



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

DATE 24 February 2026
TIME 9:30 AM - 1:00 PM
LOCATION Dolau Cothi Board Room, Corporate Headquarters, Picton
Terrace/Microsoft Teams meeting

Finance and Performance Committee Meeting

24 February 2026

Agenda - 24 February 2026

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 16 DECEMBER 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 16 DECEMBER 2025

9:35 AM, 5 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.5 SELF-ASSESSMENT OF COMMITTEE EFFECTIVENESS: OUTCOME REPORT

9:40 AM, 10 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.6 ASSURANCE AND RISK REPORT

9:50 AM, 15 min

Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

2 ESCALATION OVERVIEW

10:05 AM, 0 min

2.1 ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

10:05 AM, 15 min

Shaun Ayres (Hywel Dda UHB - Director of Delivery)

3 ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

10:20 AM, 0 min

3.1 DEMAND AND CAPACITY PLANNING 2026/27 (INCLUDING RECOVERY OF THERAPIES AND REFERRAL TO TREATMENT)

10:20 AM, 30 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

3.2 SAVINGS IDENTIFICATION 2026/27 FOR OPERATIONAL TEAMS

10:50 AM, 30 min

Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

4 FINANCE

11:20 AM, 0 min

4.1 FINANCIAL PERFORMANCE ASSURANCE REPORT

11:20 AM, 20 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance), Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)

4.2 INVESTMENT, BENEFITS REALISATION AND DISINVESTMENT REPORT

11:40 AM, 10 min

Sian Jenkins (Hywel Dda UHB - Deputy Director of Finance)

4.3 THREE YEAR FINANCIAL PLAN 2026-29

11:50 AM, 20 min

Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance)

4.4 BALANCE SHEET REPORT

12:10 PM, 5 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

4.5 PROCUREMENT SCRUTINY

12:15 PM, 10 min
Gemma Deverill (NWSSP - Procurement)

4.6 PLANNING OBJECTIVE UPDATE REPORT Q3 2025/26

12:25 PM, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

5 PERFORMANCE

12:30 PM, 0 min

5.1 INTEGRATED PERFORMANCE ASSURANCE REPORT

12:30 PM, 10 min
Anthony Tracey (Hywel Dda UHB - Digital Director)

5.2 NWSSP PERFORMANCE REPORT QUARTER 3 2025/26

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

6 FOR APPROVAL

12:45 PM, 0 min

6.1 FINANCIAL PROCEDURES

12:45 PM, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7 FOR INFORMATION

12:50 PM, 0 min

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

12:50 PM, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7.2 JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

12:55 PM, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

7.3 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26

1:00 PM, 0 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

8 ANY OTHER BUSINESS

1:00 PM, 0 min

9 DATE OF NEXT MEETING

1:00 PM, 0 min

- **Thursday 30 April 2026; 09:30 - 12:30**

Table of contents

2026-02-24 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 16 DECEMBER 2025	14
Attachments	
Draft Minutes FPC 16 December 2025	15
1.4 - TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 16 DECEMBER 2025	41
Attachments	
FPC Table of Actions 16 December 2025	42
1.5 - SELF-ASSESSMENT OF COMMITTEE EFFECTIVENESS: OUTCOME REPORT	44
Attachments	
Self-Assessment of Committee Effectiveness FPC 24 February 2026	45
1.6 - ASSURANCE AND RISK REPORT	51
Attachments	
FPC Governance Arrangements Feb 2025 FINAL clean	52
2 - ESCALATION OVERVIEW	65

2.1 - ESCALATION OVERSIGHT AND HIGHLIGHT REPORT	66
Attachments	
Escalation Oversight and Highlight Report FPC 24 February 2026	67
3 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES	91
3.1 - DEMAND AND CAPACITY PLANNING 2026/27 (INCLUDING RECOVERY OF THERAPIES AND REFERRAL TO TREATMENT)	92
Attachments	
Demand and Capacity Assessments 2026-27 FPC 24 February 2026	93
3.2 - SAVINGS IDENTIFICATION 2026/27 FOR OPERATIONAL TEAMS	130
Attachments	
Ops and CCG Savings Identification 2026-27 FPC 24 February 2026	131
4 - FINANCE	154
4.1 - FINANCIAL PERFORMANCE ASSURANCE REPORT	155
Attachments	
Financial Performance Assurance Report M10 2025-26 FPC 24 February 2026	156
Appendix 1 Month 10 2025026 Financial Performance Assurance Report	164
Appendix 2 2025-26 Strategic Cash Welsh Government Response Letter	206
4.2 - INVESTMENT, BENEFITS REALISATION AND DISINVESTMENT REPORT	208
Attachments	
Investment, Benefits Realisation and Disinvestment Report FPC 24 February 2026	209
Appendix 1 Investment Update	214
4.3 - THREE YEAR FINANCIAL PLAN 2026-29	218

