Escalation Assessment with Prophet Forward Look Analysis

Finance and Performance Committee, 24 February 2026

Purpose, Scope and Committee Decision

Purpose

This paper provides the Finance and Performance Committee (FPC) with an integrated assessment combining: (a) current performance against Targeted Intervention (TI) de-escalation criteria; (b) Prophet time series forward projections for the six most challenged metrics; (c) Month 10 financial position; and (d) internal escalation framework standings. The Prophet analysis quantifies the gap between business-as-usual trajectory and target achievement, defining the scale of transformational action required in the 2026/27 Annual Plan.

Scope

Performance against TI de-escalation criteria within the remit of the Finance and Performance Committee: Finance (Level 4: MD1–MD4), R1 Ophthalmology (Level 4: MD5), Urgent and Emergency Care (UEC) (Level 4: MD6–MD9), and Planned Care and Cancer (Level 3: MD10–MD19). Prophet forward projections (35 months of data, 15-month forecast to March 2027) for six concern areas: R1 Ophthalmology, Delayed Follow-Ups, Pathways of Care Delays, Ambulance Handovers, 12-Hour ED Waits, and Diagnostic Endoscopy. Month 10 financial monitoring and internal escalation framework positions. Note: HCAI criteria (MD6–MD8 Quality domain) are reported separately to the Quality, Safety and Experience Committee (QSEC). The paper will highlight the percentage points gap in the likelihood of achieving the current escalation criteria which covers both Level 4 (Targeted Intervention) and Level 3 (Enhanced Monitoring).

Caveat

The focus of this paper is to understand performance and finance against the de-escalation criterion. There will inevitably be other considerations such as the 2026-29 Performance Framework. However, the mitigation is relatively straightforward. The Annual Plan will seek to achieve the maximum level of performance and quality within the availability of resources at the Health Boards disposal. In turn, regardless of what metric is applied, this ensures that when Board endorse the Annual Plan, they can do so knowing that the annual plan will seek to maximise all resources.

2025/26 YTD Financial Position – Month 10

Hywel Dda
University Health Board

REPORTED DEFICIT (YTD)
£16.1m
Plan £25.0m | £8.9m favourable

EOY FORECAST
£22.1m
Revised TCT £30.0m | £7.9m better

SAVINGS IDENTIFIED
£50.3m
Target £46.4m | £3.9m over-identified

UNDERLYING DEFICIT
£58.4m
Recurrent FYE schemes £18.4m identified

Key Financial Drivers – Month 10 Position

Key Driver (£m)	In-Month	YTD	EOY Forecast
Planned Deficit	2.5	25.0	30.0
Savings Gap / (Improvement)	0.2	(5.2)	(3.9)
Under / (Over) Delivery	0.0	0.3	0.3
Core Operational Variation	(1.4)	(4.0)	(4.3)
Reported Position	**1.3**	**16.1**	**22.1**

Alert / Advise / Assure Assessment

Area	Status	Commentary
Core Operational Variation	ADVISE	Run rate improved but worsening trajectory signals risk to 26/27 opening position
Savings Delivery	ASSURE	£50.0m forecast to deliver against £46.4m target; £3.6m over-achievement
Cash	ADVISE	Strategic cash request aligned to £22.1m; awaiting WG confirmation
Underlying Deficit	ALERT	£58.4m does not support breakeven by 2027/28; recurrent schemes insufficient
Capital	ADVISE	Significant M11-M12 expenditure forecast; risk of underspends on All Wales schemes

Implications for 2026/27: The improving in-year position (£22.1m vs £30.0m plan) provides a stronger baseline for 2026/27 planning. However, the worsening run rate trajectory in M10 (c.£2.8m vs required £2.4m), driven by primary care prescribing, medical agency, and surge capacity, presents a material risk to the opening position. Urgent mitigating actions on spend containment are required before year-end to protect the 2026/27 starting point.

Financial Bridge: 2025/26 Outturn to 2026/27 Plan

Hywel Dda
University Health Board

Three-Year Financial Roadmap

Year 0
2025/26
Improve from
£31.5m to £22.1m

Year 1
2026/27
Target c.£14m deficit
Breakeven by Mar 27

Year 2
2027/28
Annual breakeven
(non-recurrent)

Year 3
2028/29
Recurrent breakeven
Reduced underlying

Key Requirements for 2026/27 Annual Plan

Requirement	WG Expectation	Current Position	Gap
Investment-free plan	Plan must be deliverable within existing envelope; no new investment without WG sign-off	Architecture designed for constrained planning; savings pipeline under development	RED
Savings pipeline with risk assessment	Committed pipeline with BRAG rating; recurrent focus to reduce underlying deficit	Recurrent FYE of £18.4m identified in 25/26; significant further work required for 26/27	RED
Triangulated D&C analysis	Activity, workforce and finance assumptions must be consistent and evidence-based	D&C approaches not yet consistent across organisation; methodology needs to be explicit	AMBER
Quantified milestones	Clear, dated milestones for each ministerial priority; SMART objectives	Goal-card template designed to capture this; completion across all bundles pending	AMBER
Breakeven trajectory	Quarterly improving deficit with in-month breakeven by March 2027	Current underlying deficit of £58.4m requires c.£44m of additional savings identification	RED

