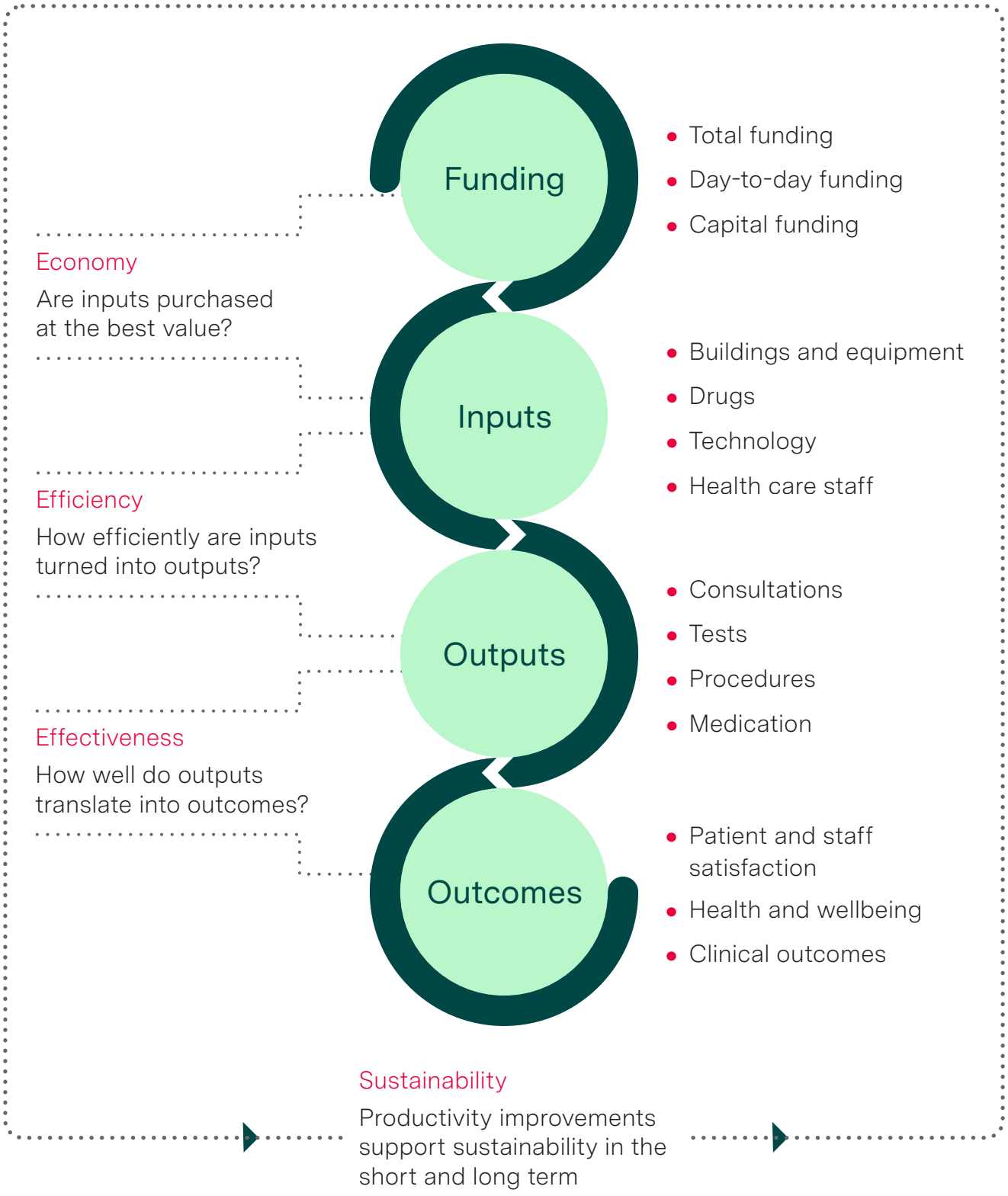
We can think of this in three steps (Figure 1):

- **Funding** is used to purchase **inputs**, such as staff time and equipment.
- Inputs are combined to create **outputs** – consultations, tests, procedures and admissions.
- We measure how these outputs translate into **outcomes** – sustainable improvements in health, wellbeing and patient experience.

System productivity in health care goes beyond asking whether the NHS turns inputs into as much care as possible (**efficiency**). It is also whether the health service obtains good value when buying supplies (**economy**), whether care improves people's health (**effectiveness**), and whether gains are **sustainable**.

By defining productivity more broadly – focusing on value – we aim to connect this concept with what matters most to staff, patients and policymakers alike.[18] But this brings challenges. Measurement is vital to decision making. While there are various measures of productivity available, none capture everything.[19] At present, the approach adopted by the Office for National Statistics (ONS) and others gets closest. This compares output – weighted by cost – to inputs, with an additional quality adjustment. We will generally rely on this approach as a guide, but we will supplement it with further data on broader outcomes and value.

Figure 1: Defining system productivity



Source: Adapted from Aldridge S, Hawkins A, Xuereb C. Improving public sector efficiency to deliver a smarter state. UK government; 2016. Contains public sector information licensed under the Open Government Licence v3.0 (www.nationalarchives.gov.uk/doc/open-government-licence/version/3).

NHS productivity landscape

- **NHS productivity improved steadily from the mid-1990s to the late 2010s, delivering more and better care for the resources used.**
- **Shorter hospital stays (enabled by technological innovation) have been a critical driver of past gains, but both went into reverse after the onset of the COVID-19 pandemic.**
- **The NHS experienced a sharper and more prolonged pandemic productivity downturn than in other countries and sectors.**
- **The relationship between health outcomes and productivity is complex, with periods of productivity growth not always translating into improved outcomes.**
- **Even before the pandemic, the UK was considered relatively efficient but not relatively effective compared with other health systems, raising questions about whether an increasingly hospital-centric NHS is allocating resources to the right activities.**

As productivity can be defined and measured in many ways, we describe these measures in the Appendix, with explanatory notes.

NHS productivity trends

NHS productivity in England (according to the ONS measure) fell sharply at the start of the pandemic, reversing some of the gains made during the previous 25 years.[20] Productivity growth was achieved by increasing outputs (a metric that combines different types of health care activity) faster than the inputs (eg staff) needed to deliver that care. In addition, the quality of care increased. However, this sharply reversed in the pandemic. Many non-urgent operations were postponed early on, creating an initial productivity shock. Even after services resumed, productivity remained below its pre-pandemic baseline.

Inputs

Inputs grew by 3.7% per year on average between 1995/96 and 2022/23, according to the ONS, with faster growth in the 2000s (4.9% per year) than in the 2010s (2.1%). While staff (labour) is the single biggest cost, accounting for just over 50% of expenditure in 2022/23, the strongest growth over time has come from goods and services. This includes areas

such as drugs and other materials but also agency staff and independent sector spend (ie when non-NHS providers are commissioned to deliver NHS care).[21] The weakest growth has been in capital consumption, such as for buildings and equipment.

Outputs

These inputs are used to deliver care across different services, in the form of appointments, admissions, tests, treatments and procedures. Collectively, these are measured as outputs, which rose by 4.0% per year between 1995/96 and 2022/23.[20] Again, growth was faster in the 2000s (5.2%) than in the 2010s (3.4% up to 2018/19). Much of the growth came from hospital and community health services, which is consistent with funding flows that show the NHS becoming increasingly hospital-centric over this period.[22]

Outputs can also be adjusted for quality, accounting for survival rates, health improvements, waiting times and patient experience. By this measure, care quality improved steadily, rising by around 10 percentage points between 2001/02 and 2018/19 – equivalent to 0.5% growth a year.*

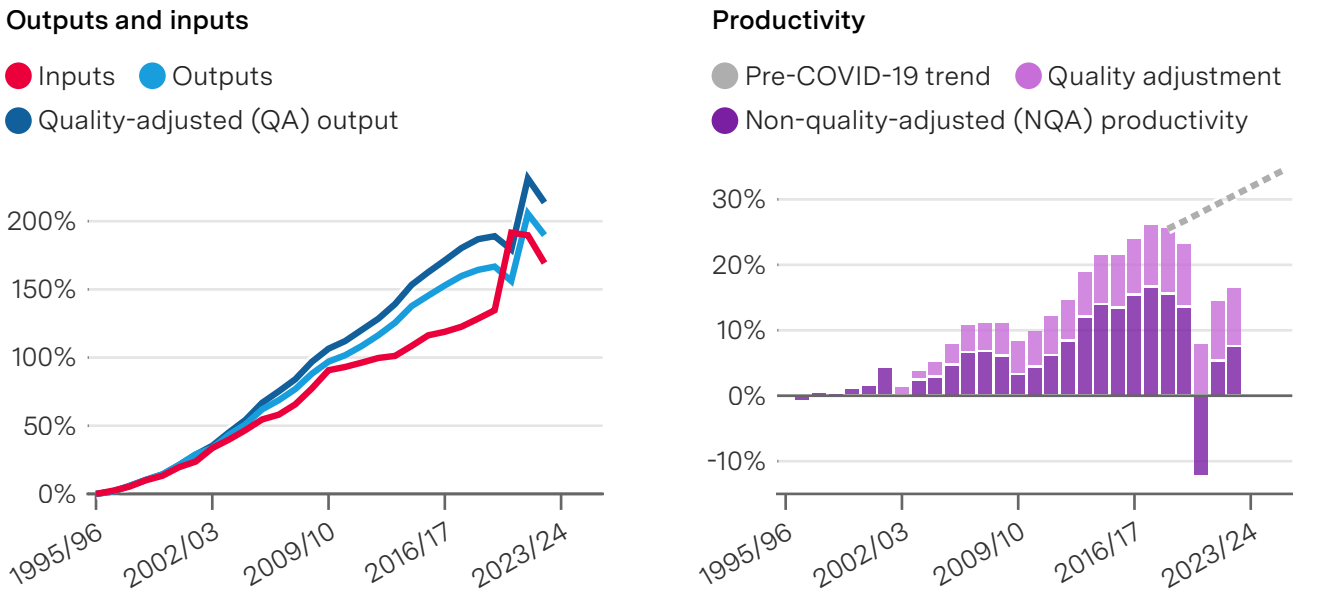
Outputs grew faster than inputs over the 25 years before the pandemic, which means the NHS became more productive.

* Quality adjustments were not incorporated in the measure until the early 2000s.

Productivity (ONS measure)

Outputs grew faster than inputs over the 25 years before the pandemic, which means the NHS became more productive (Figure 2). This peaked before the pandemic. In 2018/19, productivity was 16% higher than in 1995/96 on a non-quality-adjusted (NQA) basis, equivalent to growth of 0.6% per year.[20] Once quality is factored in, gains were even greater: by 2018/19, quality-adjusted (QA) productivity was 26% above 1995/96 levels (1.0% per year growth). The ONS's estimates are similar to those from the Centre for Health Economics.[23]

Figure 2: The efficiency and quality of NHS care increased before the COVID-19 pandemic
Percentage change in NHS inputs, outputs and productivity versus 1995/96, England



Source: ONS.

Even before the pandemic, productivity growth varied over time (Table 1). There was little growth before 2002/03 (0% NQA productivity and 0.2% QA productivity) and moderate growth for the rest of the 2000s (0.5% and 1.0% respectively). Partly this is explained by rapid funding growth in the 2000s, resulting in marked input growth, that took time to be absorbed and translated into faster output growth. Productivity growth was highest in the early 2010s (2.0%, 2.3%), as funding and input growth slowed but outputs continued to rise. Growth slowed after 2014/15 (0.3%, 0.8%),

even before the pandemic led to a sudden fall. The slow recovery from the productivity shock means that by 2022/23 the NHS had lost a decade of productivity improvement.

Table 1: Funding and productivity growth over time (England)

	1995/96 to 2002/03	2002/03 to 2009/10	2009/10 to 2014/15	2014/15 to 2018/19	2018/19 to 2022/23
Health funding (real terms)	n/a	5.4%	1.1%	1.5%	5.4%
Inputs	4.2%	5.2%	1.8%	2.3%	4.2%
Outputs					
NQA	4.2%	5.7%	3.8%	2.7%	2.3%
QA	4.4%	6.2%	4.2%	3.2%	2.3%
Productivity					
NQA	0.0%	0.5%	2.0%	0.3%	-1.8%
QA	0.2%	1.0%	2.3%	0.8%	-1.8%

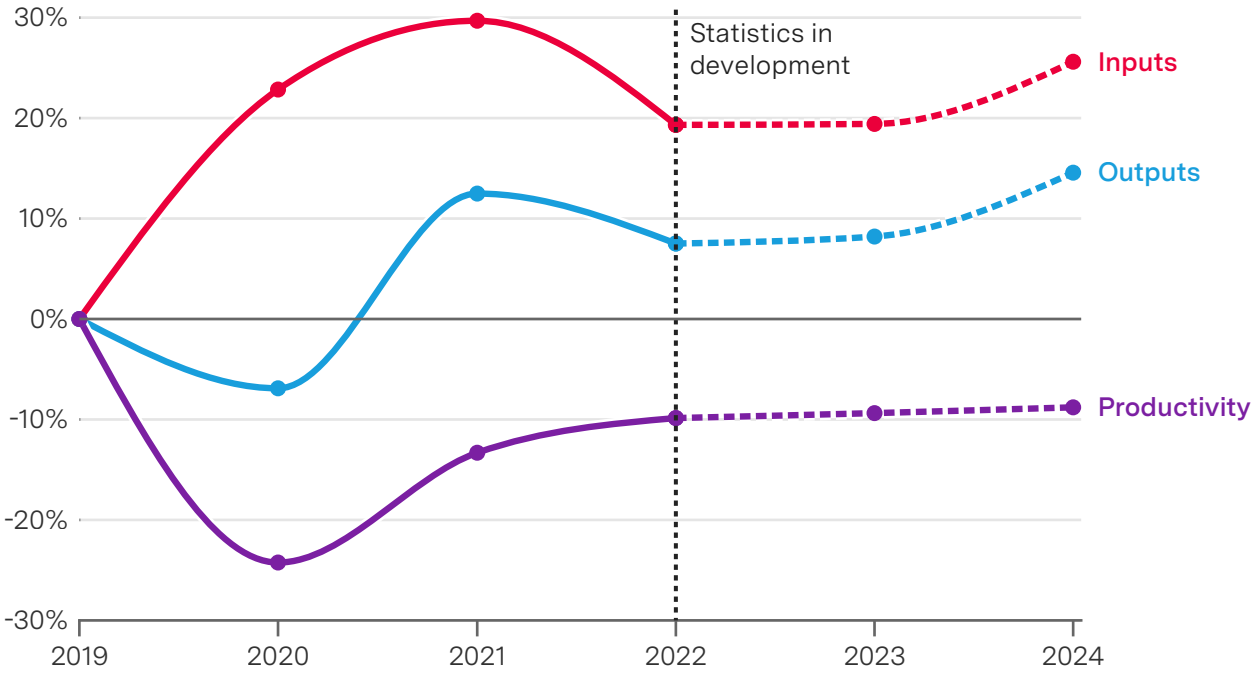
Source: Productivity of health care in England, ONS; NHS funding and expenditure, House of Commons library; GDP deflator, HM Treasury · QA = quality-adjusted, NQA = non-quality adjusted. Calculated using compound annual growth rate from start to end year.

Recent trends

The most recent full year of data for health care productivity in England from the ONS is 2022/23. According to its experimental series* – which is for the UK rather than England, and for calendar rather than financial years – health care productivity remained 9% below pre-pandemic levels in 2024 (Figure 3).[2] The ONS cites considerable uncertainty surrounding this estimate. NHS England has been developing its own approach to measuring productivity and reports faster growth in acute productivity in recent years than the ONS data suggest, with a 2.7% increase in acute hospital productivity in 2024/25.[24]

* This is classified as a statistic 'in development' (see Appendix).

Figure 3: Estimated health care productivity in 2024 remained 9% below 2019 levels
Percentage change in inputs, outputs and productivity versus 2019, UK



Source: ONS public service productivity, quarterly (healthcare), July 2025 · Figures from 2022 onwards are experimental statistics in development.