Attachments

Three Year Financial Plan 2026-29 FPC 24 February 2026	219
Appendix 1 Financial Plan Assessment 2026-29	227
Appendix 2 Financial Budget Accountability Letter 2026-27	271
Appendix 3 HDdUHB Accountable Officer Letter 13 February 2026	285

4.4 - BALANCE SHEET REPORT 287

Attachments

Balance Sheet Report FPC 24 February 2026	288
Appendix 2 Balance Sheet Dashboard 31 December 2025	294

4.5 - PROCUREMENT SCRUTINY 301

Attachments

Procurement Scrutiny FPC 24 February 2026	302
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4.6 - PLANNING OBJECTIVE UPDATE REPORT Q3 2025/26 308

Attachments

Planning Objective Update Report Q3 2025-26 FPC 24 February 2026	309
Annex 1 Planning Objective Highlight Report Q3 2025-26	313

5 - PERFORMANCE 318

5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT 319

Attachments

IPAR M10 2025-26 FPC 24 February 2026	320
Appendix 1 IPAR Overview M10 2025-26	327

5.2 - NWSSP PERFORMANCE REPORT QUARTER 3 2025/26 358

Attachments

NWSSP Performance Report Q3 2025-26 FPC 24 February 2026	359
HDdUHB NWSSP Summary Performance Report Q3 2025-26	364
6 - FOR APPROVAL	388
6.1 - FINANCIAL PROCEDURES	389
Attachments	
Financial Procedures FPC 24 February 2026	390
FP070 Hospital Travel Cost Scheme Procedure	394
FP070 Equality Impact Assessment	411
7 - FOR INFORMATION	416
7.1 - ALL-WALES CAPITAL PROGRAMME 2025/26, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE	417
Attachments	
Capital Update February 2026 FPC 24 February 2026	418
7.2 - JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS	428
Attachments	
JCC PPF Sub-Committee Highlight Report 18 December 2025	429
7.3 - FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2025/26	433
Attachments	
FPC Work Programme 2025-26 Draft.doc	434
8 - ANY OTHER BUSINESS	439
9 - DATE OF NEXT MEETING	440

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 16
DECEMBER 2025

*Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)*

| For approval

Attachments

[Draft Minutes FPC 16 December 2025.pdf](#)

UNAPPROVED MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE MEETING

DATE OF MEETING: 9:30 AM, Tuesday 16 December 2025

VENUE: Microsoft Teams Meeting

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

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

MINUTES REF.	ITEM	ACTION
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FPC(25)106	WELCOME AND APOLOGIES	
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Mr Michael Imperato welcomed all to the Finance and Performance Committee (FPC) meeting.

Apologies had been received from:

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

FPC(25)107	DECLARATION OF INTERESTS
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There were no declarations of interest.

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

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

Mrs Sharon Daniel left the meeting

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

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

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

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

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

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

There were no questions from members of the Committee.

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

FPC(25)111 ASSURANCE AND RISK REPORT

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

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

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

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

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

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

JW

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

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

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

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

AC

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

AC

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

CSO

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

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

Mr Peter Skitt joined the meeting

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

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

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

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

RISK MANAGEMENT

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

AUDITS, INSPECTIONS AND REGULATORY REPORTS

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

MINISTERIAL DIRECTIONS

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

FPC(25)112

ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

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

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

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

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

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

Decision: The Finance and Performance Committee:

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

FPC(25)113

URGENT AND EMERGENCY CARE AND SIX GOALS UPDATE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FPC(25)114

R1 OPHTHALMOLOGY PERFORMANCE

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

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

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

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

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

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

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

FPC(25)115

PARTNERSHIP WORKING - COMMISSIONING ARRANGEMENTS

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

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

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

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

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

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

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

RE/HT/
JW

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

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

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

Decision: The Finance and Performance Committee:

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

FPC(25)116

CLINICAL CARE GROUP FINANCIAL SAVINGS ACTION PLANS

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

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

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

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

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

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

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

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

Mr Shaun Ayres left the meeting

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

Ms Carly Hill joined the meeting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms Gemma Deverill joined the meeting

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

Decision: The Finance and Performance Committee:

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

FPC(25)119

PLANNING FOR 2026/27

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

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

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

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

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

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

Decision: The Finance and Performance Committee:

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

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

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

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

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

Decision: The Finance and Performance Committee:

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

FPC(25)121

PROCUREMENT SCRUTINY

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

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

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

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

Ms Gemma Deverill left the meeting

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

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

FPC(25)122

INTEGRATED PERFORMANCE ASSURANCE REPORT

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

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

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

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

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

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

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

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

Mr Peter Skitt joined the meeting

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

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

FPC(25)123

NWSSP PERFORMANCE REPORT QUARTER 2 2025/26

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

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

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

FPC(25)124

FINANCIAL PROCEDURES

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

There were no questions from members of the Committee.