Conditional funding of £26.0m is contingent on achieving breakeven by 2027/28– this underpins the urgency of the 26/27 plan

Executive Summary: De-escalation Position and Forward Look

Planned Care
3 of 12 met — AMBER

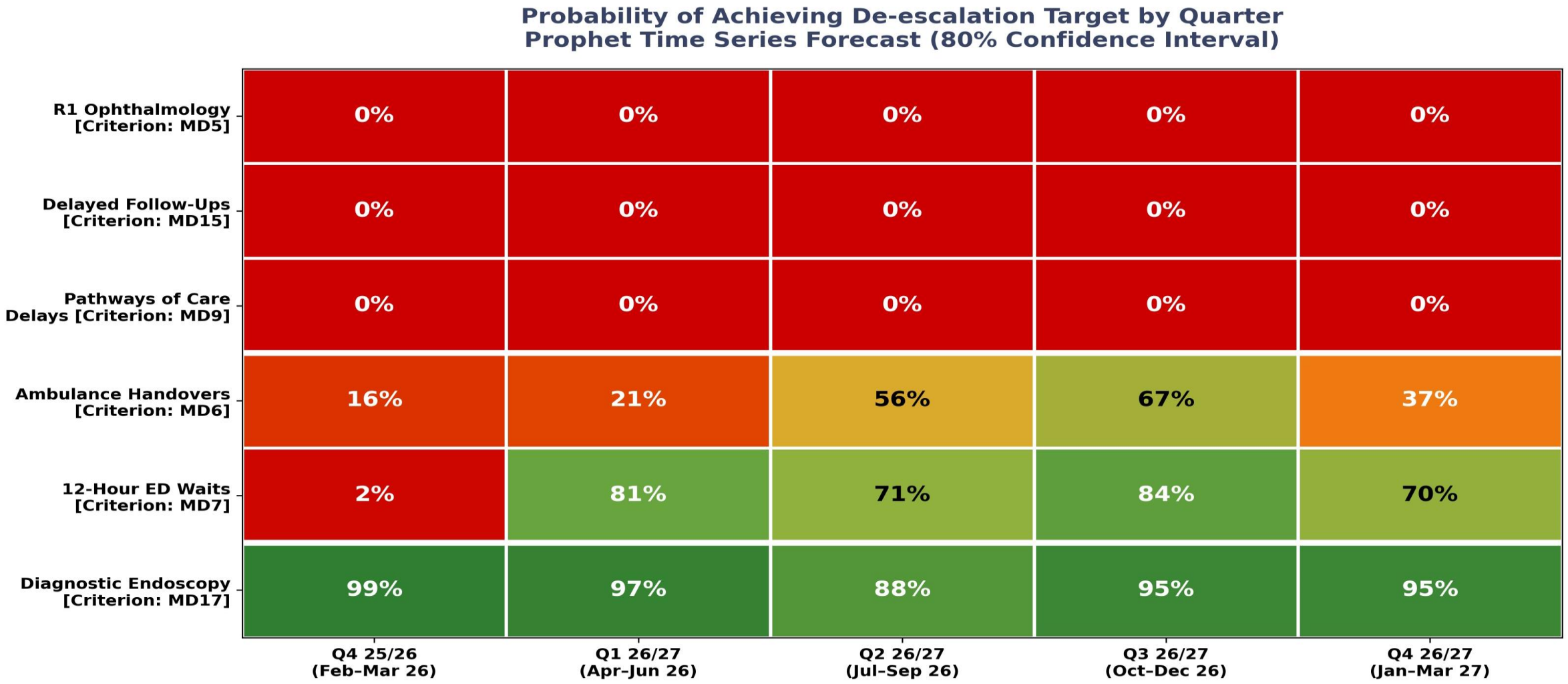
UEC
0 of 4 sustained — RED

CAMHS
3 of 3 met — GREEN

Classification	Metrics	Annual Plan Requirement
Tier 1: Unachievable (0%)	R1 Ophthalmology, Delayed Follow-Ups, Pathways of Care	Priority Recovery Programmes with executive owners and alternative trajectories for WG
Tier 2: Seasonal (70–74%)	Ambulance Handovers, 12-Hour ED Waits	Winter resilience plans with site-level actions. New 15-min/45-min standards from April
Tier 3: Recovery (95%+)	Diagnostic Endoscopy	Resilience planning and endoscopy capacity investment of £372k

The Annual Plan must honestly communicate the gap to Welsh Government across all three tiers. However, the annual plan must equally ensure it demonstrates all efficiencies and productivity metrics have been fully adopted from the MAG recommendations to the enabling actions.