Understanding changes in productivity

Variation across sectors in the NHS

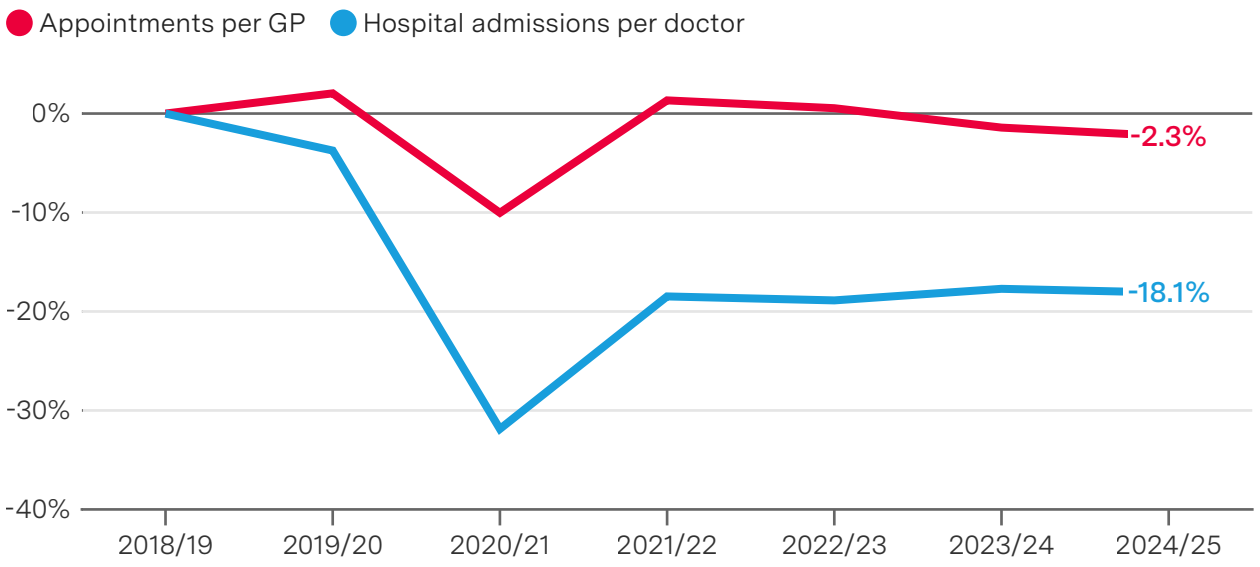
Productivity growth has likely varied across different NHS care settings. However, because current measures do not disaggregate by sector, and due to a lack of consistent, high-quality data, it is difficult to interrogate productivity trends outside of secondary care – especially for services such as mental health and community care. However, proxy indicators over time show differing trends between hospital services and general practice:

- **Hospital services**: before the pandemic, most output growth – and probably much of the productivity gain – was in hospital and community health services. In hospitals, admissions per doctor, after falling in the early 2000s, increased between 2006/07 and 2018/19, and the complexity of care (captured in acute care) also increased. Outpatient attendances and procedures per consultant grew rapidly between 2000/01 and 2018/19.[25]
- **General practice**: by contrast, appointments per general practice staff member declined over the two decades before the pandemic.

This proxy does not account for rising complexity – patients were on average older and had more comorbidities – or higher quality of care.[26] It also masks variation by staff group.

Since the pandemic, the pattern has flipped: GP appointments per GP are slightly below 2018/19 levels, but hospital admissions per doctor remain markedly lower (Figure 4). These simple aggregates mask considerable change in both settings, with substantial growth in the non-GP workforce in primary care,[27] and more same-day emergency care in hospitals. A fuller account of the productivity impacts of such changes is needed.

Figure 4: The number of appointments per GP has recovered more quickly than admissions per doctor
Percentage change in activity per staff member versus 2018/19, England



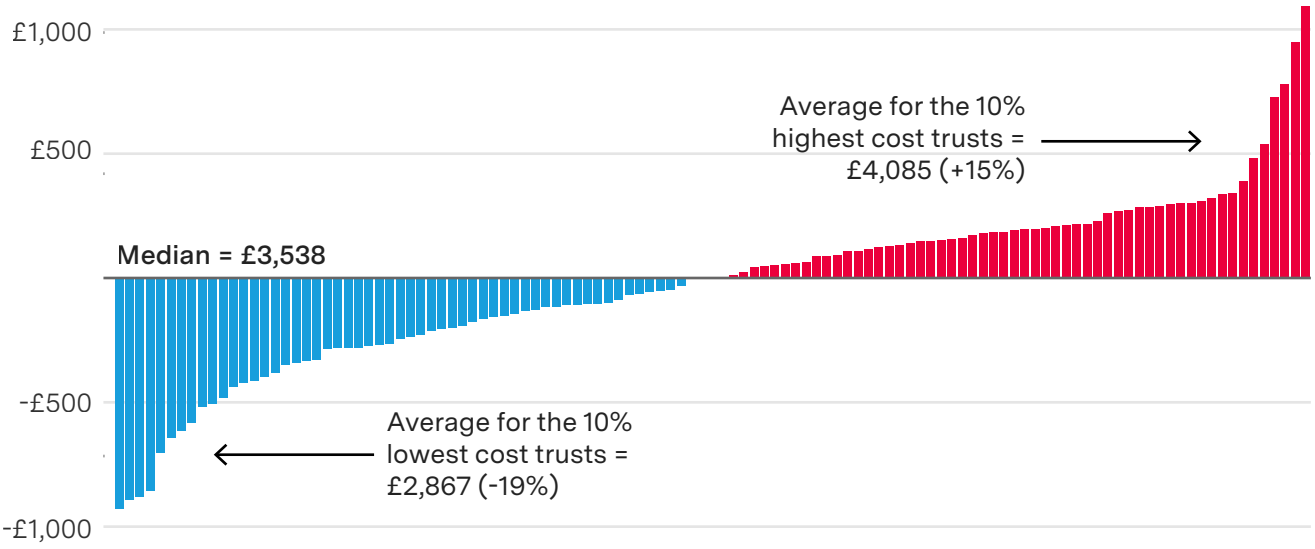
Source: NHS Digital: Appointments in General Practice, Provisional Monthly Health Episode Statistics, General Practice Workforce, NHS Workforce Statistics · Hospital admissions per doctor includes all admissions. Appointments per GP includes only those appointments delivered by GPs.

Variation within NHS sectors

NHS productivity varies not only between sectors but also across organisations within sectors.[28] This is not unique to the NHS – there is considerable variation between businesses across the UK economy.[29,30] While some variation is inevitable and warranted, interventions such as the NHS England programme Getting it Right First Time have focused on identifying 'unwarranted variation'. This has been a consistent focal point in health care policy, notably as part of the interim report of the

Carter Review of productivity in hospitals (2015), which estimated that the NHS could save up to £5bn a year by 2019/20 by reducing unwarranted variation.[31]

Figure 5: Trusts in the lowest cost group had 19% lower activity costs than the median
Variation in cost per weighted activity unit (WAU) across acute, non-specialist trusts compared with the median, 2023/24, England (£)



Source: NHS Model Health System (2023/24) · WAU is a standardised unit of health care activity. Adjusted for market forces factor. One WAU is equivalent to the average amount of clinical activity that can be produced for £3,500 by the average hospital.

Comparing the cost of providing one weighted activity unit (WAU) – a standardised unit of health care activity – across acute trusts reveals notable variation. Comparing trusts by their cost per WAU shows that the median cost of one WAU is £3,538 (Figure 5). This is 19% lower for the group of trusts with the lowest cost, and 15% higher for those with the highest cost. Reducing this variation in the cost of providing hospital care could present an opportunity to improve whole-NHS productivity.

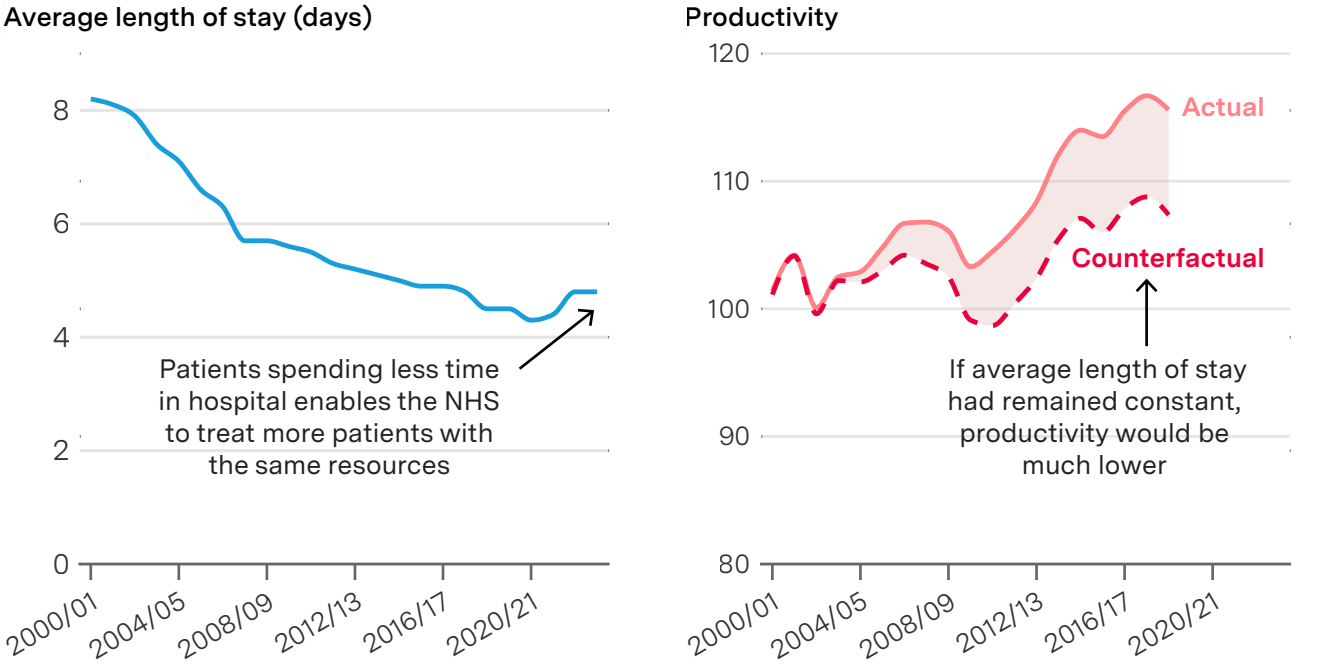
Variation in productivity is not confined to acute care or hospitals but, again, data quality is weaker for other care settings. Recent research found modest productivity differences across general practice, with most practices operating within a narrow band of efficiency.[32] By contrast, research has identified much greater variation across mental health providers, reflecting differences in case mix, service configuration and local demand.[33,34,35,36]

Sources of productivity gains

Many factors have contributed to increased NHS productivity, including the switch from expensive branded drugs to cheaper generic alternatives and improvements in the quality of care, such as higher post-operative survival rates. However, as noted earlier, hospitals account for much of the increase in outputs. Shorter stays and greater use of day-case surgery (not requiring an overnight stay) have been critical drivers of gains in this sector.[25]

The average length of a hospital stay in 2018/19 was 4.5 days, down from 8.4 days in 2000/01 (Figure 6). Our analysis shows that, under a counterfactual scenario in which the average length of stay stayed constant at 2000/01 levels, the NHS would have been able to admit a quarter fewer cases in 2018/19 due to bed capacity constraints. That would have eliminated half the total gains witnessed in NQA productivity up to 2018/19.

Figure 6: Average length of stay has fallen notably since 2000/01; if it had remained constant, pre-pandemic productivity growth would have halved
Non-quality-adjusted (NQA) productivity under actual and counterfactual scenario where average length of stay remained constant at 2000/01 levels, England



Source: Health Foundation calculations based on data from the ONS and NHS Digital · Productivity recorded is NQA.

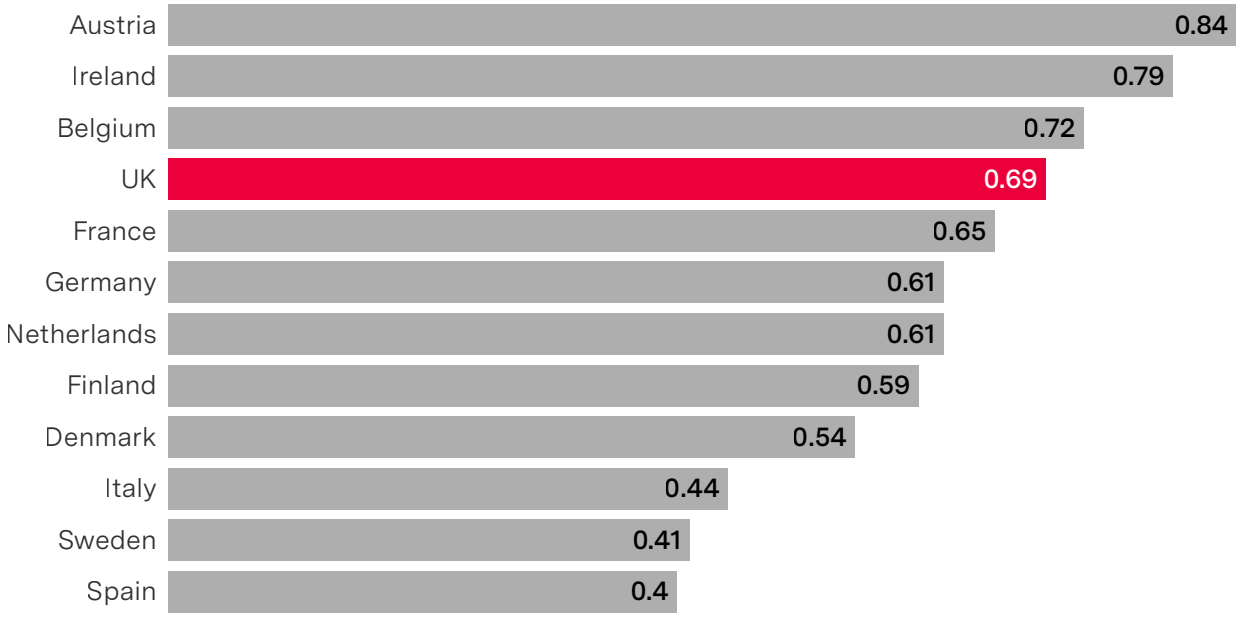
Together, shorter stays in hospital and a shift towards day cases have been enabled by less invasive surgery, faster diagnostics and safer anaesthesia, supported by services outside of hospital such as reablement and adult social care. These have been reinforced by national policy levers (particularly financial incentives) and benchmarking (NHS RightCare and Getting It Right First Time, for example) and ultimately delivered by front-line clinical and operational leadership.[34,38] The length of hospital stays increased at the onset of the COVID-19 pandemic;[39] bringing this down is a policy priority.

How does the NHS compare internationally?

International comparisons

When comparing health care data internationally, caution is needed due to differences in data collection and reporting, as well as broader variability in the context and design of health care systems between countries. That said, the NHS has long been considered a relatively efficient health care system (Figure 7). For instance, it has high use of cheaper generic drugs, a low length of stay, high levels of bed occupancy and low administration costs.[39,40]

Figure 7: The UK was judged to have a relatively efficient health care system before the pandemic
DEA score: total health expenditure (per capita in PPP) versus hospital discharges (2012 or latest)

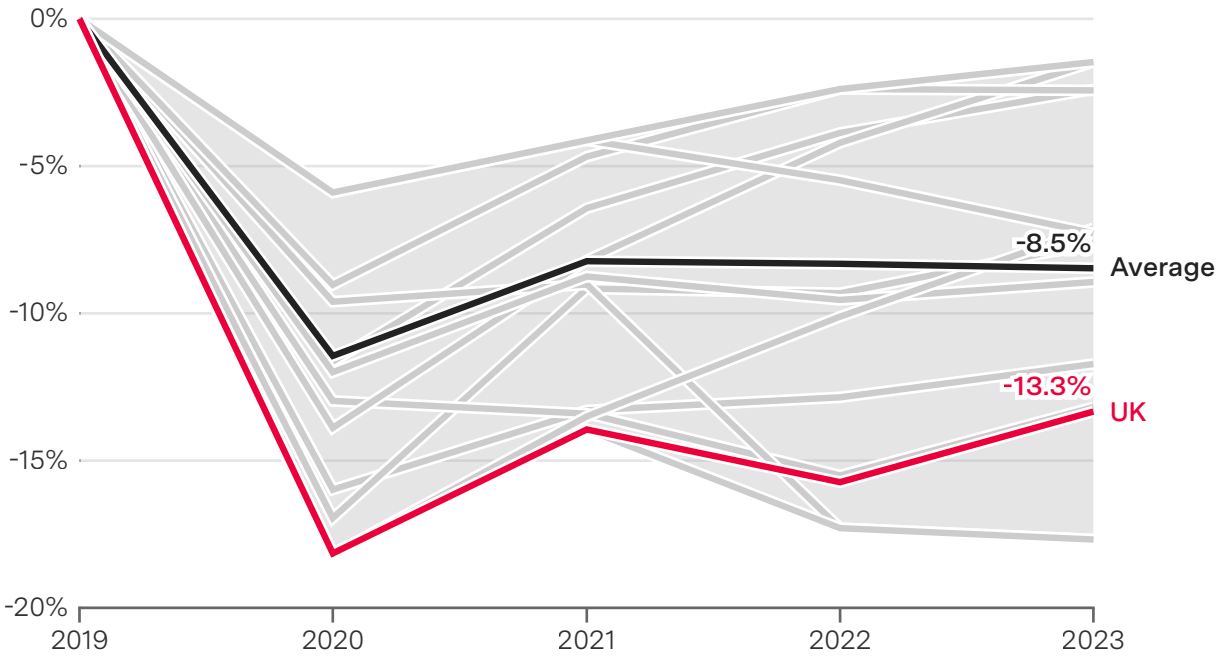


Source: Intermediate outputs (Model 4), Annex 5, Efficiency estimates of health care systems (2015), European Commission · Includes a subset of comparator countries. DEA = data envelopment analysis; PPP = purchasing power parity.