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

- Financial Procedure 1049 – Use of Consultancy

FPC(25)125

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

Mr Thomas Alexander joined the meeting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Huw Thomas left the meeting

Decision: The Finance and Performance Committee:

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

FPC(25)126

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

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

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee:

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

FPC(25)127

JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

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

There were no questions from members of the Committee.

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

meeting on 23 October 2025.

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

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

There were no questions from members of the Committee.

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

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

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

There were no questions from members of the Committee.

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

FPC(25)130 ANY OTHER BUSINESS

There was no other business transacted at the meeting.

FPC(25)131 DATE OF NEXT MEETING

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

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

1.4

9:35 AM, 5 Mins

**1.4 - TABLE OF ACTIONS FROM FINANCE
AND PERFORMANCE COMMITTEE HELD
ON 16 DECEMBER 2025**

***Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)***

| For approval

Attachments

[FPC Table of Actions 16 December 2025.pdf](#)

FINANCE AND PERFORMANCE COMMITTEE / PWYLLGOR CYLLID A PHERFFORMIAD
16 DECEMBER 2025
TABLE OF ACTIONS / TABL GWEITHREDOEDD

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
FPC(25) 111	16 December 2025	ASSURANCE AND RISK REPORT	To discuss with Chair to add consideration of long-term risks/Board Assurance Framework to the Committee Work Plan	JW	24 February 2026	In progress.
FPC(25) 111	16 December 2025	ASSURANCE AND RISK REPORT	To present an update on the risks associated with the Ministerial Direction on the Delivery of Autism Services (Corporate Risk 1032, Operational Risk 1287 and Operational Risk 1290) to a future FPC meeting.	AC	24 February 2026	In progress.
FPC(25) 111	16 December 2025	ASSURANCE AND RISK REPORT	To review the overdue recommendations arising from audits and inspections under the responsibility of the Community and Integrated Medicines CCG.	AC	24 February 2026	Complete. Same action raised at ARAC 10/02/2026. ARAC to be primary lead Board Committee for action.
FPC(25) 111	16 December 2025	ASSURANCE AND RISK REPORT	To circulate the Allied Health Professions and Health Science CCG Financial Risk Slides to members of the Committee.	CSO	16 December 2026	Complete. Slides circulated 16/12/2025.
FPC(25) 113	16 December 2025	URGENT AND EMERGENCY CARE AND SIX GOALS UPDATE	To frame the request for future Escalation Response – Recovery Action Plans and Improvement Trajectory reports to codify the request of the	HT/CSO	13 January 2026	Complete. Revised request used in the Call For Papers.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress/Date Achieved
			Committee to incorporate milestones and timelines for future Calls For Papers and share with Committee.			
FCP(25) 115	16 December 2025	PARTNERSHIP WORKING - COMMISSIONING ARRANGEMENTS	To discuss whether there was any merit in seeking internal audit support to investigate clinical coding of HDdUHB activity by SBUHB.	RE/HT/ JW	24 February 2026	Complete. Has been explored however it is considered that the appropriate route is through Commissioning and Contracting. HDdUHB have written to SBUHB and awaiting a response.
FPC(25) 119	16 December 2025	PLANNING FOR 2026/27	To update savings detail within Financial Plan to include milestones and timelines for population of savings schemes for scrutiny at next FPC meeting.	HT	24 February 2026	Complete. Milestones and timelines incorporated into future Finance Reports and within the Three Year Financial Plan.
ALL	16 December 2025	QUORACY	To confirm Clinical Executive support for items minded to approve during the period that the meeting was inquorate.	MH	10 January 2026	Complete. MH confirmed content to approve items considered while meeting was inquorate.

1.5

9:40 AM, 10 Mins

1.5 - SELF-ASSESSMENT OF COMMITTEE EFFECTIVENESS: OUTCOME REPORT

*Michael Imperato
(Hywel Dda UHB -
Independent Board
Member)*

| For assurance

Attachments

Self-Assessment of Committee Effectiveness FPC 24 February 2026.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance and Performance Committee Self-Assessment Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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 the report is to present the outcome of the Finance and Performance Committee (FPC) Self-Assessment 2025/2026 process to the Committee.