Probability of Target Achievement by Quarter – Prophet Forecast (80% CI)



Tier 1: Structurally Unachievable (0%) | Tier 2: Conditional / Seasonal | Tier 3: Recovery Projected (95%+)
Colour coding: GREEN (>60%) AMBER (30–60%) RED (<30%). Forecasts represent business-as-usual trajectory.

Source: Prophet time series model using 35 months of tracking data (March 2023 – January 2026). Colour coding: GREEN (>60%), AMBER (30–60%), RED (<30%). Forecasts represent business-as-usual trajectory.

TI De-escalation: Planned Care and Cancer (January 2026)

Criterion	Value	Target	Status
SCP 62-day cancer [MD10]	**65.8%**	63%	Met — sustained since Jul 2025
NOP <52 weeks [MD11]	**99.9%**	100%	Effectively met
RTT <104 weeks [MD13]	**99.9%**	100%	Effectively met
RTT <26 weeks [MD12]	**64.7%**	75%	10.3pp gap, improving trend
RTT <36 weeks [MD14]	**75.7%**	80%	4.3pp gap, broadly static
Therapies <14wks [MD19]	**76.5%**	90%	13.5pp gap, slight improvement
R1 Ophthalmology [MD5]	**39.4%**	65%	25.6pp gap — structurally unachievable
Delayed Follow-Ups [MD15]	**15,753**	11,368	Below 16,682 baseline but Jan increase
Endoscopy <8wks [MD17]	**65.1%**	85%	Dropped from 86.6% (Nov) — Tier 3 recovery

3 of 9 meeting target. Radiology, ultrasound and CAMHS reported separately.

TI De-escalation: Urgent and Emergency Care (January 2026)

Ambulance Handovers >1hr: 716 (Jan) [MD6]
Target: ≤680 (11% reduction)
Sep - Nov below target but Jan deterioration. Winter pressures.

12hr ED waits: 9.6% (Jan) [MD7]
Target: no more than 7%
Not met - deteriorating from 7.95% (Sep). 2.6pp above.

Clinical Assessment: 68 mins (Jan) [MD8]
Target: median 60 minutes
Not met - deteriorated from 58 mins baseline; improved from 83 min peak (Aug) but 8 mins above.

Pathways of Care Delays: 213 (Jan) [MD9]
Target: 174 (5% reduction)
Not met - above baseline (203). Volatile, no sustained trend.

Committee Assurance Assessment:

UEC performance remains the most challenged domain. Ambulance handovers achieved sustained improvement (Septempter – November 2025) but winter pressures reversed this. Prophet classifies ambulance handovers and 12-hour Emergency Department (ED) waits as Tier 2 (Conditionally Achievable with seasonal dependency), and pathways of care as Tier 1 (Structurally Unachievable). The UEC business case for 7-Day Clinical Streaming Hub and SDEC expansion quantifies the intervention impact on these metrics. CCG detailed UEC trajectories for 2026/27 are in development and will set out phased improvement aligned to business case milestones.

Part 2

Prophet Forward Look Deep Dives

Statistical forward projections for the six most challenged de-escalation criteria

35 months of data | 15-month forecast to March 2027 | 80% confidence interval

Deep Dive: R1 Ophthalmology Pathways [Criterion MD5]

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De-escalation Criterion
65% R1 ophthalmology patient pathways to be waiting within or no longer than 25% of their target date for an outpatient appointment
Target: 65% compliance | Sustainability: Maintained for 3 months

Tier 1: Structurally Unachievable

P(target): 0%

Prophet Forecast Assessment

Prophet projects performance of 39.6% by March 2027 – virtually unchanged from the current 39.4%. The 80% confidence interval ranges from approximately 36% to 43%, meaning even in the most optimistic scenario, the Health Board would still be over 20pp below target. The current rate of improvement (approximately 0.5pp/month) is insufficient by an order of magnitude. To reach 65% by March 2027 would require improvement at approximately 1.7pp per month – more than three times the current rate.

Annual Plan Implications

This requires a fundamentally different approach to ophthalmology capacity, workforce, and pathway redesign. CCG modelling confirms ophthalmology as one of five specialties requiring recovery support to prevent 104-week breaches during 2026/27. Without intervention, ophthalmology contributes to a forecast 5,335 patients exceeding 104 weeks by March 2027. The Annual Plan must either include a credible transformational programme with quantified capacity modelling, or the organisation needs an honest conversation with Welsh Government about the achievability of this criterion within a realistic timeframe. The target trajectory should be evidence-based.

Recommended Annual Plan Actions

Include ophthalmology as a named Priority Recovery Programme in the 2026/27 Annual Plan with: a dedicated executive owner; regional capacity agreements (particularly with Swansea Bay University Health Board); a quantified outsourcing/insourcing plan; and quarterly milestone trajectories. CCG critical next steps include: confirmation of realistic Removals Other Than Treatment (ROTT) assumptions; quantification of further optimisation and OP Transformation benefits; agreement of regional capacity assumptions for ophthalmology and orthopaedics; and application of recurrent planned care recovery funding. FPC should receive monthly progress reports. The gap between achievable trajectory and the 65% de-escalation criterion must be explicitly communicated to Welsh Government.