Since the pandemic, however, the UK seems to have experienced both a steeper fall in hospital activity and a more protracted recovery than many peers, suggesting a deeper drop in productivity (Figure 8).

Figure 8: The UK experienced one of the sharpest falls in hospital discharges since the pandemic and has recovered more slowly

Percentage change in hospital discharges in the UK and peer countries versus 2019



Source: OECD Hospital aggregates (data accessed: 10 October 2025).

Comparison with other sectors

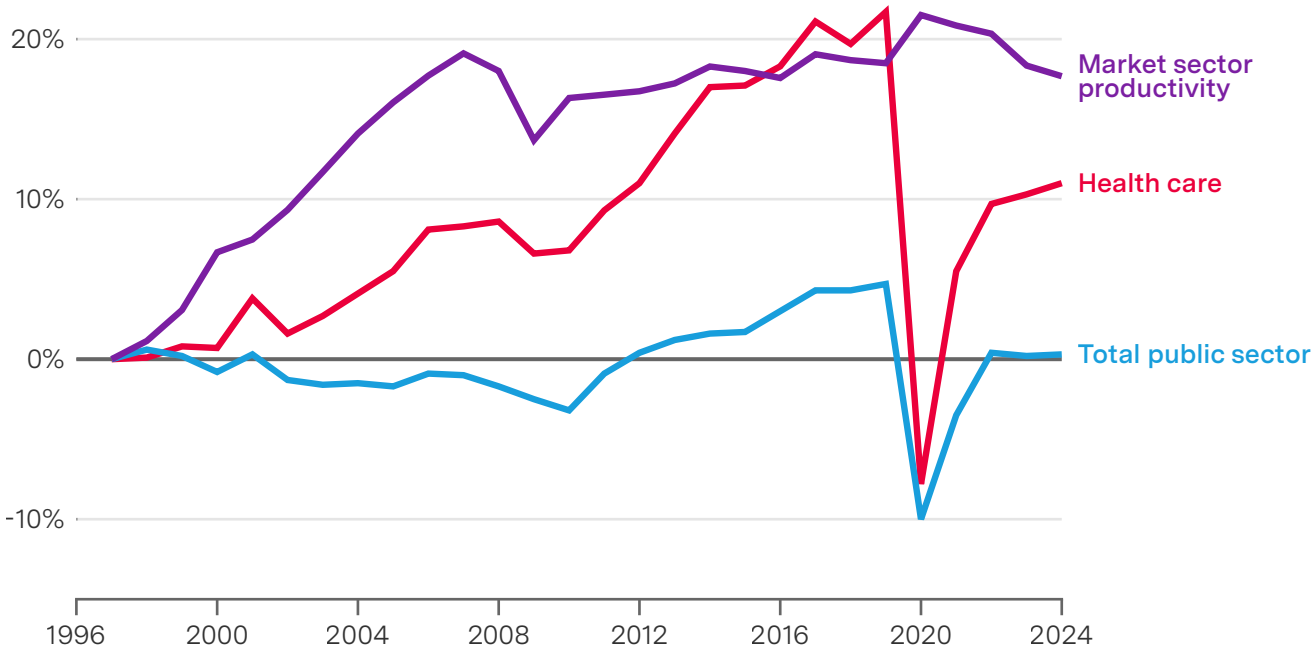
Comparing changes in health care productivity with that of the wider public sector and the market (private) sector reveals (Figure 9):

- Productivity growth was robust before the pandemic: the NHS performed very strongly in the 2010s, recording higher growth than the market sector prior to COVID-19. Productivity growth was also much higher than other public services.*
- The productivity slowdown since the pandemic has been more pronounced in health care compared with both the wider public and market sectors, albeit health care is now recovering.

* This measure shows the NQA comparison, but the difference is even greater once QA productivity is included.

Figure 9: Health care productivity outperformed other sectors before the pandemic but the slowdown since has been more severe

Percentage change in productivity versus 1997 by sector, UK



Source: ONS annual multi-factor productivity and public service productivity (total and health care).

Broader system productivity

The ONS approach to measuring productivity is world leading, but it does not cover all the wider issues raised by our definition of system productivity in health care. Here we consider two further aspects: the link between funding and inputs (economy) and the link between outputs and outcomes (effectiveness).

Economy: funding productivity

The **economy** of the NHS is the value for money it receives when purchasing resources to deliver care. Since 2002/03, there have been periods when funding has increased faster than inputs and periods where the opposite holds. Overall, the Institute for Fiscal Studies finds that health care 'funding productivity' (how many outputs the health service can buy with every pound of spending) has risen, but by less than the rate recorded under the standard ONS measure.[42]

Pay is the NHS's largest cost, accounting for around two-thirds of spending. Wage growth can push up spending faster than the inputs needed to deliver care, but this may be necessary to recruit and retain staff and is partly driven by pay trends in the wider economy.[42,43]

By contrast, there are areas of spend where the NHS has more control and has not always secured value for money. Major capital programmes have faced cost overruns and procurement has not always made best use of the NHS's collective buying power.[44,45,46] Reliance on agency staffing has also raised costs without building long-term capacity.

Taken together, these trends mean that even during periods of rising NHS funding the service has not always translated additional spending into proportionate increases in inputs (and then activity or outcomes). Importantly, though, the cheapest option is not always the best value – as seen in patient transport contracts that were underpriced.[47]

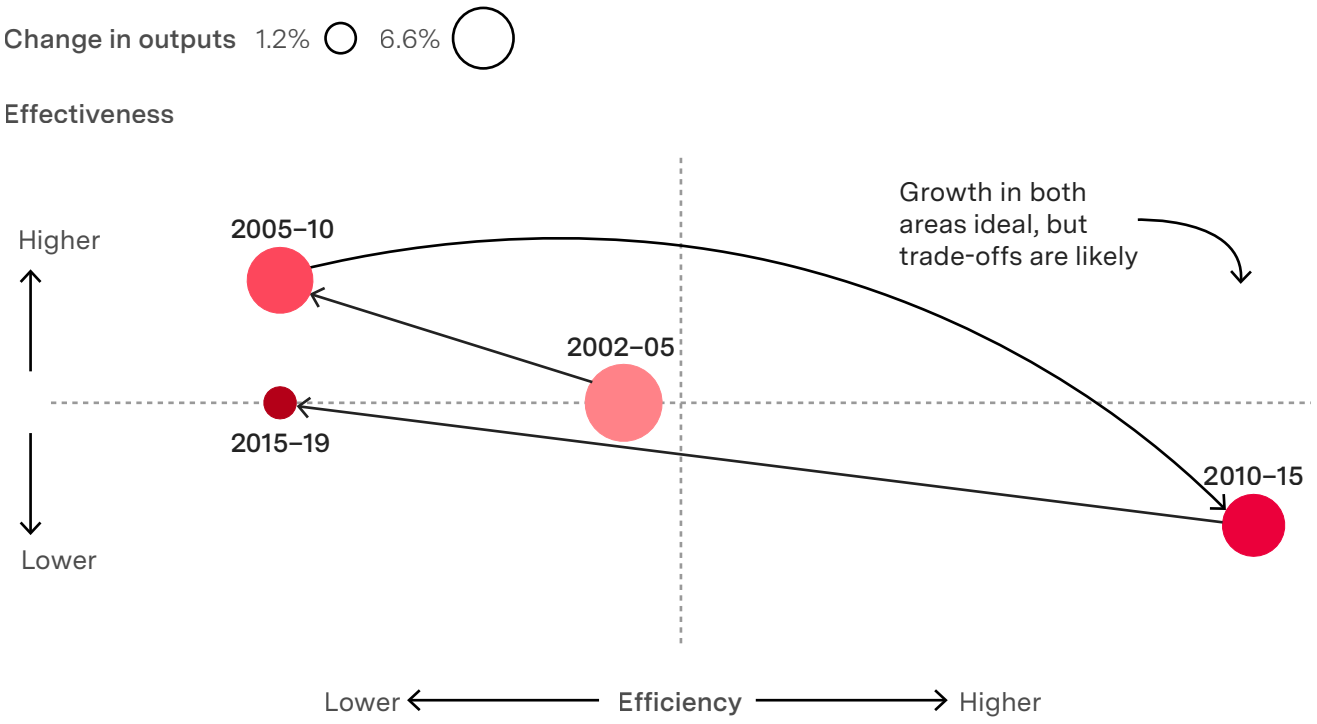
Effectiveness: outputs and outcomes

Effectiveness is about whether care delivered by the NHS translates into better outcomes for patients and the wider population. In other words, it measures how well NHS activity turns into improved population health or experience. Ideally, both **efficiency** (more output per input) and **effectiveness** (better outcomes from outputs) improve together. But past trends hint at a tension between the two.

In the 2000s, England saw major improvements in outcomes such as avoidable mortality, infant mortality and avoidable hospital admissions, but productivity growth was relatively weak. In the 2010s, the picture shifted: growth in inputs slowed and outputs held up; productivity was high but progress against many outcomes (proxied in Figure 10 by avoidable mortality) stalled.

Figure 10: In the early 2010s, efficiency was high compared with previous periods, but progress on outcomes stalled

Growth in efficiency versus growth in effectiveness by time period, England



Source: Efficiency: ONS public service productivity estimates: health care, England (2022); Effectiveness: ratio of outputs (ONS, 2022) to progress derived from ONS. Avoidable mortality in England and Wales (2023) · Metrics are calculated using compound annual growth rate from start to end year.

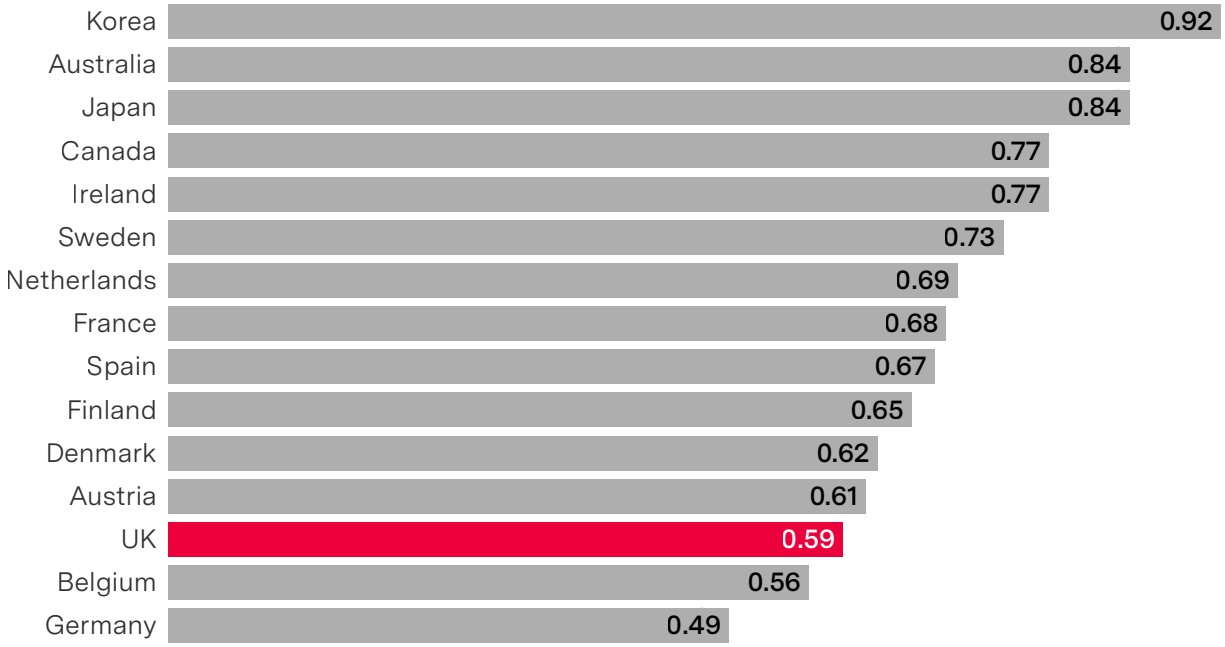
Box 1: Efficiency–effectiveness trade-offs?

All being equal, greater efficiency should support better outcomes. But more activity is not always more effective. For example, in screening programmes, targeted testing often outperforms broad-based programmes; wide testing can produce low-value care (many negatives) and even harm (false positives). The Organisation for Economic Co-operation and Development (OECD's) research shows a sizeable share of inpatient costs reflect harm from care.[48]

Overall, research suggests there is scope to improve the cost effectiveness of UK health care (Figure 11). Studies suggest that some spending on new medicines (2000–2020) delivered less overall health than the care it replaced,[49] and some other National Institute for Health and Care Excellence (NICE)-approved innovations may have reduced net health once trade-offs are counted.[50,51] Meanwhile, primary care, community services and public health – often better value – appear to have been underfunded.[52]

Figure 11: Research suggests the UK could have improved the effectiveness of spend even before the pandemic

DEA score: health expenditure (share of GDP) versus age-standardised mortality rates, 2019



Source: How do health system features influence health system performance? OECD and the Health Foundation · DEA = data envelopment analysis. Selected peer countries.

Diagnosing the problem

- **There is no single cause of the NHS productivity slowdown.**
- **Rising patient complexity, undermanagement, lack of physical capacity – both in and outside of hospital – and staff turnover all contributed to the recent increase in hospital stays.**
- **Many issues predate the COVID-19 pandemic and cast doubt on the sustainability of productivity gains in the 2010s.**
- **There are opportunities to increase productivity, but experts are not confident the NHS will meet its 2% target.**
- **The NHS must avoid a 'diagnosis without delivery' trap that could lead to prolonged weaker productivity growth.**

Causes of NHS productivity slowdown

Many organisations have explored the NHS productivity slowdown. The Health Foundation-commissioned report, *The NHS productivity puzzle*, from the Institute for Government (IfG) and Public First, identified under management, lack of capital and the loss of senior staff as key factors.[53] Other studies are consistent with the IfG and Public First assessment, pointing to pressures on patient capacity and flow – both through and out of hospitals – as well as workforce, capital and estates, technology and data, and the finance/measurement and incentive environment (Table 2).

The causes of the NHS productivity slowdown are multifaceted and interdependent; they must be tackled together, not with isolated fixes.