Cefndir / Background

In line with Section 10.2.1 of Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Section 10.2.2 also states that each Committee must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

In addition to the annual Committee self-assessment process, after each meeting Independent Member (IM) Reflective Sessions take place to gather feedback and insights from Members on the meeting, in terms of what has gone well, what could have gone better, how quality has informed discussions, and issues that need to be raised at the Committee Chair's meeting. This feedback helps with the evaluation process and continuous improvement.

During previous years, Committee self-assessments have been based on a comprehensive review of feedback provided by the Committee Membership from the completion of a long questionnaire assessment. While these approaches provided valuable insights, they also led to survey fatigue and limited engagement. Feedback from a recent Corporate Governance Conference has highlighted the need for a proportionate process for assessment that avoids unnecessary complexity. This year's approach will streamline the assessment, focusing on critical governance behaviours and outcomes rather than exhaustive questionnaires.

This year's Committee self-assessment form focuses on five core areas of governance and assurance:

Financial Oversight and Stewardship

The Committee provides effective oversight of the Health Board's financial planning, financial performance and delivery against Health board financial plans/objectives, and control, ensuring use of public funds in line with NHS Wales principles of value and transparency.

Performance Monitoring and Delivery

The Committee effectively monitors performance against national and local NHS Wales targets, including quality, access, workforce, and operational delivery, as well as overseeing delivery against de-escalation criteria aligned to the Committee.

Risk Management and Assurance

The Committee ensures that financial and operational risks are clearly identified, monitored, and mitigated through effective governance and assurance mechanisms.

Strategic Alignment and Value-Based Healthcare

The Committee supports delivery of the Health Board's strategic objectives and promotes the principles of Value-Based Healthcare (VBHC), ensuring financial and performance decisions improve outcomes and sustainability.

Financial Strategy and Long-Term Sustainability

The Committee receives sufficient assurance on the development and implementation of a clear, coherent, and sustainable financial strategic plan for the Health Board.

Asesiad / Assessment

To improve response rates, taking into account that there is a process of continuous improvement through the IM post-committee Reflective Sessions, a short questionnaire was circulated to members to gather feedback on 5 key areas for the Committee (see above).

Respondents were asked to rate their level of agreement to 5 statements relating to key areas of focus for the Committee on a scale of 1–5. (1 - strongly disagree up to 5 – strongly agree) and to provide more information to support their rating.

Below are the statements relating to 5 key areas of focus for the Committee and the average ratings based on the responses received 5 (out of 9) responses were received (56% response rate).

Area and Statement	Average Rating
Financial Oversight and Stewardship <i>The Committee provides effective oversight of the Health Board's financial planning, financial performance and delivery against Health</i>	4.6

<i>board financial plans/objectives, and control, ensuring use of public funds in line with NHS Wales principles of value and transparency.</i>	
Performance Monitoring and Delivery <i>The Committee effectively monitors performance against national and local NHS Wales targets, including quality, access, workforce, and operational delivery, as well as overseeing delivery against de-escalation criteria aligned to the Committee.</i>	4.2
Risk Management and Assurance <i>The Committee ensures that financial and operational risks are clearly identified, monitored, and mitigated through effective governance and assurance mechanisms.</i>	4.6
Strategic Alignment and Value-Based Healthcare <i>The Committee supports delivery of the Health Board's strategic objectives and promotes the principles of Value-Based Healthcare, ensuring financial and performance decisions improve outcomes and sustainability</i>	4.2
Finance Strategy and Long Term Sustainability <i>The Committee receives sufficient assurance on the development and implementation of a clear, coherent, and sustainable financial strategic plan for the Health Board.</i>	4

The following themes were provided:

What has gone well:

- Clearer reporting: report format is helpful and enables transparency
- Papers are generally good quality with increased focus on delivery, efficiency and outcomes, enabling strong Independent Member (IM) challenge.
- Good attendance from Executives and IMs.
- Positive shift in Committee behaviour: finance and performance correlates more effectively.
- Increasing emphasis on forward action plans, trajectories and ownership.
- Strong questioning and assurance on whether mitigations are in place.
- Root cause analysis is more evident, with focused updates from relevant functions

What we want to strengthen going forward:

- Consistent operational risk management and assurance: Whilst there is a robust corporate regime around risk management and assurance there are inconsistent practices across functions, leading to uneven visibility of risk and assurance.
- Continue refining papers to support strategic, not operational, decision-making: some papers (e.g. action plans, business cases) still lack clarity, making strategic alignment difficult to evaluate. Updates from functions vary in quality and robustness; some prevent the Committee from gaining assurance on corrective actions.