Deep Dive: Delayed Follow-Up Appointments [Criterion MD15]

De-escalation Criterion
Continuous monthly improvement towards achieving a 12% reduction in the number of patients delayed by 100% for their follow up appointment in three consecutive months
Target: 11,368 (12% reduction from baseline) | Sustainability: Maintained for 3 months

Tier 1: Projected Deterioration

P(target): 0%

Prophet Forecast Assessment

Prophet projects deterioration to approximately 16,854 patients by March 2027, compared to the current 15,753 and the 11,368 target. Despite the 1,450-patient reduction since July 2025, the model identifies the underlying trend as upward. The recent reduction is interpreted as a temporary dip within a longer-term pattern of rising demand. To achieve the target, a further 4,385-patient reduction (28%) is needed.

Annual Plan Implications

The Prophet projection directly challenges the narrative of recent improvement. The model's assessment is that the current rate is insufficient to overcome structural drivers (demand growth, workforce constraints, capacity limitations) that have pushed the backlog consistently above 15,000 for three years. CCG demand and capacity modelling across therapy and outpatient services confirms demand growth of 5% per annum against static funded capacity. A specialty-level analysis is essential to identify where alternative models (Patient-Initiated Follow-Up, See-on-Symptoms, virtual clinics) can reduce demand.

Recommended Annual Plan Actions

Specialty-level demand and capacity analysis identifying which specialties contribute the largest volumes and where alternative models (patient-initiated follow-up, See on Symptoms, virtual clinics, clinical validation) can make the greatest impact. A realistic year-end position should be modelled based on available capacity. Clinical safety oversight through QSEC should be formalised given patient safety implications of this backlog.

Deep Dive: Pathways of Care Delays [Criterion MD9]

De-escalation Criterion
Continuous reduction in delayed pathways of care (with a focus on those caused by assessment issues) of 5% for three consecutive months
Target: 174 (5% reduction from agreed baseline of 203) | Sustainability: Maintained

Tier 1: Projected Deterioration

P(target): 0%

Prophet Forecast Assessment

Prophet projects deterioration to approximately 267 delays by March 2027, substantially above both the current 213 and the 174 target. The confidence interval is wide (approximately 180–355), reflecting high volatility, but even the lower bound only occasionally touches the target. Persistent failure to reduce below baseline despite multiple improvement initiatives suggests structural constraints have not been addressed.

Annual Plan Implications

This metric reflects systemic challenges at the hospital-community interface beyond the Health Board's sole control. The underlying structural constraints (community care capacity, social care availability, housing, local authority assessment timeliness) have not been materially addressed. Carmarthenshire accounts for 58% of all delays – the annual plan must acknowledge this as a whole-system challenge. However, many delays remain within the control of the Health Board, so the challenge/target could be met by internal improvements.

Recommended Annual Plan Actions

Specific partnership commitments with local authority social care services, particularly in Carmarthenshire (58% of delays). A joint capacity modelling exercise should quantify the community care gap and identify the specific volume of packages, placements, and assessments required. County-level breakdown should drive targeted action plans with named leads from both health and social care.

Deep Dive: Ambulance Handovers >1 Hour [Criterion MD6]

De-escalation Criterion

Continuous reduction of ambulance handovers over an hour of at least 11% in three consecutive months

Target: ≤680 (11% reduction from agreed baseline of 964) | Sustainability: Maintained for 3 months

Tier 2: Conditional / Seasonal

P(target): 74% by Mar 27

Prophet Forecast Assessment

Prophet projects a forecast of 610 handovers by March 2027, below the 680 target, with 74% probability. However, significant seasonal variation: Q2 2026/27 shows 56%, Q3 67%, but Q4 falls to 37%. Summer months consistently outperform winter. The GGH site effect (143 handovers in October 2025 rising to 382 in January 2026) is the primary driver of winter deterioration. The 3-month sustained run is most likely during July – November 2026.

Annual Plan Implications

The seasonal pattern means the Health Board is most likely to achieve sustained improvement during summer/autumn. However, the winter regression pattern observed in both 2024/25 and 2025/26 is projected to repeat. The annual plan must include a specific winter resilience plan with site-level actions for GGH as the priority. Performance must be maintained below 680 throughout winter, not just during summer months. I is important to note, that in 2025/26 the Health Board did achieve 3 months below the 680 target.

Recommended Annual Plan Actions

Specific winter resilience plan for ambulance handovers with site-level actions for GGH as priority. Front door streaming, clinical decision-making capacity, and ambulatory care pathway expansion should be quantified in terms of expected impact. The plan should set a trajectory maintaining performance below 680 throughout winter. Monthly site-level reporting to FPC from September 2026 with escalation triggers.

Note: The 1-hour handover metric is dropped from the 2026/27 framework. 15-minute and 45-minute standards apply from April 2026.