Table 2: Causes of the NHS productivity slowdown

Theme	What is slowing productivity?
Patient capacity and flow	Discharge delays; higher acuity/complexity; low out-of-hospital capacity, including adult social care; blocked beds and longer length of stay
Workforce and management	Undermanagement; burnout and sickness; experience mix/supervision burdens; industrial action; lack of flexible deployment
Capital and estates	Underinvestment; £13.8bn maintenance backlog; slow approvals; weak workforce–capital alignment
Technology and data	Legacy systems; poor interoperability; under-resourced change; rigid workflows/systems
Finance/ measurement and incentives	Return to block payments in acute care; short-termism and heavy assurance burdens; repeated provider deficits; concentration of care in hospitals

Source: Institute for Government/Public First, The Health Foundation, Nuffield Trust, The King's Fund, Institute for Fiscal Studies, NHS Providers, Healthcare Financial Management Association, NHS Confederation, NHS England.[22,54,55,56,57,58,59,60]

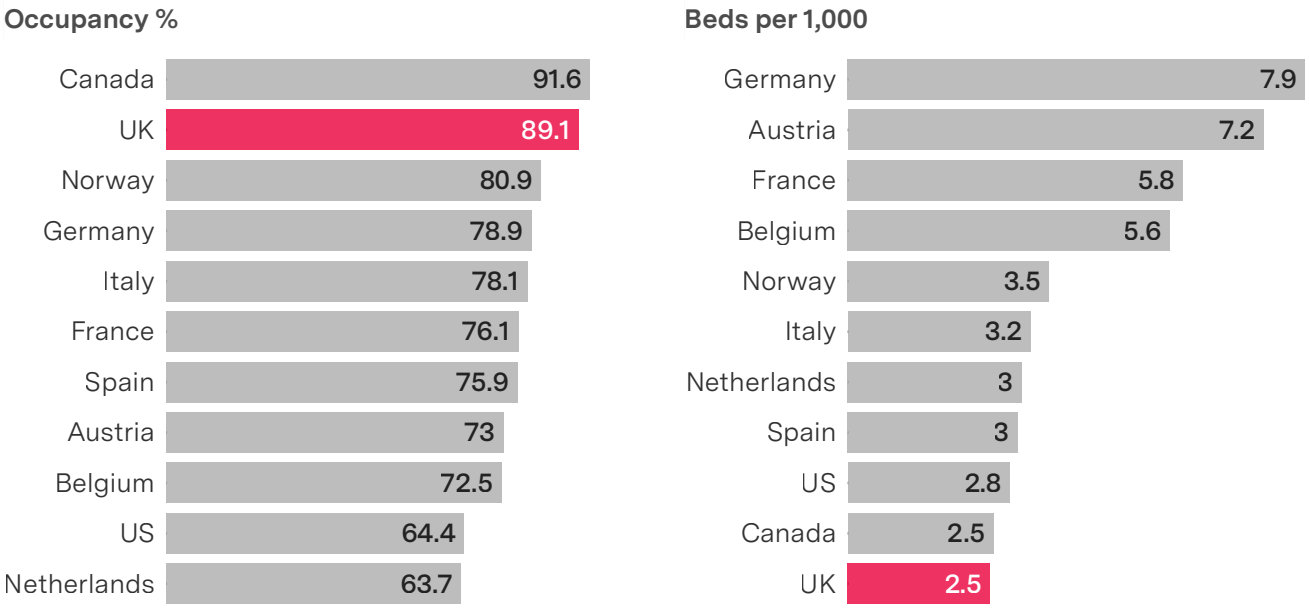
There is broad consensus that the causes of the NHS productivity slowdown are multifaceted and interdependent: for example, poor estates worsen flow, and limited management capacity slows technology adoption. This means they must be tackled together, not with isolated fixes.

A second consensus is that many challenges predate the pandemic. The 2010s saw the NHS deliver strong productivity gains. However, constraints on inputs, notably capital investment and pay/workforce growth, boosted in-year productivity measures while storing up pressures and limiting future capacity. Sustainability matters: choices that improve measured productivity in the short term can lower potential in the medium term – this has important implications for how we think about productivity.[61,62]

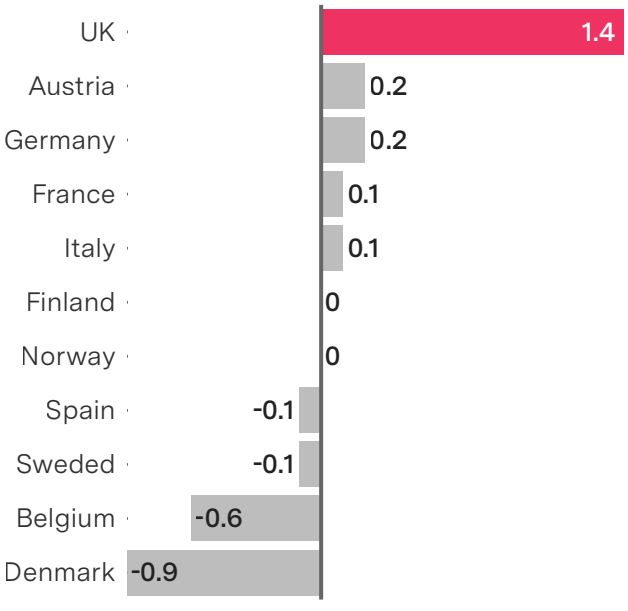
International analysis

International comparisons reinforce these two main findings: that the NHS productivity shock is multifaceted and has long roots. Data show the UK entered the pandemic with low bed capacity and high occupancy. Average length of stay then rose, putting pressure on capacity while the hospital workforce expanded. Hospital activity, proxied by hospital discharges, fell. That combination – more inputs, despite other constraints, resulting in lower output – helps to explain the scale of the NHS productivity shock.

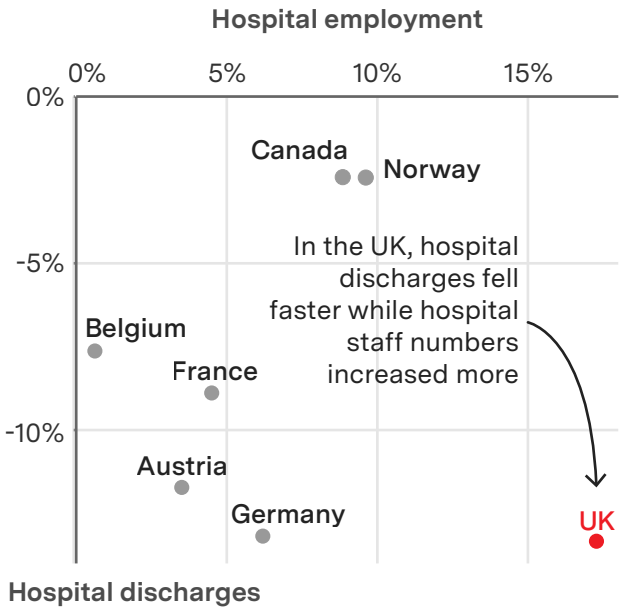
Figure 12: The UK entered the pandemic with low bed supply and high bed occupancy
Hospital bed occupancy and supply of beds, UK and other countries, 2019



Hospital stays lengthened but the UK had little spare capacity...
Change in average length of stay in hospital (days), 2023 versus 2019



...and activity fell and has not recovered: the UK is an outlier
Percentage change in hospital employment and hospital discharges, 2023 versus 2019



Source: OECD Health Statistics (via the OECD SDMX API, accessed 10 October 2025). Measures used: Hospital beds per 1,000 population – 2019 (Hospital resources dataset); Bed occupancy – Curative care hospitals (HC1), 2019 (Hospital aggregates); Average length of stay (ALoS) – Inpatient, total (indicator), 2019 & 2023 (Hospital aggregates); Discharges – Inpatient, total, 2019 & 2023 (Hospital aggregates); Hospital employment – FTE, 2019 & 2023 (Health employment).

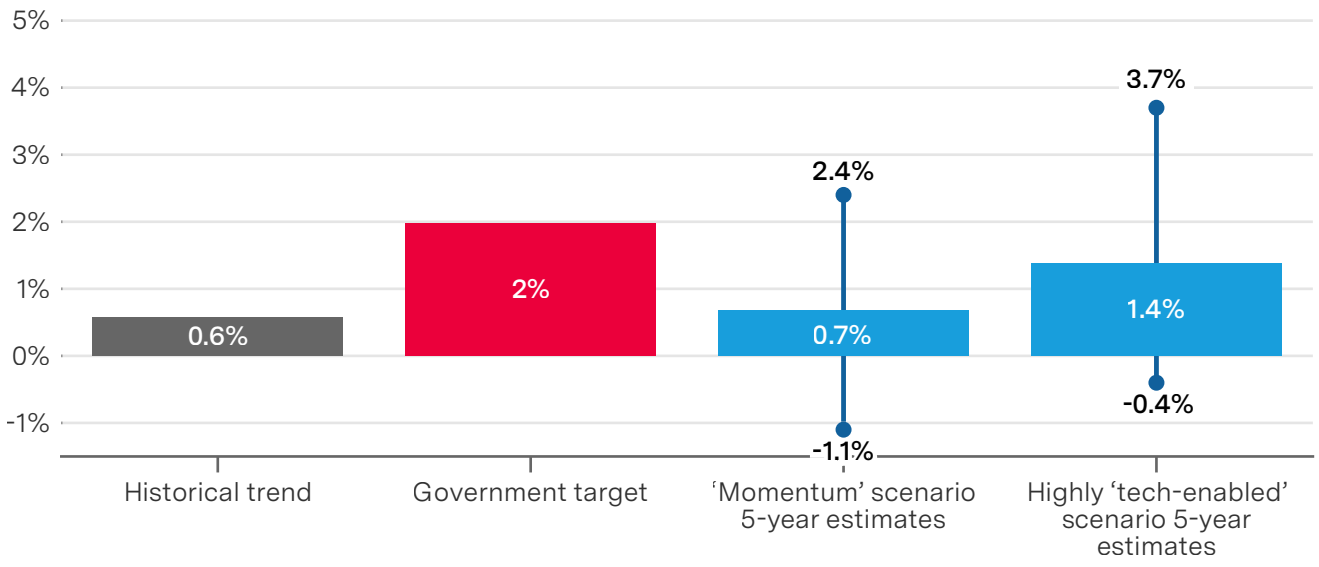
Avoiding ‘diagnosis without delivery’

The 2025 Spending Review set a multi-year funding increase and an ambitious 2% annual productivity target,* underpinned by operational and clinical improvement, digital transformation and workforce initiatives.[14] Faster growth is plausible in the short term, as services recover productivity lost at the start of the pandemic by reducing length of stay and agency costs, but the longer term outlook is less certain.[63]

The Health Foundation, supported by The Strategy Unit, convened a diverse group of 14 experts with research, policy and front-line experience to consider the outlook for productivity. These experts judged this growth hard to sustain and were not confident that productivity growth would meet the 2% annual NHS target under current policies (estimates equate to a 15% chance, roughly 1 in 6, that the target will be met) (Figure 13).[15]

Figure 13: Based on the current direction of travel, experts did not think the government’s 2% productivity target would be met

NHS annual productivity (NQA) growth rates (historical trend, target, expert estimates)



Source: Historic trend: ONS growth in NQA health care productivity, 1995/96 to 2018/19; Scenario estimates: analysis of results from a productivity expert elicitation session run by the Health Foundation and The Strategy Unit, July 2025 · ‘Momentum’ scenario assumes continuation of current direction of travel. Hypothetical ‘tech-enabled’ scenario assumes adequate funding, sustained investment and support for adoption of technology for a highly tech-enabled NHS.

* It has not been made wholly explicit what metric this target is being compared against, as there are multiple different measures available from the ONS and NHS England, among others. The productivity plan contributes directly to efficiency gains and is compared with the NHS’s non-quality-adjusted growth rate over time: this suggests the 2% target is a non-quality-adjusted measure.[14]

Failure to meet the 2% target would impact near-term public sector efficiency plans and performance, requiring the government to either accept lower standards of care or award more funding.[64] According to Health Foundation analysis, if NHS productivity grows by 1% a year instead of 2%, the NHS would need about £9bn extra each year to the end of this parliament to provide the same level of care.[10]

However, there are also risks associated with attempting to meet this target, namely that the pursuit of short-term productivity gains crowds out longer term priorities. The last time the NHS achieved 2% annual productivity growth (NQA) in the early 2010s, subsequent growth was much weaker (0.3% NQA) (Table 1).

Policy should pair immediate gains with longer term enablers. The same experts convened by the Health Foundation believed that technology could boost NHS productivity but only with the right investment and if adopted and implemented at scale (Figure 13). They also shared concerns over elements such as workforce retention and limited capital investment.[15] Moreover, many policy ambitions for improving quality and productivity reflect long-standing aims (such as care closer to home, prevention and reducing variation) that have seen limited progress – and there are real tensions to manage (for example, pushing hospital efficiency while investing in out-of-hospital care).[22,65,66]

The risk, echoing productivity performance in the wider UK economy post-2008, is 'diagnosis without delivery': repeated identification of barriers and solutions but without execution. The root causes – underinvestment, misallocated resources, skills mismatches and limited management capacity – overlap and reflect the core drivers of productivity growth.[67,68,69] To realise the opportunities of the next decade, the NHS needs a cohesive package of reforms to support sustained and sustainable productivity growth. The next section presents a framework to guide this.

A framework for improving productivity

What are the drivers of productivity?

Governments and research bodies have long employed practical models to make productivity understandable and actionable.

For instance, HM Treasury's 'five drivers of productivity' – investment, innovation, skills, enterprise and competition – provide an accessible structure that shaped policy.[70] Research by the World Bank identified a similar set of core drivers – innovation, education, infrastructure, market efficiency and institutions[71] – while the OECD stresses inclusiveness and tackling variation.[72,73,74] Despite differences in emphasis, these approaches overlap in important ways.[71]

We identify four main drivers of productivity that can be applied to health care (Figure 14):

1. **workforce**: the people who support care delivery
2. **capital**: the buildings, equipment and digital infrastructure
3. **technology and innovation**: the adoption, implementation and spread of technologies
4. **transformation**: the things that enable the system to work more effectively, including leadership and management, coordination and governance.

Workforce

People get more done when they have the right skills, work in well-run teams and focus on high-value tasks. Large-scale studies consistently link both the quantity and quality of education to increased output and faster adoption of new technologies.[75,76,77] But it is not just about cognitive ability – soft skills such as sociability and teamwork are also predictors of outcomes.[78] Effective management and a positive team climate help to translate skills into performance.[79] Structured training and a strong team culture improve safety and reliability across sectors.[80] Finally, reducing low-value administrative activities – such as meetings, duplicative reporting and complex approvals – helps to free up time for core tasks and delivers productivity gains.[81]

Capital

Providing people with better tools, equipment and buildings helps them to produce more, with fewer errors and less disruption.[82] Many years of research have shown that capital investment raises output per worker – and more recent evidence shows investing in information technology (IT) enables even higher returns.[83,84] But it matters how money is invested and managed: programmes perform better when assets are chosen, placed and maintained well, with clear approval steps and follow-through.[85,86] Targeted upgrades that remove bottlenecks can unlock additional gains.[87]

Technology and innovation

New ideas and better methods are fundamental to adding value over time. The biggest gains arrive when proven technologies are adopted widely and paired with process change. For example, a productivity boom in the late-1990s reflected widespread IT adoption while redesigning workflows.[84,88] Studies show that who adopts new ideas and technologies, how quickly and how thoroughly explains large productivity differences across places and sectors.[89,90] Practical enablers – including standards, training, interoperable data and proportionate quality assurance – reduce adoption costs and help spread the benefits.[91,92]

Transformation

The system can only improve productivity when goals, rules, incentives and resources align – and when the system can shift people, money and assets to higher-value inputs and settings. A robust evidence base links institutional quality – especially policy stability and regulatory quality – to increased investment and productivity.[93,94] At the economic level, better allocative efficiency – whether changing the input mix or shifting resources to more productive firms and sectors – raises output and productivity.[95,96] Finally, within organisations, stronger management practices can raise productivity by deploying resources more effectively across sites and products, without necessarily needing more inputs.[79,97]

Applying the drivers to health care

While insight can be obtained from broader definitions of productivity, health care is distinct in several important ways.

Competition: as patients do not face the full costs of NHS health care, market signals such as price and consumer choice are muted. For that reason, competition often plays a relatively limited role in a publicly funded system, though competition-like mechanisms can be used as policy tools.

Balance: health care services often pursue several, potentially conflicting objectives at once, such as access, safety, efficiency, clinical effectiveness and equity. For this reason, it is important that productivity balances economy (getting best value when purchasing inputs), efficiency (turning inputs into care) and effectiveness (generating outcomes that matter to patients).