Deep Dive: 12-Hour Emergency Department Waits [Criterion MD7]

De-escalation Criterion

Continuous monthly improvement towards achieving no more than 7% of patients waiting over 12 hours at each individual site and across the health board

Target: ≤7% patients waiting over 12 hours | Sustainability: Continuous improvement

Tier 2: Seasonal Achievement Likely

P(target): 70% Q4 26/27

Prophet Forecast Assessment

Prophet projects March 2027 at 5.4% (below 7% target) with 100% probability at that point. But the picture is nuanced: Q4 25/26 shows only 2% (current winter), Q1 2026/27 81%, Q2 71%, Q3 84%, Q4 70%. The confidence interval suggests winter months may exceed 9–10%. Site-level variation is significant: Withybush Hospital (WGH) at 17.35% versus Prince Philip Hospital (PPH) at effectively zero. July 2025 showed 7.3% is achievable; the challenge is winter.

Caveat: The Health Board has not sustained <7% at any point in three years. Treat the 70% probability with appropriate caution and subject to clear operational plans.

Annual Plan Implications

A targeted approach to the two or three most challenged sites would have a disproportionate impact. The annual plan should include site-specific improvement targets that aggregate to 7% overall. Site-level winter plans should be developed by September 2026, with particular focus on WGH (where performance is more than double the target). Monthly targets should demonstrate year-on-year improvement even during winter months.

Recommended Annual Plan Actions

Site-specific improvement targets aggregating to 7% overall. Site-level winter plans developed by September 2026, with particular focus on WGH. Monthly site-level reporting with trajectory variance analysis. Consider targeted plans in WGH. The trajectory should anticipate the seasonal pattern and set realistic monthly targets demonstrating year-on-year improvement during winter.

Deep Dive: Diagnostic Endoscopy [Criterion MD17]

De-escalation Criterion
85% of patients waiting for a diagnostic endoscopy to be waiting less than 8 weeks
Target: 85% compliance (<8 weeks) | Sustainability: Maintained for 3 months

Tier 3: Recovery Projected

P(target): 95%+ throughout 26/27

Prophet Forecast Assessment

Prophet treats the January 2026 collapse (65.1%, down from 86.6% in November) as an outlier. Recovery above the 85% target from February 2026 onwards is projected with 95%+ probability throughout 2026/27. The full 35-month trajectory (from 27.1% in March 2023 to sustained achievement above 85% through most of 2025) provides strong evidence that the underlying capability to meet this criterion exists.

Annual Plan Implications

The key risk is not the underlying trajectory but vulnerability to single-month capacity events (equipment failure, workforce absence, demand surges) that can cause dramatic deterioration. The 21.5% collapse in January 2026 demonstrates this fragility. CCG modelling for 2026/27 identifies a capacity gap of 3 lists per week when factoring 5% elective demand growth and 30% inpatient/emergency demand increase, with 936 patients forecast to breach the 8-week GI target by March 2027 without additional capacity. A plan to relocate 3 urology sessions from GGH endoscopy to release capacity for GI demand has been developed at an estimated cost of £372k (pay and non-pay).

Recommended Annual Plan Actions

Endoscopy capacity resilience and growth plan: relocate 3 urology sessions from GGH endoscopy to create 3 additional GI lists per week, requiring investment in 1 whole-time equivalent (WTE) B8a Clinical Endoscopist trainee, 1 WTE B6 Nurse, 1.1 WTE B5 Nurse, and 3.48 WTE B3 support (£294k pay, £78k non-pay). Root cause analysis of the January 2026 collapse by March 2026, with findings informing contingency protocols. The plan should set a trajectory maintaining performance above 85% in every month. Another key consideration is the adoption of Galeas Bladder testing as this creates a cascading benefit to both GI diagnostics and Urology.

Annual Plan Context: RTT Planned Care Trajectories [MD11–MD14]

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Planning Framework Requirement

Maximum 104-week wait for total pathway. 52-week Stage 1 target removed for 2026/27 but modelling undertaken for 26-week forecast. CCG demand and capacity modelling based on core funded capacity with 12 months derived demand.

Baseline: Funded capacity only | Excludes: ROTT, productivity gains, recovery funding, regional capacity

CCG Initial Assessment | **Pre-Mitigation**

CCG Demand and Capacity Position

Stage 1 (52 weeks): 52-week compliance expected in all specialties except Rheumatology. However, without recovery support for Ophthalmology, ENT, Dermatology, Neurology and Rheumatology, a potential 9,316 patients could be waiting over 26 weeks by March 2027. Stage 4/Total Pathway (104 weeks): Without recovery support for Urology, Trauma and Orthopaedics, Ear, Nose and Throat (ENT), Ophthalmology and Dermatology, potential for 5,335 patients exceeding 104 weeks by March 2027. Each of these specialties has required additional solutions (Waiting List Initiatives, insource, outsource) during 2025/26.

Mitigations Under Development

These are pre-mitigation trajectories based on core funded capacity only. They represent the do-nothing scenario before CCG productivity, optimisation, regional and recovery interventions are applied. The scale of the gap defines the quantum of intervention required in the 2026/27 annual plan. CCG plans to refine these trajectories are in development, with key next steps outlined below and the CCG plans under development to refine these pre-mitigation trajectories include: agreement of realistic ROTT assumptions by specialty; confirmation of further optimisation and productivity improvements (OP Transformation, GIRFT theatre standards, theatre optimisation); quantification of regional capacity benefits from orthopaedics and ophthalmology programmes; and application of recurrent planned care recovery funding to mitigate forecast breach volumes.

Critical Next Steps (from CCG Planning)

1. Agreement of realistic ROTT assumptions by specialty reflecting reduced waiting times achieved during 2025/26. 2. Confirmation of CCG plans for further optimisation and productivity improvements by specialty (including OP Transformation, GIRFT standards and theatre optimisation) with quantified capacity and activity benefits. 3. Confirm proposed delivery solutions and associated cost for forecast breach volumes, including reprioritisation between specialties. 4. Agreement of planning assumptions for regional capacity benefits (orthopaedics and ophthalmology). 5. Agreement of plans for application of recurrent planned care recovery funding. These mitigations will materially reduce the pre-mitigation trajectory; the scale of residual gap will determine the honest assessment presented to Welsh Government.

Annual Plan Context: Therapies 14-Week Trajectories [Criterion MD19]

De-escalation Criterion
90% of patients waiting for therapy services to be waiting less than 14 weeks
Target: 90% compliance (<14 weeks) | Current: 76.5% | Gap: 13.5pp

Tier 1: Without Recovery

3,229 breaches by Mar 27

AHP & HS CCG Demand and Capacity Assessment

Therapy direct access breaches have risen from 2,216 (March 2025) to 2,719 (December 2025) reflecting significant demand increases across services. Without additional workforce support, breaches are forecast to grow to 3,229 by March 2027. Speech and Language Therapy (SALT) and Occupational Therapy forecast achievement of the 14-week target. The three services driving deterioration are: Physiotherapy (1,934 breaches), Podiatry (936 breaches), and Nutrition and Dietetics (359 breaches). Demand has increased circa 40% above pre-pandemic levels in Orthotics and Podiatry.

Recovery Workforce Requirements

Recovery to the 14-week target will not be achieved without significant additional workforce support. The CCG has quantified the requirement across the three challenged services. Successful recruitment of temporary external solutions in Nutrition & Dietetics and Orthotics and Podiatry is considered unlikely due to previous experience. Conversely, there is moderate confidence in Physiotherapy recruitment. The total investment requirement identified by the Allied Health Professions and Health Science (AHP&HS) CCG has identified 15 WTE additional workforce at a recurrent cost of £839k to achieve zero breaches by end of 2026/27. Nutrition and Dietetics: 3 WTE B7 (£186k), zero breaches by December 2026. Orthotics and Podiatry: 3 WTE B6 + 1 WTE B7 (£214k), zero breaches by February 2027. Physiotherapy: 5 WTE B6 + 3 WTE B7 (£439k), zero breaches by January 2027. Recruitment of external temporary workforce in Dietetics and Podiatry is considered unlikely based on previous experience. Moderate confidence in Physiotherapy recruitment.

Recommended Annual Plan Actions

Include therapy workforce as a named priority in the 2026/27 annual plan. Phased substantive recruitment across Physiotherapy, Podiatry, and Nutrition and Dietetics with start-in-post targets: May 2026 (Podiatry), June 2026 (Dietetics), phased from April 2026 (Physiotherapy). The Paediatric Occupational Therapy (OT) service has identified productivity opportunities that should be progressed independently. A full demand and capacity service review is underway across these specialties and will provide a refined position. Total investment: £839k recurrent.

Annual Plan Context: Diagnostic Radiology Trajectories [Criteria MD16/MD18]

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De-escalation Criterion

85% of patients waiting for a diagnostic radiology examination to be waiting less than 8 weeks

Target: 85% (<8 weeks) | 2025/26 stabilisation funding enabling near-achievement by March 2026

At Risk Without Investment

4,407 breaches by Mar 27

AHP&HS CCG Radiology Assessment

Historical and forecast 5% annual demand growth drives a structural deficit of 957 exams per week (CT −490, MRI −182, NOUS −285). £3.4m recurrent stabilisation funding during 2025/26 plus £1.3m non-recurrent from Welsh Government has enabled significant improvement with potential achievement of 8-week compliance by March 2026. Without continuation of the non-recurrent investment into 2026/27, 8-week breaches are forecast to increase to approximately 4,407 by March 2027. Whilst, it is not a linear relationship, the read across would suggest that the Cancer diagnostic pathways consume approximately 56% of the total radiology deficit.