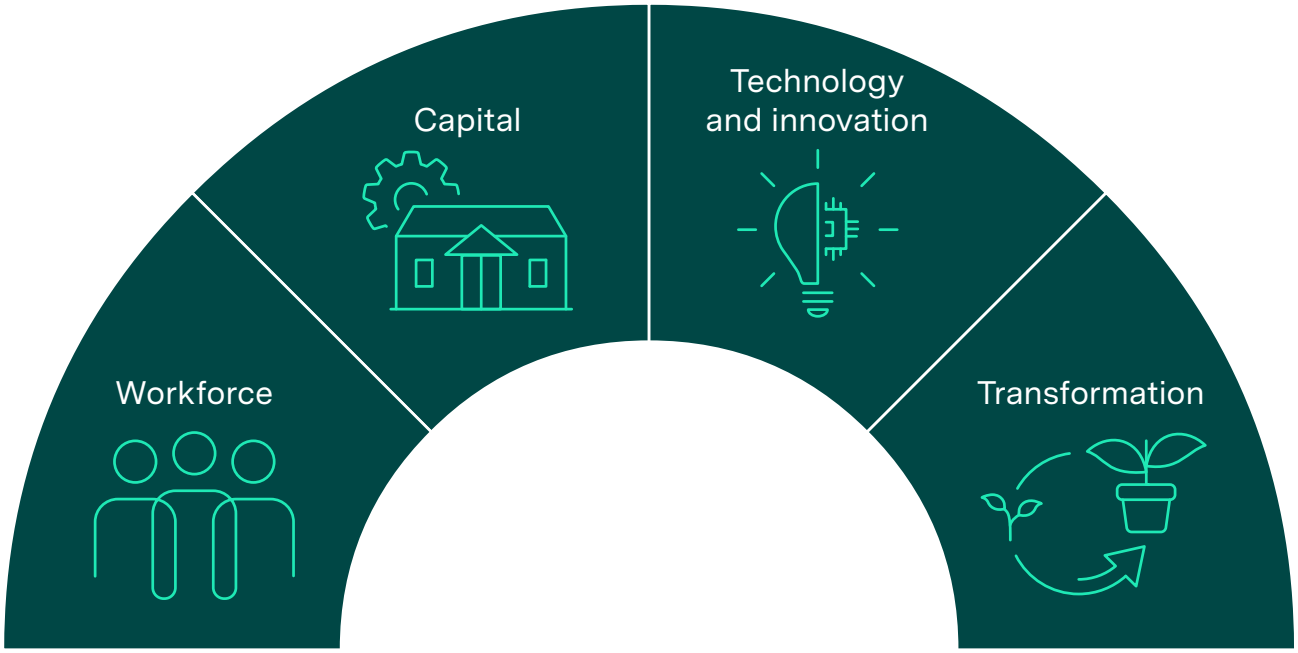
Human-centred: care poses higher risk and assurance requirements than many other sectors. However much digital technologies and automation are adopted within the NHS, staff will remain at its heart.

Complexity: the NHS is a composite system, delivering services across a wide range of settings and with responsibilities spread across national bodies, regulators and local organisations. No single actor has complete control and there are many policy levers, which can result in duplication, gaps or misaligned incentives. These can make system-wide reform difficult. The OECD's performance and resilience work shows that gains come when several levers move together, so that different actors pull in the same direction.[98]

Figure 14: A framework for NHS productivity

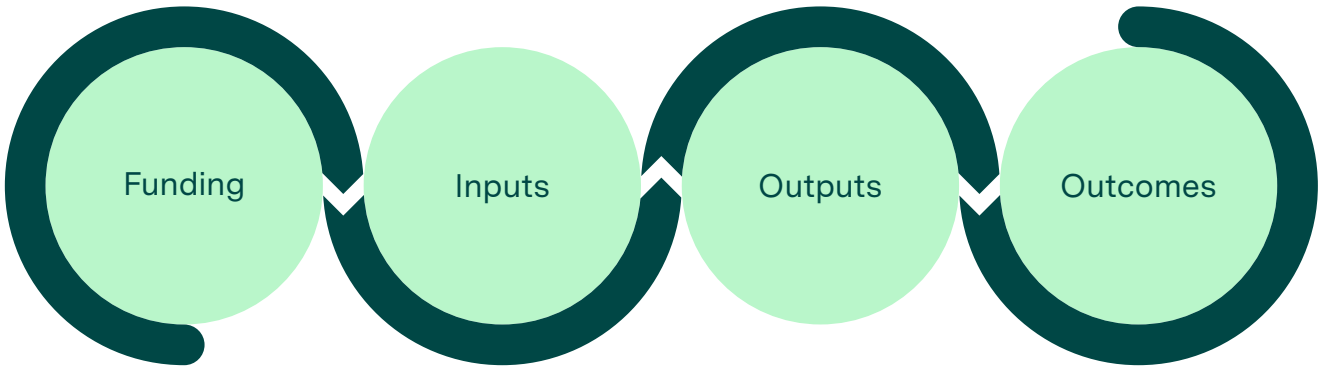
The NHS needs a broader and purposeful framework for productivity. Our framework is grounded in the understanding that **health care is a complex system**.

We identify **four main drivers of productivity**:



Policymakers have access to a wide variety of **policy levers** that can be applied to these drivers – including incentives, targets, regulations and guidance.

Our goal is to generate policy solutions that **improve productivity** and ultimately **health outcomes**:



Workforce

Scope

This driver includes how the workforce is trained, deployed and supported, how careers progress, and how teams and cultures enable safe, effective care. The NHS in England directly employs around 1.5 million people across clinical and non-clinical roles, in addition to the large numbers employed in general practice, pharmacy and dentistry. This is not to mention those in the voluntary, community and social enterprise sector, independent sector partners, and a large volunteer base who also support the delivery of care. This driver will focus on the workforce employed or commissioned by NHS organisations while recognising the contribution of other sectors to NHS productivity.

Context

Productivity rises when the right skills meet the right need at the right time; when clinical time is not swallowed by administration;[99] and when tools, supervision and culture help teams perform.[100]

NHS pressure points include losing experienced staff, high sickness and burnout rates, rigid roles and slow progression, inflexible training pipelines, thin management capacity and environments where staff are frustrated by process or equipment faults.

Exploratory questions

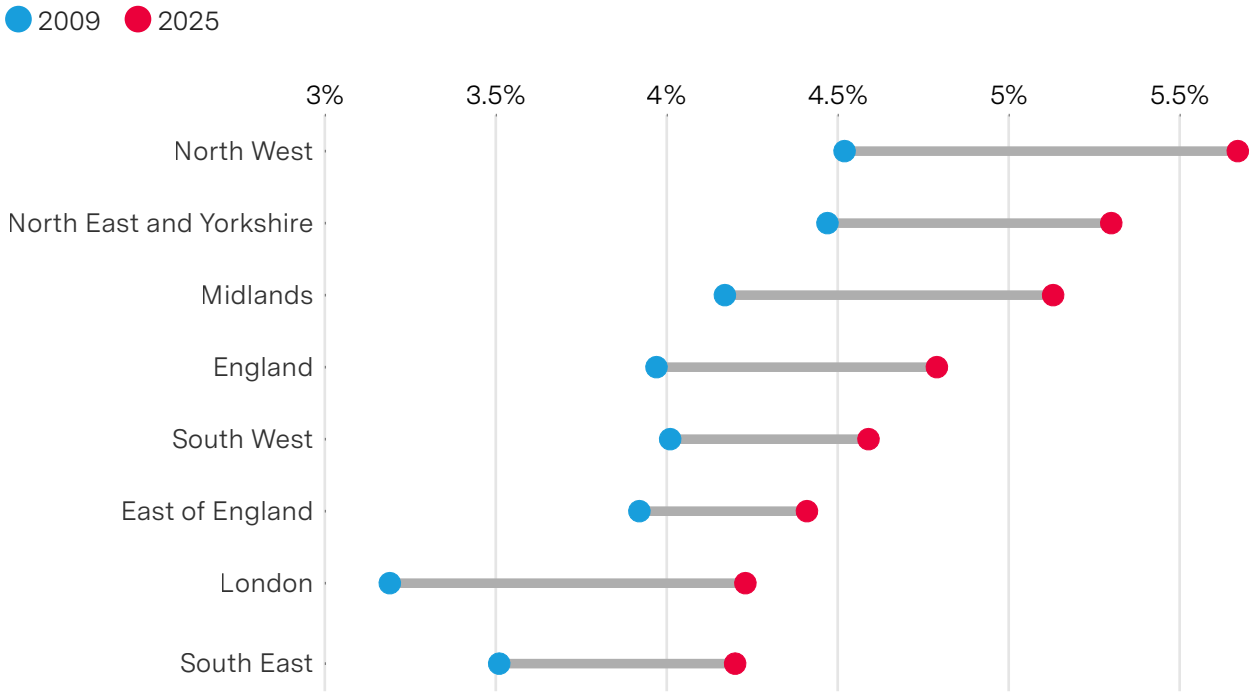
- What mix of roles and skills do teams need in different care settings to meet changing demand?
- How should the NHS reshape day-to-day work so that scarce clinical time is spent on clinical care rather than administration?
- Which broad retention levers – flexibility, progression, wellbeing and pay architecture – most reliably stabilise teams?
- How should education and continuing professional development evolve so that skills keep pace with new models of care?

Case study: Improving workforce efficiency

University Hospitals Sussex NHS Foundation Trust used the HealthRota e-rostering system to match staff skill mix to shift needs, to improve shift flexibility. Staff could share availability, swap shifts and receive rotas via email. The reported improvements in staff retention and efficiency, and lower locum doctor costs, are in line with evidence from wider systematic reviews.[101,102]

Figure 15: NHS staff absence rates have risen across England and are particularly high in the North West

Monthly staff absence rates by NHS England region, April 2025 versus April 2009 (%)



Source: NHS Sickness Absence Rates, April 2025 – Staff in NHS Trusts and other core organisations.

Key fact

Google's Project Aristotle found that psychological safety – not pay or cognitive ability – was the strongest predictor of team success[100]

Capital

Scope

Capital covers the NHS's estate, equipment and core digital infrastructure – both the stock in use and the flow of new investment – across hospitals, primary and community services, and partner providers. It includes what is bought, how it is procured, where it is placed and how assets are maintained and shared.

Context

Modern, reliable assets – scanners, theatres, IT and estates – improve patient safety and flow, as well as clinician effectiveness; ageing or fragile kit drives downtime, cancellations and repeat tests. Barriers include ageing buildings and digital infrastructure, a large maintenance backlog, slow and centralised approvals, fragmented funding pots that are hard to reallocate, and weak alignment between capital plans and workforce/service plans. Despite significant underinvestment in capital, budgets are often not fully used.[103] There are opportunities to prioritise high-impact upgrades, simplify routes to invest and protect capital so that it delivers over time.

Exploratory questions

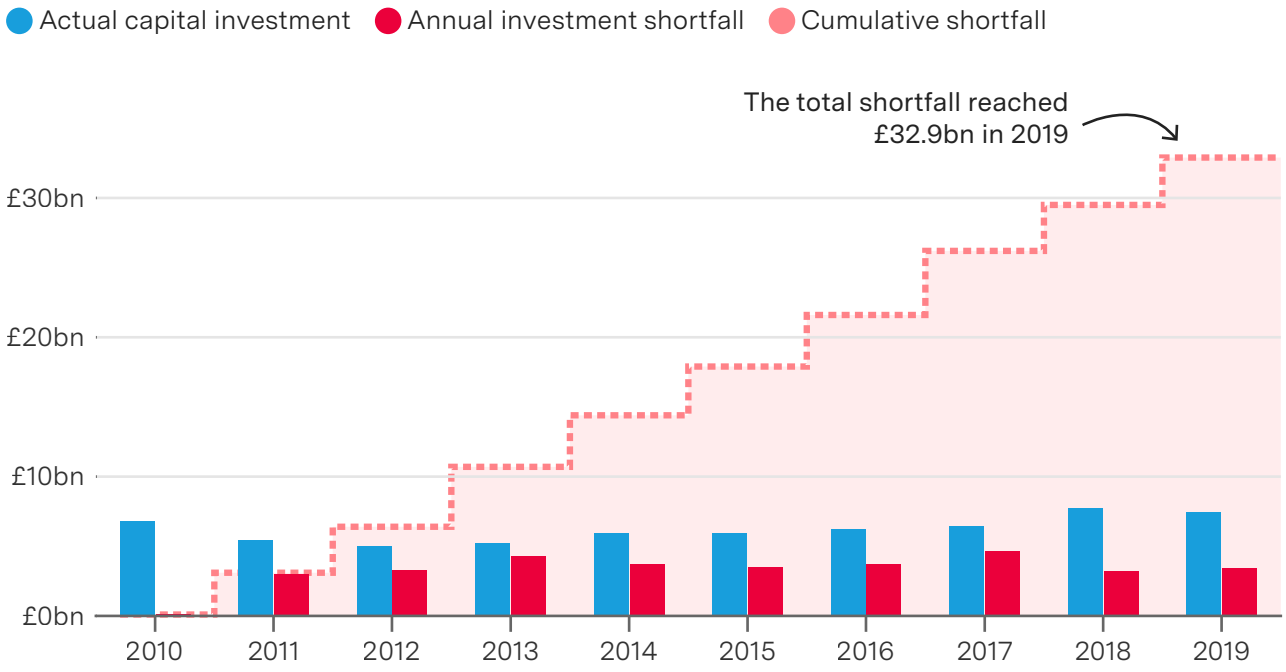
- What processes would make procurement and approvals simpler, faster and more reliable?
- How should the NHS allocate capital across places and sectors to have the greatest impact on flow, safety and capacity?
- What are the most strategic investments to meet the needs of the future population, and how can capital budgets be protected from short-term raids?
- How can capital planning be tied directly to workforce and service redesign so that assets are used to full effect?

Case study: Achieving economy in capital procurement

When NHS organisations pool purchases of expensive equipment, they can negotiate lower prices and better terms.[105] A £300m fund established in 2012 enabled trusts to buy high-cost imaging equipment together via NHS Supply Chain, using standard specifications and whole-life costing; programme updates reported further multi-million savings from bundled deals. The National Audit Office's 2024 review confirmed that aggregating demand and standardising purchases secures better prices and value – though take-up across the NHS remains uneven.[101]

Figure 16: During the 2010s, the UK would have needed to invest £32.9bn more to match spending of comparable countries

Capital investment and investment shortfall in health care compared with other countries, 2010–2019 (2019 prices)



Source: OECD Health Statistics 2022 · European average for capital only covers Austria, Denmark, Finland, France, Greece, Ireland, Luxembourg and Sweden due to data availability.

Key fact

NHS capital per worker has fallen by 36% in real terms since 2010[104]

Technology and innovation

Scope

This is the data, digital systems and technologies that support care, including but not limited to: electronic patient records, decision support, AI, remote monitoring, virtual wards and automation – plus the pathway redesign and change management needed to make them work in practice. The emphasis is on adoption at scale, not just choosing 'big bets'.