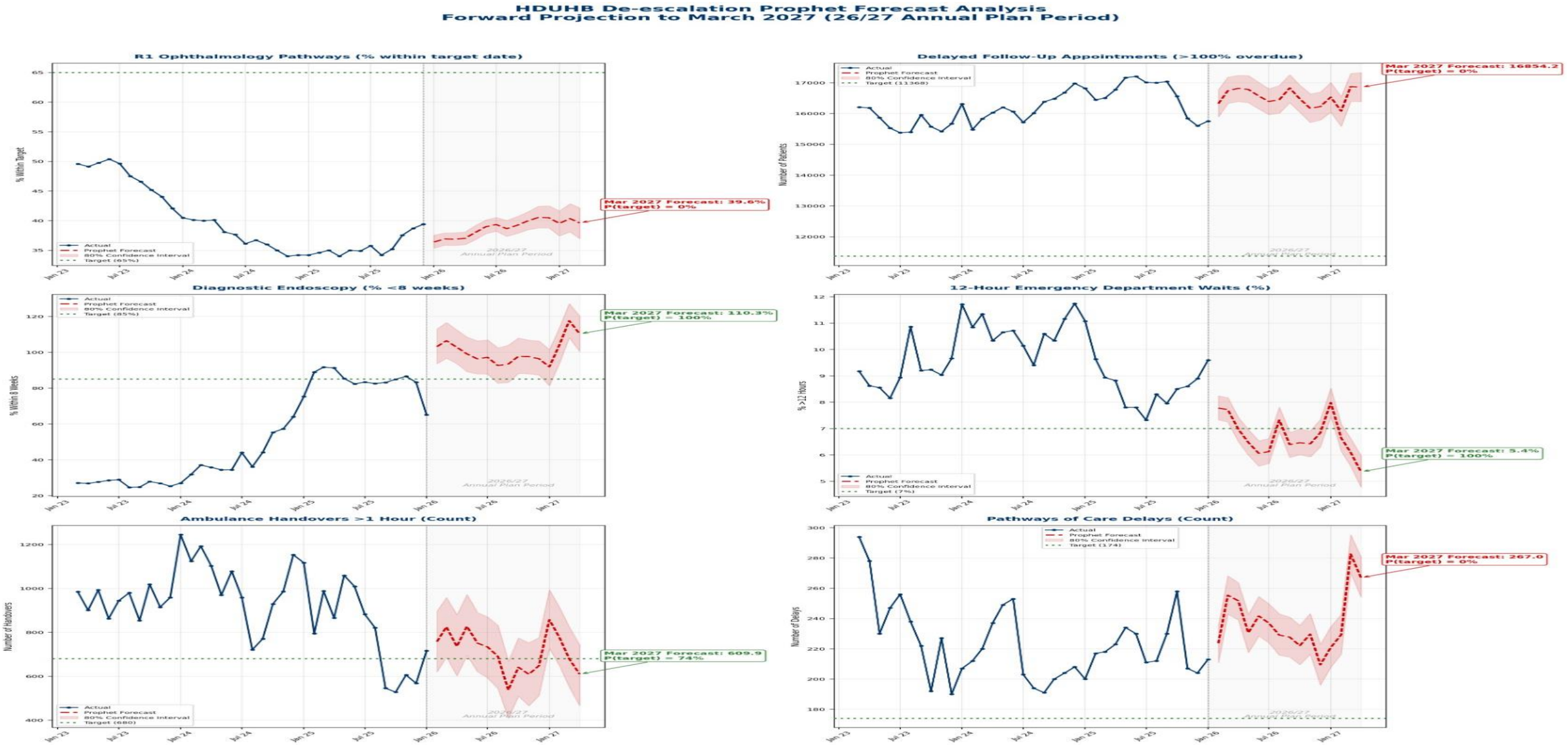
Cross-Cutting Constraints

Radiology capacity is the binding constraint on multiple planned care and cancer metrics simultaneously. The diagnostic deficit directly constrains cancer pathway velocity (urology, lower GI, lung, gynaecology) and planned care referral to treatment (RTT) performance. Histopathology (169 cancer requests/week with no capacity baseline) represents an additional blind spot. The annual plan must resolve the tension between MRI Musculoskeletal (MSK) pathway changes to meet national guidance will require movement of Radiology funding to Physiotherapy services (impact on trajectories being analysed). MRI is currently delivering at 135.6% of funded capacity through variable pay and outsourcing. The cancer pathway assumes sustained MRI outsourcing at 20 scans/week for prostate mpMRI. These two positions are in direct tension: AHP&HS CCG plans to reduce variable pay whilst Planned and Specialist Care (P&SC) cancer trajectory depends on sustained MRI over-delivery. This cross-CCG dependency must be resolved.

Recommended Annual Plan Actions

Continuation of non-recurrent radiology investment (£1.3m) as the minimum required to prevent deterioration. Resolution of MRI cross-CCG dependency between AHP variable pay reduction plans and P&SC cancer pathway requirements. Commission histopathology capacity baseline to address the diagnostic blind spot. The cancer diagnostics analysis quantifies the full investment requirement at £7.88m over three years for a sustainable model, with current variable pay and outsourcing costs of £3.53m per year representing the cost of the status quo.