Context

Innovations such as AI could transform health care delivery.[107] But new technologies tend to raise productivity most when embedded in redesigned workflows, not layered on existing processes.[108] This works best when underpinned by interoperable data and confident users. Progress is often slowed by legacy systems, uneven digital maturity and limited implementation capacity. Crucially, incentives can help shape uptake: adoption is spurred when services retain some of the savings or time released. Appropriate assurance processes and evaluation can help manage safety (including for AI) without creating burdens that deter rollout.[109]

Exploratory questions

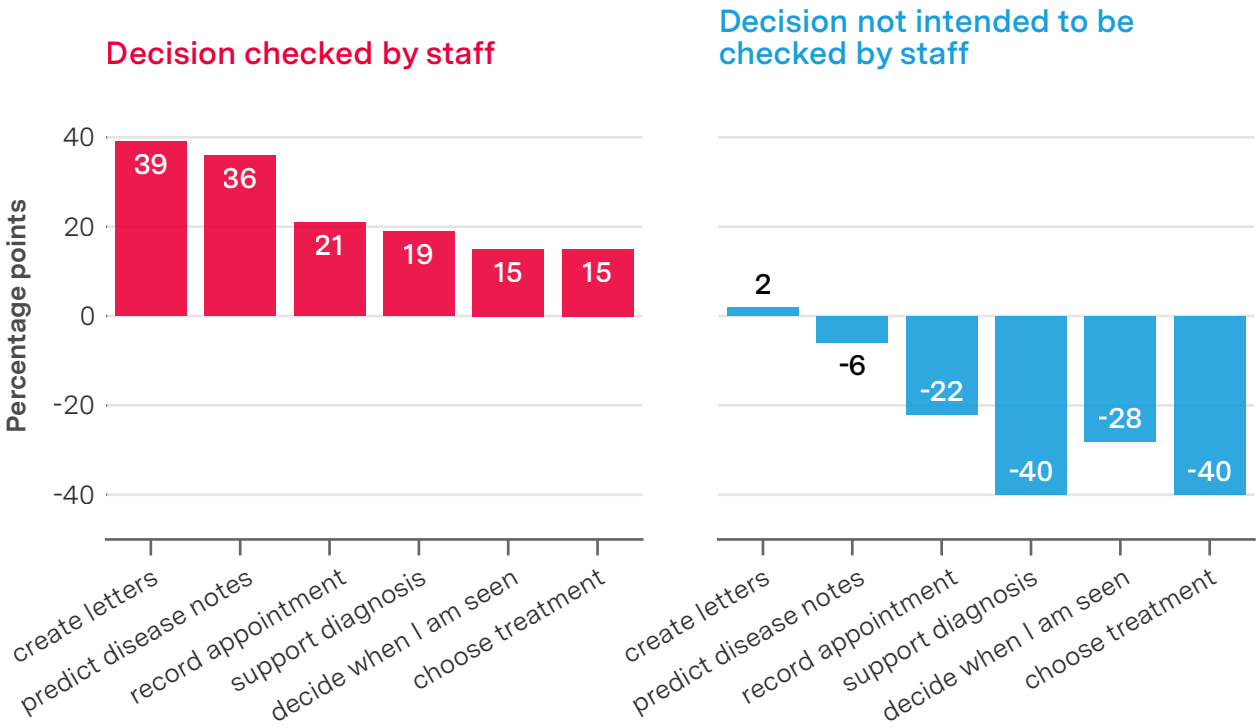
- How can the NHS identify pathways that benefit most from digital redesign to materially improve flow and outcomes?
- What incentives, common standards, funding models and commercial approaches would make interoperability and spread the default?
- How much management and improvement capacity is needed to make adoption stick, and where should it sit?
- How can benefits, safety and equity be monitored most effectively so that confidence grows as tools are scaled up?

Case study: Supporting effectiveness in community palliative care

As part of the EnComPaSS Integration project in Sheffield, senior staff in a community palliative care setting could provide remote support to colleagues via mobile technology. This allowed junior colleagues to operate more independently, so fewer joint visits were required. An evaluation of this pilot found it led to a reduction in A&E admissions and patients reported improved quality of care.[111]

Figure 17: The public does not, on balance, support the use of AI in the NHS if the outputs are not checked by staff

'I would be happy for the NHS to use AI to...'



Source: UK public survey fieldwork carried out online and by phone by Censuswide, 7 June to 8 July 2024; total sample size 7,201 adults (85% from England, 8% Scotland, 5% Wales and 3% Northern Ireland); figures have been weighted and are representative of all UK adults (aged 16 years and older) · Scores are calculated as the percentage point difference between the proportion who would be happy and the proportion who would not be happy with each scenario. X-axis labels have been paraphrased for ease of reading.

Key fact

70% of integrated care systems (ICSs) have electronic bed management systems, but fewer than 40% report seeing benefits[110]

Transformation

Scope

Transformation is the leadership, management, governance and incentive environment that sets direction and aligns action. It covers who decides what, how money and accountability flow, how performance is measured and how learning spreads across the system. It involves leaders in the Department of Health and Social Care (DHSC), NHS England, regulators, ICSs and providers.

Context

Productivity is reinforced by sufficient management capacity and capability, clear priorities, consistent rules and empowered local delivery.[112] However, weak leadership, frequent policy shifts, unclear central–local boundaries, conflicting oversight signals and reductions in management capacity pull the other way. It is key to understand where resources are most needed and allocate them accordingly. Aligning finance, regulation and performance management around patient-centred outcomes – and building leadership skills throughout the system to execute decisions on these – creates the conditions for sustained improvement.

Exploratory questions

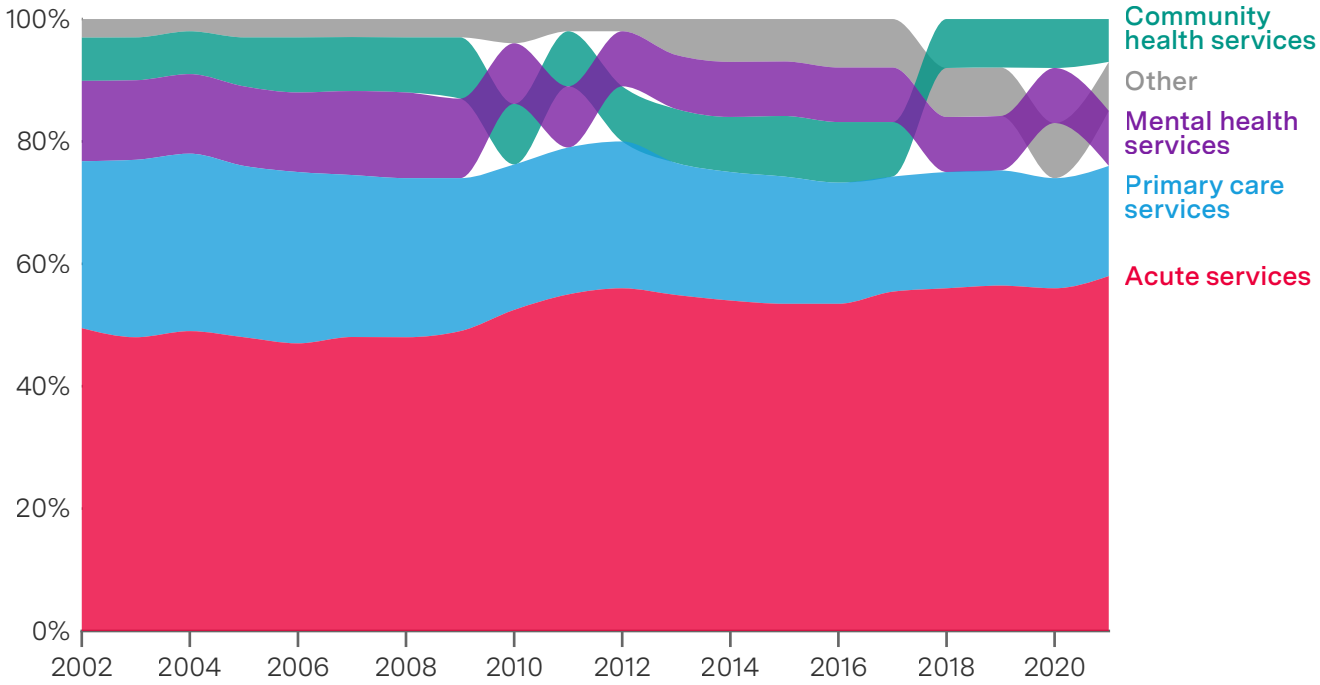
- What should be decided nationally and locally, and how is accountability enforced at each level?
- How can the NHS align finance, regulation and performance management so they pull in the same direction on productivity and outcomes?
- What leadership and management capabilities are missing at system and provider level, and how can they be built at pace?
- What data architecture and improvement approaches can best surface bottlenecks and quickly spread what works?

Case study: Leadership for efficient and effective care

From 2015, five trusts in England worked with the Virginia Mason Institute in Seattle, Washington, US to build a system of continuous improvement. The independent evaluation reported that more clinical time had been released and there was better patient flow in targeted pathways. The most sustained gains occurred when boards stuck to a few priorities, modelled the methods, and protected staff time for improvement.[114]

Figure 18: Acute care has accounted for a growing share of NHS spend in England over the past two decades

Estimated NHS group spend by health care service, 2002–2021



Source: Independent investigation of the NHS in England (Figure VIII.1.1) · There was a change in methodology in 2010 and 2013.

Key fact

60% of NHS trusts have a 'first-time' CEO[113]

From problems to solutions

This report has primarily looked to the past to describe the trends and challenges. But this Commission is especially focused on identifying practical policy solutions for stronger productivity growth.

We know that these solutions will need to be firmly grounded in the evidence of what works. IfG research found that reviews create most impact when they diagnose the real problem, align with delivery capacity and consider implementation.[115]

We will need to consider the evolving landscape. Over the next decade, the health and care system will be shaped by several major forces, including the rate of economic growth and its impact on public finances, an ageing population with many more people living with major illness,[116] and rapid technological change.

For the NHS, the government's 10-year plan sets the high-level policy direction. But locally, leaders and commissioners are dealing with long waiting lists, operational pressures and tight finances, with many providers struggling to balance their books.[117] Our goal is to suggest actions that are bold but can deliver productivity improvements within these real-world constraints.

Our plan of action

Between now and spring 2026, pairs of commissioners will co-author one policy options paper per driver. These will consider how national policy levers can be applied to improve productivity across the NHS in England. Our scope is restricted to health; we will not focus directly on reforms to adult social care or the wider determinants of health, although these are important and changes at the interface with health may be considered.

From spring to autumn 2026, these four policy options papers will be brought together into a final roadmap. This will provide decision makers with a coherent package of reforms to improve productivity, while helping to meet patient need, improve staff experience and support the sustainability of the NHS.

Get involved

Productivity is complex, so identifying policy options will take time – and we cannot do it alone. We will engage with a variety of stakeholders to build our understanding, gather evidence and challenge our thinking. We invite input on our work, including feedback on the scope and direction.

The publication of this report coincides with the launch of our call for evidence. We invite submissions from a wide range of respondents. It is an opportunity to shape this work, including providing general reflections on NHS productivity, your views on the main opportunities and challenges, and your proposed policy options to take those opportunities and meet those challenges.

Evidence and insights will also be gathered from public-facing expert panel events, roundtables, site visits and data analysis – all of which will inform the solutions proposed in the policy options papers and the final roadmap.

Productivity is complex, so identifying policy options will take time – and we cannot do it alone.

Who we are

Co-chairs

Anita Charlesworth and Tera Allas

Secretariat

Stephen Rocks, Alison Moulds, Katie Fozzard, Juney De Aguilar and Hannah Chhoa-Howard

Commissioners

Capital

Richard Murray (Former CEO, The King's Fund)
John Hall (Consultant, former Director of Strategy, DHSC, and former Head of Health Spending, HM Treasury)

Workforce

Habib Naqvi (Director, NHS Race and Health Observatory)
Jim Buchan (Senior Visiting Fellow, Health Foundation)

Technology and innovation

Catherine Davies (Director, Digital Healthcare Council)
Matthew Bell (Director and Joint-Head of Public Policy, Frontier Economics)

Transformation

Rachel Wolf (Founding Partner, Public First)
Ben Gershlick (Head of Performance and Planning, University College London Hospitals NHS Foundation Trust)

Expert advisory group members

Hugh Alderwick (Health Foundation)
Hareth Al-Janabi (University of Birmingham)
Duleep Allirajah (The Richmond Group of Charities)
Siva Anandaciva (The King's Fund)
Adriana Castelli (University of York)
Jagjit Chadha (University of Cambridge)
Francesca Colombo (OECD)
Alexandra Eavis (Genomics)
Beccy Fenton (KPMG)
Sara Gorton (Unison)
Katharine Halliday (Getting It Right First Time)
Tim Horton (Health Foundation)
Stephanie Kuku (WHO)
Amrita Kumar (Frimley Health NHS Foundation Trust)
Jacob Lant (National Voices)
Tim Leunig (NESTA)
Adam Memon (NHS England)
Emma Norris (The Institute For Public Policy Research)
Damian O'Boyle (Healthy.io)
Irene Papanicolas (Brown University)
Belinda Phipps (United Response)
Charlotte Refsum (Tony Blair Institute for Global Change)
Peter Spilsbury (The Strategy Unit)
Thea Stein (Nuffield Trust)
Richard Stubbs (Health Innovation Yorkshire and Humber)
Matthew Style (DHSC)
Matthew Taylor (NHS Confederation)

References

1. Health Foundation. NHS Productivity Commission. The Health Foundation; 2025 (www.health.org.uk/funding-and-partnerships/programmes/nhs-productivity-commission).
2. Office for National Statistics (ONS). Public service productivity, quarterly, UK: January to March 2025. ONS; 2025 (www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/bulletins/publicserviceproductivityquarterlyuk/januarytomarch2025).
3. Nuffield Trust. NHS performance dashboard. Nuffield Trust; 2025 (www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-dashboard).
4. Taylor B, Lobont C, Dayan M, Merry L, Jefferies D et al. Public satisfaction with the NHS and social care in 2024: Results from the British Social Attitudes Survey. Nuffield Trust; 2025 (www.nuffieldtrust.org.uk/research/public-satisfaction-with-the-NHS-and-social-care-in-2024-Results-from-the-British-Social-Attitudes-survey).
5. Health Foundation. Public perceptions of health and social care. The Health Foundation; 2025 (www.health.org.uk/funding-and-partnerships/programmes/public-perceptions-of-health-social-care).
6. Organisation for Economic Co-operation and Development (OECD). Fiscal Sustainability of Health Systems. OECD; 2024 (www.oecd.org/en/publications/fiscal-sustainability-of-health-systems_880f3195-en.html).
7. Lorenzoni L, Marino A, Morgan D, James C. Health spending projections to 2030: New results based on a revised OECD methodology. OECD; 2019 (www.oecd.org/en/publications/health-spending-projections-to-2030_5667f23d-en.html).
8. Rocks S, Issa Z, Watt T, Douglas HR. Health care funding projections. Health Foundation; 2025 (www.health.org.uk/reports-and-analysis/working-papers/health-care-funding-projections).
9. Watt T, Raymond A, Rachet-Jacquet L, Head A, Kypridemos C. Health in 2040: Projected Patterns of Illness in England. Health Foundation; 2023 (www.health.org.uk/reports-and-analysis/reports/health-in-2040-projected-patterns-of-illness-in-england).
10. Rocks S, Raymond A, Issa Z, Thorlby R. What does the 2025 Spending Review mean for the NHS? Health Foundation; 2025 (www.health.org.uk/reports-and-analysis/analysis/what-does-the-2025-spending-review-mean-for-the-nhs).
11. Tierney AA, Gayre G, Hoberman B, Mattern B, Ballesca M et al. Ambient Artificial Intelligence Scribes: Learnings after 1 year and over 2.5 million uses. NEJM Catal Innov Care Deliv 2025; 6 (https://doi.org/10.1056/CAT.25.0040).
12. Reddy S, Fox J, Purohit MP. Artificial intelligence-enabled healthcare delivery. J R Soc Med. 2019; 112: 22–8 (https://doi.org/10.1177/0141076818815510).
13. Machin S. Wage controversies: Real wage stagnation, inequality and labour market institutions. LSE Public Policy Review; 2024 (https://ppr.lse.ac.uk/articles/10.31389/lseppr.103).
14. HM Treasury. Spending Review 2025: Departmental Efficiency Plans. UK government; 2025 (www.gov.uk/government/publications/departmental-efficiency-delivery-plans).

15. Cook J, de Lacy J, Wood J, Mohammed MA. 10-Year Productivity Forecast for the English NHS: An Expert Elicitation Study. Strategy Unit; 2025 (www.strategyunitwm.nhs.uk/publications/10-year-productivity-forecast-english-nhs-expert-elicitation-study).

16. Department of Health and Social Care (DHSC). NHS Constitution for England. UK government; 2023 (www.gov.uk/government/publications/the-nhs-constitution-for-england).

17. UK government. Health and Care Act 2022. UK government; 2022 (www.legislation.gov.uk/ukpga/2022/31/contents).

18. Hurst L, Mahtani K, Pluddemann A, Lewis S, Harvey K et al. Defining value-based healthcare in the NHS. Centre for Evidence-Based Medicine; 2019 (www.cebm.ox.ac.uk/resources/reports/defining-value-based-healthcare-in-the-nhs).

19. NHS Arden and Greater East Midlands (GEM) Commissioning Support Unit (CSU). Measuring productivity in Health Care. NHS Arden and GEM CSU; 2025 (www.ardengemcsu.nhs.uk/showcase/news-events/news-events/new-report-published-to-modernise-productivity-measurement-in-healthcare).

20. Office for National Statistics (ONS). Public service productivity, healthcare, England: financial year ending 2022. ONS; 2024 (www.ons.gov.uk/economy/economicoutputandproductivity/publicservicesproductivity/articles/publicservicesproductivityestimateshealthcare/financialyearending2022).