Prophet Forecast Charts – Forward Projection to March 2027



Blue = Actual | Red dashed = Prophet Forecast | Pink = 80% CI | Green dotted = Target | Grey shading = 2026/27 Annual Plan Period

Internal Escalation Framework Summary (January 2026)

Finance	Level	Key Issue
C&IM	L3	Overspent, savings gap
MH&LD	L3	Deteriorating, savings gap
P&SC	L3	Significant overspend
Op AHP&HS	L3	Savings gap unresolved
E&F	L3	Savings delivery gap
COO / Primary	L2	Gap but underspent

Performance	Level	Key Issue
C&IM	L3	Ambulance, 12hr ED, PoC
MH&LD	L3	ASD 14.7%, Psych 57%
P&SC	L3	FUps 15,753; R1 Ophth 39.4%
Primary Care	L3	GDP below trajectory
AHP&HS	L3	Therapies: 2,582 above
E&F	L3	Cleaning audits below 95%
Exec Nursing	L3	HCAI exceeding targets

Community and Integrated Medicine, Mental Health and Learning Disability and Planned and Specialist Care are at Level 3 for both Finance and Performance. Three CCGs are approaching Level 4 financial triggers with recovery plans consistently overdue.

Internal Escalation Framework: Health Board Overview

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Directorate	Q&S	Gov	WF	Fin	Strat	Pop H	Perf	L3s
C&IM	3	3	2	3	3	3	3	6
COO Mgmt	1	2	2	2	1	3	n/a	1
MH&LD	3	1	1	3	3	3	3	5
P&SC	2	3	2	3	3	3	3	5
Primary Care	2	2	1	2	2	3	3	2
Op AHP&HS	2	1	2	3	3	3	3	4
Exec AHP&HS	1	1	n/a	1	1	2	n/a	0
E&F	2	1	2	3	1	2	3	2
Exec Finance	1	2	1	1	1	2	n/a	0
Medical	1	1	2	1	1	3	n/a	1
Pharmacy	2	1	2	2	2	3	n/a	1
Exec Nursing	1	1	2	1	1	3	3	2
Exec PH	1	1	2	1	1	2	2	0
Exec Strategy	1	1	1	1	1	3	n/a	1
Exec WOD	1	1	1	1	1	2	n/a	0
Gov & Comms	1	1	2	1	1	2	n/a	0
Total L3s	**2**	**2**	**0**	**5**	**4**	**10**	**7**	

Internal Escalation: Key Movements (Dec 2025 → Jan 2026)

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Escalated Up ▲	Domain	New Level	Reason
Pharmacy & Meds Mgmt	Quality & Safety	L2	Complaints: longest open 277 days
P&SC	Governance	L3	Risk mgmt: 29% overdue, WHCs: 30% overdue
Gov & Comms	Workforce	L2	PADR: 81.3%, Mandatory Training: 84.5%
MH&LD	Strat, Planning	L3	Sustained fragility; savings/UEC clarity needed
De-escalated Down ▼	**Domain**	**New Level**	**Reason**
Exec Dir Nursing	Governance	L1	Audit/inspection compliance improved
MH&LD	Workforce	L1	Improved sickness, pay progression, ER mgmt
E&F	Population Health	L2	Improved flu immunisation and engagement

Net position: 4 escalations up vs 3 de-escalations. Governance domain (Planned and Specialist Care now Level 3) is an area of emerging concern.

Governance Implications for Finance and Performance Committee

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Implication	Affected Areas	Detail
Financial recovery plans required	C&IM, MH&LD, P&SC	Three CCGs approaching Level 4 triggers. 2026/27 plan must include credible financial recovery trajectories.
Finance–performance correlation	C&IM, MH&LD, P&SC	Same CCGs at Level 3 for both domains. Integrated improvement planning essential.
Population Health: widespread L3	10 of 16 functions	BCI plans and flu immunisation. Not directly FPC remit but signals organisational-wide pressure.
De-escalation requirement	All domains	Sustained improvement for 3 consecutive months to move L3→L2. Mirrors WG TI criteria.

Healthcare-Associated Infections (HCAI) performance reported separately to QSEC. Strategy, Planning and Fragile Services reported to the Strategy and Planning Committee (SPC)..

Recommendations

The Finance and Performance Committee is asked to:

- **SCRUTINISE** the trajectories presented in this paper, including the Prophet forward look projections and Clinical Care Group pre-mitigation demand and capacity positions, and take assurance that these are being used to inform realistic and evidence-based improvement targets within the 2026/27 annual plan..
- **RECOGNISE** the risks the organisation is carrying into 2026/27, specifically: the underlying deficit of £58.4m; the worsening Month 10 2026/27 run rate trajectory; three Tier 1 metrics where Prophet projects zero probability of target achievement; and the pre-mitigation referral to treatment, therapies and radiology trajectories. The honest gap assessment must be communicated with Welsh Government as part of the Annual Plan.
- **NOTE** that three Clinical Care Groups (Community and Integrated Medicine, Mental Health and Learning Disabilities and Planned and Specialist Care) are approaching Level 4 financial escalation triggers with recovery plans consistently overdue. Should sustained improvement not be demonstrated, Level 4 oversight will need to be applied