21. Coughlan E, Keith J, Gardner T, Peytrignet S, Hughes J et al. Waiting for NHS hospital care: the role of the independent sector in delivering orthopaedic and ophthalmic care. Health Foundation; 2023 (www.health.org.uk/reports-and-analysis/analysis/waiting-for-nhs-hospital-care-the-role-of-the-independent-sector-in).

22. Darzi A. Independent investigation of the National Health Service in England. UK government; 2024 (www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england).

23. Castelli A, Gaughan J, Nazerai A. Productivity of the English National Health Service 2022/23 Update. Centre for Health Economics; 2025 (https://pure.york.ac.uk/portal/en/publications/productivity-of-the-english-national-health-service-202223-update).

24. NHS England. Comparison between the recently published ONS quarterly public service productivity statistics and NHS England productivity statistics. NHS England; 2025 (www.england.nhs.uk/blog/comparison-between-ons-nhse-productivity-statistics).

25. Tallack C, Charlesworth A, Kelly E, McConkey R, Rocks S. The bigger picture. Health Foundation; 2020 (www.health.org.uk/publications/reports/the-bigger-picture).

26. Wyatt S, Mohammed MA, De Dumast L, Marshall T. Long-term trends in English general practice consultation rates from 1995 to 2021: a retrospective analysis of two electronic health records databases. BMJ Open. 2024; 14: e088845 (https://bmjopen.bmj.com/content/14/12/e088845).

27. Institute for Government (IfG). General practice across England: The number and type of appointments are related to patient satisfaction. IfG; 2025 (www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england/appointments-satisfaction?utm_source=chatgpt.com).

28. Castelli A, Street A, Verzulli R, Ward P. Examining variations in hospital productivity in the English NHS. Eur J Health Econ. 2015; 16: 243–54 (https://doi.org/10.1007/s10198-014-0569-5).

29. Roper S. The changing landscape of firm-level productivity – anatomy and policy implications. The Productivity Institute; 2023 (www.productivity.ac.uk/research/the-changing-landscape-of-firm-level-productivity-anatomy-and-policy-implications).

30. Office for National Statistics (ONS). Trends in UK business dynamism and productivity. ONS; 2025 (www.ons.gov.uk/economy/economicoutputandproductivity/productivitymeasures/bulletins/trendsinukbusinessdynamismandproductivity/2024).

31. Carter P. Review of operational productivity in NHS providers: interim report June 2015. UK government; 2015 (www.gov.uk/government/publications/productivity-in-nhs-hospitals).

32. Williams K, Croft S, Mohammed MA, Wyatt S. Estimating productivity levels in primary medical services across clinical commissioning groups in England and the impact of the COVID-19 pandemic: a data envelopment analysis. BMC Health Serv Res. 2023; 23: 1194 (https://doi.org/10.1186/s12913-023-10117-2).

33. Moran V, Jacobs R. An international comparison of efficiency of inpatient mental health care systems. Health Policy. 2013; 112: 88–99 (https://doi.org/10.1016/j.healthpol.2013.06.011).

34. Moran V, Jacobs R. Comparing the performance of English mental health providers in achieving patient outcomes. Soc Sci Med. 2015; 140: 127–35 (https://doi.org/10.1016/j.socscimed.2015.07.009).

35. Ride J, Kasteridis P, Gutacker N, Aragon Aragon MJ, Jacobs R. Healthcare costs for people with serious mental illness in England: an analysis of costs across primary care, hospital care, and specialist mental healthcare. Appl Health Econ Health Policy. 2020; 18: 177–88 (https://doi.org/10.1007/s40258-019-00530-2).

36. Rowen D, Powell PA, Hole AR, Aragon MJ, Castelli A et al. Valuing quality in mental healthcare: a discrete choice experiment eliciting preferences from mental healthcare service users, mental healthcare professionals and the general population. Soc Sci Med. 2022; 114885 (https://doi.org/10.1016/j.socscimed.2022.114885).

37. Farrar S, Yi D, Sutton M, Chalkley M, Sussex J, Scott A. Has payment by results affected the way that English hospitals provide care? Difference-in-differences analysis. BMJ. 2009; 339 (https://doi.org/10.1136/bmj.b3047).

38. Lewis R, Edwards N. Improving length of stay: what can hospitals do?. Nuffield Trust; 2015 (www.nuffieldtrust.org.uk/research/improving-length-of-stay-what-can-hospitals-do).

39. Mooney A, Keith J, Marszalek K, Stafford M, Gardner T. What's driving increasing length of stay in hospitals since 2019? Health Foundation; 2023 (www.health.org.uk/reports-and-analysis/briefings/what-s-driving-increasing-length-of-stay-in-hospitals-since-2019).

40. Organisation for Economic Co-operation and Development (OECD). Health at a Glance 2023. OECD; 2023 (https://doi.org/10.1787/7a7afb35-en).

41. Medeiros J, Schwierz C. Efficiency estimates of health care systems. European Commission; 2015 (http://dx.doi.org/%20%20%20%2010.2765/49924).

42. Warner M, Zaranko B. The fiscal implications of public service productivity. Institute for Fiscal Studies; 2024 (https://ifs.org.uk/publications/fiscal-implications-public-service-productivity).

43. van Ark B, Hoskins J, Jörden N. Public Sector Productivity – managing the Baumol cost disease. Productivity Insights Paper No. 025. Productivity Institute; 2023 (www.productivity.ac.uk/research/public-sector-productivity-managing-the-baumol-cost-disease).

44. Timmins N. The most expensive breakfast in history: revisiting the Wanless review 20 years on. Health Foundation; 2021 (www.health.org.uk/reports-and-analysis/reports/the-most-expensive-breakfast-in-history).

45. National Audit Office. NHS Supply Chain and efficiencies in procurement. National Audit Office; 2024 (www.nao.org.uk/reports/nhs-supply-chain-and-efficiencies-in-procurement).

46. Hinrichs S, Jahagirdar D, Miani C, Guerin B, Nolte E. Learning for the NHS on procurement and supply chain management: a rapid evidence assessment. Health and Social Care Delivery Research. 2014; 2: 1–132 (https://doi.org/10.3310/hsdr02550).

47. Moore A, Hignett K. NHSE reviewing patient transport contracting after string of failures. Health Service Journal; 7 October 2019 (www.hsj.co.uk/integrated-care/nhse-reviewing-patient-transport-contracting-after-string-of-failures/7026076.article).

48. Slawomirski L, Kelly D, de Bienassis K, Kallas KA, Klazinga N. The economics of diagnostic safety. OECD; 2025 (https://doi.org/10.1787/fc61057a-en).

49. Naci H, Murphy P, Woods B, Lomas J, Wei J et al. Population-health impact of new drugs recommended by the National Institute for Health and Care Excellence in England during 2000–20: a retrospective analysis. The Lancet. 2025; 405: 50–60 (https://doi.org/10.1016/S0140-6736(24)02352-3).

50. Lomas J, Martin S, Claxton K. Estimating the marginal productivity of the English National Health Service from 2003 to 2012. Value in Health. 2019; 22: 995–1002 (https://doi.org/10.1016/j.jval.2019.04.1926).

51. Lomas J, Claxton K, Martin S, Soares M. Resolving the "cost-effective but unaffordable" paradox: estimating the health opportunity costs of nonmarginal budget impacts. Value in Health. 2018; 21: 266–75 (https://doi.org/10.1016/j.jval.2021.11.1375).

52. Martin S, Claxton K, Lomas J, Longo F. The impact of different types of NHS expenditure on health: Marginal cost per QALY estimates for England for 2016/17. Health Policy. 2023; 132: 104800 (https://doi.org/10.1016/j.healthpol.2023.104800).

53. Freedman S, Wolf R. The NHS productivity puzzle. Institute for Government; 2023 (www.instituteforgovernment.org.uk/publication/nhs-productivity).

54. NHS Providers. Briefing on the NHS productivity challenge. NHS Providers; 2024 (https://nhsproviders.org/resources/briefing-on-the-nhs-productivity-challenge).

55. Cavallaro F, Grimm F, Allen L, Keith J, Tallack C. Why are delayed discharges from hospital increasing? Seeing the bigger picture. Health Foundation; 2023 (www.health.org.uk/reports-and-analysis/analysis/why-are-delayed-discharges-from-hospital-increasing-seeing-the-bigger).

56. Barron J, Tether V. Are people getting less from the NHS? NHS Confederation; 2024 (www.nhsconfed.org/articles/are-people-getting-less-nhs).

57. Stein T. Productivity in the NHS: what's getting in the way? Nuffield Trust; 2024 (www.nuffieldtrust.org.uk/news-item/productivity-in-the-nhs-what-s-getting-in-the-way).

58. Kelly E, Tallack C. NHS productivity: from diagnosis to action. Health Foundation; 2024 (www.health.org.uk/features-and-opinion/blogs/nhs-productivity-from-diagnosis-to-action).

59. Wood K. The NHS productivity challenge. HFMA; 2024 (www.hfma.org.uk/publications/nhs-productivity-challenge).

60. The King's Fund. Productivity in the NHS and health care sector. The King's Fund; 2024 (www.kingsfund.org.uk/insight-and-analysis/data-and-charts/productivity-nhs-health-care-sector).

61. Coyle D. Healthcare as social infrastructure: productivity and the UK NHS during and after COVID-19. In: Grosskopf S (ed.) The Cambridge Handbook of Healthcare: Productivity, Efficiency, Effectiveness. Cambridge University Press; 2024.

62. Coyle D, Dreesbeimdiek K, Manley A. Productivity in UK healthcare during and after the COVID-19 pandemic. Productivity Institute; 2021 (www.productivity.ac.uk/research/productivity-in-uk-healthcare-during-and-after-the-covid-19-pandemic).

63. Anderson H. Following the money: Are NHS finances too good to be true? HSJ; 7 Oct 2025 (www.hsj.co.uk/finance-and-efficiency/following-the-money-are-nhs-finances-too-good-to-be-true/7040139.article).

64. Harvey-Rich O, Warner M. The outlook for public sector productivity. In: IFS Green Budget 2025. Institute for Fiscal Studies; 2025 (https://ifs.org.uk/publications/outlook-public-sector-productivity).

65. Dixon J. 10-year 'Plan for Change' or 'plus ça change'?. Health Foundation; 2025 (www.health.org.uk/features-and-opinion/blogs/10-year-plan-for-change-or-plus-a-change).

66. Marshall L, Charlesworth A, Hurst J. The NHS payment system: evolving policy and emerging evidence. Nuffield Trust; 2014 (www.nuffieldtrust.org.uk/research/the-nhs-payment-system-evolving-policy-and-emerging-evidence).

67. Chadha JS. The productivity puzzle. Gresham College Lecture; 21 Sep 2017 (www.gresham.ac.uk/watch-now/productivity-puzzle).

68. Chadha JS, Samiri I. Understanding UK productivity using a macroeconomic lens. J Econ Surv. 2025 (https://doi.org/10.1111/joes.70001).

69. Allas T, D. Zenghelis. The UK's capital gap: A short-fall in the trillions of pounds that will take decades to bridge. Productivity Institute; 2025 (www.productivity.ac.uk/research/the-uks-capital-gap-a-short-fall-in-the-trillions-of-pounds-that-will-take-decades-to-bridge).

70. Fawcett N, Cameron G. The Five Drivers: an empirical review. University of Oxford; 2005 (www.researchgate.net/publication/5218306_The_Five_Drivers_an_empirical_review).

71. Kim YE, Loayza N. Productivity growth: Patterns and determinants across the world. Policy Research Working Paper, World Bank; 2019 (https://hdl.handle.net/10986/31710).

72. Sharpe A, Uguccioni J. Decomposing the productivity-wage nexus in selected OECD countries, 1986-2013. International Productivity Monitor, Centre for the Study of Living Standards. 2017; 32: 25 (https://ideas.repec.org/a/sls/ipmsls/v32y20172.html).

73. Fragkandreas T. Innovation-productivity paradox: Implications for regional policy. In: OECD-EC High-Level Expert Workshop Series, Productivity Policy for Places; 2021: 1–48 (https://doi.org/10.13140/RG.2.2.27560.44800).

74. McSorley L. Inequality, well-being and (inclusive) productivity growth. In: McCann P, Leahy T, Vorley T (eds.) Productivity Perspectives. Edward Elgar Publishing; 2020.

75. Barro RJ. Human capital and growth. American Economic Review. 2001; 91: 12–7 (www.jstor.org/stable/2677725).

76. Hanushek EA, Woessmann L. Education and the Economics of Growth. The MIT Press; 2015 (www.jstor.org/stable/j.ctt17kk9kq).

77. Benhabib J, Spiegel M. Human capital and technology diffusion. In: Aghion P, Durlauf S (eds.) Handbook of Economic Growth. Elsevier; 2005 (https://EconPapers.repec.org/RePEc:eee:grochp:1-13).

78. Heckman JJ, Kautz T. Hard evidence on soft skills. Labour Econ. 2012; 19: 451–64 (www.sciencedirect.com/science/article/pii/S0927537112000577).

79. Bloom N, Van Reenen J. Measuring and explaining management practices across firms and countries. Q J Econ. 2007; 122: 1351–408 (https://doi.org/10.1162/qjec.2007.122.4.1351).

80. Salas E, DiazGranados D, Klein C, Burke CS, Stagl KC et al. Does team training improve team performance? A meta-analysis. Human Factors: The Journal of the Human Factors and Ergonomics Society. 2008; 50: 903–33 (https://doi.org/10.1518/001872008X375009).

81. Laker B, Pereira V, Budhwar P, Malik A. The surprising impact of meeting-free days. MIT Sloan Management Review; 18 January 2022 (https://sloanreview.mit.edu/article/the-surprising-impact-of-meeting-free-days).

82. Allcott H, Collard-Wexler A, O'Connell SD. How do electricity shortages affect industry? Evidence from India. American Economic Review. 2016; 106: 587–624 (https://doi.org/10.1257/aer.20140389).

83. Solow RM. A contribution to the theory of economic growth. Q J Econ. 1956; 70: 65–94 (https://doi.org/10.2307/1884513).

84. Jorgenson DW, Stiroh KJ. Raising the speed limit: US economic growth in the information age. In: Knowledge Economy, Information Technologies and Growth. Routledge; 2017.

85. Hulten CR. Infrastructure capital and economic growth: How well you use it may be more important than how much you have. National Bureau of Economic Research Working Paper 5847; 1996 (https://doi.org/10.3386/w5847).

86. Aschauer DA. Is public expenditure productive? J Monet Econ. 1989; 23: 177–200 (https://doi.org/10.1016/0304-3932(89)90047-0).

87. Brancaccio G, Kalouptsidi M, Papageorgiou T. Investment in infrastructure and trade: The case of ports. National Bureau of Economic Research Working Paper 32503; 2024 (https://doi.org/10.3386/w32503).

88. Brynjolfsson E, Hitt LM. Beyond computation: Information technology, organizational transformation and business performance. Journal of Economic Perspectives. 2000; 14: 23–48 (https://doi.org/10.1257/jep.14.4.23).

89. Comin D, Hobijn B. An exploration of technology diffusion. American Economic Review. 2010; 100: 2031–59 (https://doi.org/10.1257/aer.100.5.2031).

90. Comin D, Mestieri M. If technology has arrived everywhere, why has income diverged? American Economic Journal: Macroeconomics. 2018; 10: 137–78 (https://doi.org/10.1257/mac.20150175).

91. Planes-Satorra S, Paunov C. The digital innovation policy landscape in 2019. OECD Science, Technology and Industry Policy Papers; 2019 (https://doi.org/10.1787/6171f649-en).

92. Guellec D, Van Pottelsberghe de la Potterie B. From R&D to productivity growth: Do the institutional settings and the source of funds of R&D matter? Oxf Bull Econ Stat. 2004; 66: 353–78 (https://doi.org/10.1111/j.1468-0084.2004.00083.x).

93. Rodrik D, Subramanian A, Trebbi F. Institutions rule: the primacy of institutions over geography and integration in economic development. Journal of Economic Growth. 2004; 9: 131–65 (https://doi.org/10.1023/B:JOEG.0000031425.72248.85).

94. Acemoglu D, Johnson S, Robinson J. Institutions, volatility, and crises. In: Ito T, Rose AK (eds.) Growth and productivity in East Asia. University of Chicago Press; 2004.

95. Hsieh CT, Klenow PJ. Misallocation and manufacturing TFP in China and India. Q J Econ. 2009; 124: 1403–48 (https://doi.org/10.1162/qjec.2009.124.4.1403).

96. Foster L, Haltiwanger JC, Krizan CJ. Aggregate productivity growth: Lessons from microeconomic evidence. In: Hulten CR, Dean ER, Harper MJ (eds.) New developments in productivity analysis. University of Chicago Press; 2001.

97. Bloom N, Van Reenen J, Williams H. A toolkit of policies to promote innovation. Journal of economic perspectives. 2019; 33: 163–84 (https://doi.org/10.1257/jep.33.3.163).

98. Organisation for Economic Co-operation and Development (OECD). Rethinking Health System Performance Assessment. OECD; 2024 (https://doi.org/10.1787/107182c8-en).

99. Arab S, Chhatwal K, Khan HA, Rosen SD. Administrative overload harms patient care. BMJ. 2025; 390: r1747 (https://doi.org/10.1136/bmj.r1747).

100. Duhigg C. What Google learned from its quest to build the perfect team. The New York Times; 25 February 2016 (www.nytimes.com/2016/02/28/magazine/what-google-learned-from-its-quest-to-build-the-perfect-team.html).

101. O'Connell M, Barry J, Hartigan I, Cornally N, Saab MM. The impact of electronic and self-rostering systems on healthcare organisations and healthcare workers: A mixed-method systematic review. J Clin Nurs. 2024; 33: 2374–87 (https://doi.org/10.1111/jocn.17114).

102. NHS England and NHS Improvement. E-rostering the clinical workforce. NHS England and NHS Improvement; 2020 (www.england.nhs.uk/wp-content/uploads/2020/09/e-rostering-guidance.pdf).

103. NHS England. Review of the current capital allocation methodology for system envelopes. NHS England; 2022 (www.england.nhs.uk/publication/review-of-the-current-capital-allocation-methodology-for-system-envelopes).

104. Kraindler J, Gershlick B, Charlesworth A. Failing to capitalise: capital spending in the NHS. Health Foundation; 2019 (www.health.org.uk/reports-and-analysis/briefings/failing-to-capitalise).

105. National Audit Office. Managing high value capital equipment in the NHS in England. The Stationery Office; 2011 (www.nao.org.uk/wp-content/uploads/2011/03/1011822.pdf)

106. National Audit Office. NHS Supply Chain and efficiencies in procurement. NAO; 2024 (www.nao.org.uk/reports/nhs-supply-chain-and-efficiencies-in-procurement).

107. Cutler DM. What artificial intelligence means for health care. JAMA Health Forum. 2023; 4: e232652. (https://doi.org/10.1001/jamahealthforum.2023.2652).

108. Wachter R. Making IT work: harnessing the power of health information technology to improve care in England. UK government; 2016 (www.gov.uk/government/publications/using-information-technology-to-improve-the-nhs).

109. Thornton N, Hardie T, Horton T, Gerhold M. Priorities for an AI in health care strategy. Health Foundation; 2024 (www.health.org.uk/reports-and-analysis/briefings/priorities-for-an-ai-in-health-care-strategy).

110. Sollof J. DMA results show only 10-30% of trusts with an EPR have key functionality. Digital Health; 12 December 2023 (www.digitalhealth.net/2023/12/dma-results-show-only-10-30-of-trusts-with-an-epr-have-key-functionality).

111. Ariss SMB, Taylor P, Fitzsimmons D, Kyerematenge S, Mawson S. Mobile technology and delegated work in specialist community services: the EnComPaSS Integration project. BMJ Support Palliat Care. 2024; 14: e1144–51 (https://doi.org/10.1136/bmjspcare-2020-002288).

112. Jones B, Home J, Jones D. Strengthening clinical leadership and management. Health Foundation; 2024 (www.health.org.uk/reports-and-analysis/briefings/strengthening-clinical-leadership-and-management).

113. Kituno N, West D. Revealed: 60pc of trusts have a 'first-time' CEO. HSJ; 29 August 2023 (www.hsj.co.uk/workforce/revealed-60pc-of-trusts-have-a-first-time-ceo/7035420.article).

114. Burgess N, Currie G, Crump B, Dawson A. Leading change across a healthcare system: how to build improvement capability and foster a culture of continuous improvement: lessons from an evaluation of the NHS-VMI partnership. University of Warwick; 2022 (https://warwick.ac.uk/fac/soc/wbs/research/vmi-nhs/reports).

115. Paxton B, Rutter J. Lessons from past independent policy reviews. Institute for Government; 2025 (www.instituteforgovernment.org.uk/publication/lessons-past-independent-policy-reviews).

116. Watt T, Raymond A, Rachet-Jacquet L, Head A, Kypridemos C et al. Health in 2040: projected patterns of illness in England. Health Foundation; 2023 (www.health.org.uk/publications/health-in-2040).

117. Jefferies D, Wickens C. Tight Budgets and tough decisions: the impact of NHS financial decisions. The King's Fund; 2025 (www.kingsfund.org.uk/insight-and-analysis/long-reads/tight-budgets-tough-choices).

Appendix

There are several ways to measure productivity and associated metrics, many of which are featured in this report. Some are health care specific, while others are for the whole economy. Care is needed when comparing between approaches. For a review of measurement, see the report, *Measuring productivity in health care*.*

Metric	Classification	What it is (role)	Typical application
ONS: Health care productivity in England (official statistic)	NHS-wide productivity	National accounts measure of NHS output vs inputs for England, published annually	Track long-run productivity trends; inform spending reviews and policy
ONS: Public service productivity nowcasts (UK)	NHS-wide productivity	Early/partial estimates of current-year public service productivity	Near-term signal for fiscal policy and commentary; experimental dataset
Centre for Health Economics: Health care productivity in England	NHS-wide productivity	Independent academic series – similar to ONS official statistic	Track long-run productivity trends and contribution to input/output by type
NHS England: Health care productivity in acute trusts	NHS sector productivity	Trust-level output/input measures. Acute trusts but with plans to extend	Track recent trends. Benchmarking between trusts; targeting improvement support
NHS England: Labour productivity used in NHS Long Term Workforce Plan	Operational productivity	Staff-to-activity ratios used in workforce modelling	Forecast staffing needs; test impact of changes on headcount
Model Hospital/ weighted activity unit (WAU)	Operational productivity	WAU standardises diverse clinical activity; Model Hospital is a benchmarking platform	Compare cost and productivity between peers; spot outliers and improvement opportunities
ONS: Labour productivity	Whole-economy productivity	Economy-wide (and industry-level) output per worker/hour	Contextual comparison with other sectors; caution when translating to NHS

* NHS Arden and Greater East Midlands (GEM) Commissioning Support Unit (CSU). Measuring productivity in Health Care. NHS Arden and GEM CSU; 2025 (www.ardengemcsu.nhs.uk/showcase/news-events/news-events/new-report-published-to-modernise-productivity-measurement-in-healthcare).

Metric	Classification	What it is (role)	Typical application
ONS: Multi-factor productivity (MFP)	Whole-economy productivity	Output growth not explained by measured labour/capital	Long-run productivity for wider economy; caution when translating to NHS
Efficiency/ productivity scores (DEA/ Stochastic Frontier Analysis (SFA))	System-wide estimates	Frontier methods estimating relative efficiency vs best performers	Research; used to identify units furthest from 'frontier'. Sensitive to model choices
Cost-benefit and cost effectiveness (NICE)	Service resource allocation	Compares costs and health gains (eg £ per quality-adjusted life year (QALY)) to adoption thresholds	Decide which technologies/ interventions to fund within programmes and pathways

The Health Foundation is an independent charitable organisation working to build a healthier UK.

Health is our most precious asset. Good health enables us to live happy, fulfilling lives, fuels our prosperity and helps build a stronger society. Yet good health remains out of reach for too many people in the UK and services are struggling to provide access to timely, high-quality care. It doesn't have to be like this. Our mission is to help build a healthier UK by:

- Improving people's health and reducing inequalities
- Supporting radical innovation and improvement in health and care services
- Providing evidence and analysis to improve health and care policy.

We'll achieve this by producing research and analysis, shaping policy and practice, building skills, knowledge and capacity, and acting as a catalyst for change.

Everyone has a stake and a part to play in improving our health. By working together, we can build a healthier UK.

Keep up to date

TheHealthFoundation

@TheHealthFoundation

@TheHealthFoundation

The Health Foundation
8 Salisbury Square, London EC4Y 8AP
020 7257 8000
info@health.org.uk

ISBN: 978-1-918254-00-6
Registered charity number: 286967
Registered company number: 01714937
© 2025 The Health Foundation

7.4

1:00 PM, 0 Mins

7.4 - FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26

Michael Imperato (Hywel Dda UHB - Independent Board Member)

For information

Attachments

FPC Work Plan 2025-26.pdf

FINANCE AND PERFORMANCE COMMITTEE WORK PLAN APRIL 2025 – MARCH 2026

Currently, Finance and Performance Committee (FPC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2025 – March 2026.

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	15 Sept 2025 (Extra)	21 Oct 2025	16 Dec 2025	24 Feb 2026
GOVERNANCE									
Welcome and Apologies	Chair	All	✓	✓	✓		✓	✓	✓
Declarations of Interests	Chair	CSO	✓	✓	✓		✓	✓	✓
Minutes from previous meeting	Chair	CSO	✓	✓	✓		✓	✓	✓
Matters Arising (not on agenda)	Chair	All	✓	✓	✓		✓	✓	✓
Table of Actions (ToAs)	Chair	CSO	✓	✓	✓		✓	✓	✓
FPC Terms of Reference (TORs) Review (12.1)	Chair	JW	✓		✓			✓	
SRC Annual Report 2024/25 (10.4.1)	Chair	HT	✓						
FPC Annual Report 2025/26 (10.4.1)	Chair	HT	✓						
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW							✓
Self-Assessment of Committee Effectiveness: Six-Month Review (10.5)	Chair	JW			✓				
Corporate Risks Assigned to FPC (3.1.19)	HT	RW		✓					
Operational Risks Assigned to FPC (3.1.19)	HT	RW		✓					
Assurance and Risk Report	CW	RW			✓		✓	✓	✓
ESCALATION OVERVIEW									
Escalation Oversight and Highlight Report	SA	SA			✓		✓	✓	✓
ESCALATION RESPONSE – RECOVERY ACTIONS PLANS AND IMPROVEMENT TRAJECTORIES									
Clinical Care Group Financial Savings	AC	AC			✓		✓	✓	
Community and Integrated Medicine Performance and Productivity	AC	AC			✓				
Planned Care and Cancer Performance and Productivity	AC	AC			✓				
Radiology Update	AC	AC			✓				
Ambulance Handover Performance Update	AC	AC					✓		

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	15 Sept 2025 (Extra)	21 Oct 2025	16 Dec 2025	24 Feb 2026
Elective Referral to Treatment and Cancer Pathway	AC	AC					✓		
Neurodivergent and Psychological Therapies Pathway	AC	AC					✓		
Radiology and Therapies Demand and Capacity	AC	AC					✓		
Urgent and Emergency Care and Six Goals Update	AC	AC						✓	
R! Ophthalmology Update	AC	AC						✓	
Partnership Working – Commissioning Arrangements	AC	AC						✓	
Medical Stabalisation Programme Update	MH	CH						✓	
FINANCE									
Finance Report (3.1.5) to include: • Deficit Drivers Annual Refresh (3.1.2) • Financial Outlook 2025/26 • Financial Recovery/In-Year Savings Programme • Risks on delivery of key financial targets key income sources & contractual safeguards (3.1.7) [From 26/08/2025: Financial Performance Assurance Report]	HT	AS	✓	✓	✓		✓	✓	✓
Financial Plan and Strategy (3.1.4)	HT	AS	✓	✓					
(Investments and) Benefits Realisation Report	HT	SJ			✓		✓	✓	✓
Planning for 2026/27	HT	HT						✓	
Financial Systems Assurance Report (3.1.6)	HT	AS							
Finance Targeted Intervention Actions (3.1.8)	HT	SA	✓	✓					
Procurement Plan (3.1.10)	HT	GD			✓				
Procurement Update (3.1.10 & 3.1.13) • Review any investment/disinvestment	HT	GD	✓	✓	✓		✓	✓	✓
Planning Objective Update Report (3.1.17)	HT	ALP	✓ Q4/Closure	✓ Q1	✓		✓ Q2		✓ Q3
• PO2 Financial Recovery and Road Map									✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	15 Sept 2025 (Extra)	21 Oct 2025	16 Dec 2025	24 Feb 2026
• PO3 Urgent and Emergency Care • PO4 Planned Care (inc. Cancer and Diagnostics) • PO5 Mental Health and Learning Disabilities								✓	
Contracts Assurance Report (3.1.11 &12)	HT								
Balance Sheet Report	HT	AS		✓			✓		✓
Monitoring Welsh Health Circulars (under the remit of FPC)	Relevant EDs	RW		✓	Incorporated within Assurance and Risk Report				
Ministerial Directions (as and when required)	Relevant EDs	RW	✓	✓	Incorporated within Assurance and Risk Report				
FINANCE AND PERFORMANCE DEEP DIVES									
Thematic Reviews of Finance and Performance • UEC • Planned Care • Therapies • MHLD	AC	AC		✓					
Commissioned Care	JP	JP	✓						
Discharge to Assess	JP	JP		✓					
Ophthalmology performance: Getting It Right First Time (update on progress to address outstanding recommendations)	AC	SHi/VC		✓					
PERFORMANCE									
Integrated Performance Assurance Report (IPAR) (3.1.14)	HT	SH	✓	✓	✓		✓	✓	✓
Performance Management Framework (3.1.14)	HT	HT							
NHS Wales Shared Services Partnership (NWSSP) Performance Report 2024/25 (quarterly) (3.1.16)	HT	RD		✓ (Q4)	✓ (Q1)			✓ (Q2)	
Public Sector Emissions Reporting	HT	DW					✓		
FOR APPROVAL									
Financial Procedures (3.1.21)	HT	TJ	✓	✓	✓		✓	✓	✓
Policies (as required) (3.1.22)	All	All	✓	✓	✓		✓		✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	29 Apr 2025	26 Jun 2025	26 Aug 2025	15 Sept 2025 (Extra)	21 Oct 2025	16 Dec 2025	24 Feb 2026
Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.9)	HT	HT	✓	✓	✓		✓	✓	✓
FOR ASSURANCE									
Financial Choices and Decisions	SJ/SD	SJ/SD				✓			
FOR INFORMATION									
Capital Financial Management Update (3.5.3)	HT	RD	✓	✓	✓		✓	✓	✓
JCC Planning, Performance and Finance Sub-Committee Reports	HTy	JM	✓	✓	✓		✓	✓	✓
NHS Productivity Commission 'From Diagnosis to Delivery'	HT	HT						✓	
Finance and Performance Committee Work Plan 2025/26	Chair	Chair	✓	✓	✓		✓	✓	✓
ADMINISTRATION									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Issue a draft TOA within two days of the meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Circulate minutes and TOA to the Lead Director within 7 days of meeting	CSO	N/A	✓	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	✓	✓	✓	✓	✓	✓	✓

Chair: Michael Imperato **Vice Chair:** Anna Lewis **Lead Executive:** Huw Thomas

HT Huw Thomas **MH** Mark Henwood **LD** Lee Davies JP Jill Paterson

JW	Joanne Wilson	**LG**	Lisa Gostling	**SA**	Shaun Ayres	**RD**	Rhian Davies
DW	Daniel Warm	**AS**	Andrew Spratt	**GD**	Gemma Deverill	**KJ**	Keith Jones
AJ	Amorelle Jones	**SHi**	Steph Hire	**DB**	Debra Bennett	**LC**	Liz Carroll
AL	Angela Lodwick	**HTy**	Helen Tyler (JCC)	**SH**	Sally Havard	**VC**	Vicky Coppack
TJ	Timothy John	**JM**	Jacqueline Maunder (JCC)	**RW**	Rachel Williams	**CSO**	Committee Services Officer
D	Deferred	**SJ**	Sian Jenkins				

8

1:00 PM, 0 Mins

8 - ANY OTHER BUSINESS

9

1:00 PM, 0 Mins

9 - DATE OF NEXT MEETING

- **Tuesday 24 February 2026; 09:30 - 13:00**