- Assurance: The effectiveness of mitigation is not always probed in enough depth.
- Longer term focus: Short term organisational pressures are impacting longer term transformation decisions.
- Response to scrutiny: Stronger mechanisms are required for escalation when a function is repeatedly underperforming.
- Maintain the increased root-cause focussed approach for focused updates and action plans from those functions who are managing service areas that come under scrutiny.

Suggestions from Respondents

- Performance monitoring and delivery: A stronger setting of the context in terms of de-escalation would be helpful
- A mechanism to instigate a response to continued escalation for a particular function is required.

Overall Conclusion

Respondents recognise clear improvement in FPC scrutiny, reporting, and challenge. The Committee is seen as strengthening in rigour, focus, and alignment with Board principles. However, there remain systemic issues. Consistency, clarity, and longer-term organisational planning will strengthen the Committee's ability to take full assurance in several areas particularly sustainability, risk assurance, and strategic links to VBHC, and long-term organisational planning.

Area for improvement	By Whom	By When
Ensure report authors receive feedback on the quality of their papers being brought to Committee in order to improve and develop. Papers need to have a greater focus on longer term strategic matters alongside operational matters, risks, with clear, corrective actions, that provide assurance.	Executive Leads	April 2026
Committee Members to further challenge and scrutinise the effectiveness of risk control/mitigation measures for assurance.	FPC Members	April 2026
Further develop mechanisms to develop a response to continued escalation when a function is underperforming.	Director of Finance	June 2026

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **CONSIDER** the outputs from the Committee Self-Assessment process and **AGREE** to the actions to be taken to improve its effectiveness.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established.
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:	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:	FPC Terms of Reference FPC Self-Assessment digital form results
Rhestr Termâu: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	Director of Corporate Governance

Effaith: (rhaid cwblhau) Impact: (must be completed)

Ariannol / Gwerth am Arian: Financial / Service:	No Direct Impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No Direct Impacts
Gweithlu: Workforce:	No Direct Impacts
Risg: Risk:	No Direct Impacts
Cyfreithiol: Legal:	No Direct Impacts
Enw Da: Reputational:	No Direct Impacts
Gyfrinachedd: Privacy:	No Direct Impacts
Cydraddoldeb: Equality:	No Direct Impacts

1.6

9:50 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), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science)

| For assurance

Attachments

FPC Governance Arrangements Feb 2025 FINAL clean.pdf



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Assurance and Risk Report

Finance and Performance Committee, 24 February 2026

This report provides the Finance and Performance Committee (FPC) with the status of the principal risks, operational risks, and Welsh Health Circulars (WHCs).

The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that WHCs are being implemented by the Health Board.

Corporate risks, audit and inspections recommendations and Ministerial Directions are reported at alternate meetings, and due to be presented to FPC at its next meeting in April 2026.

Principal Risks:

1

Under Review

Operational Risks

19

Welsh Health Circulars

2

Risk Management - Overview



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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.

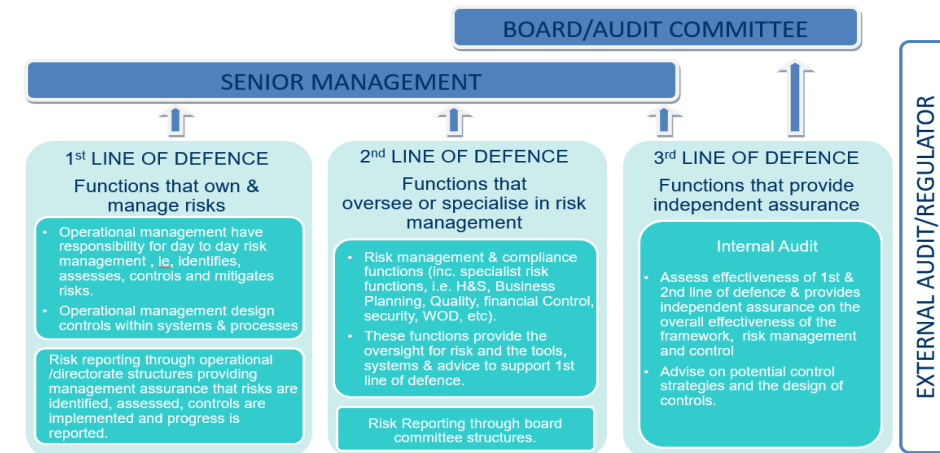
The Health Board’s risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval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

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

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

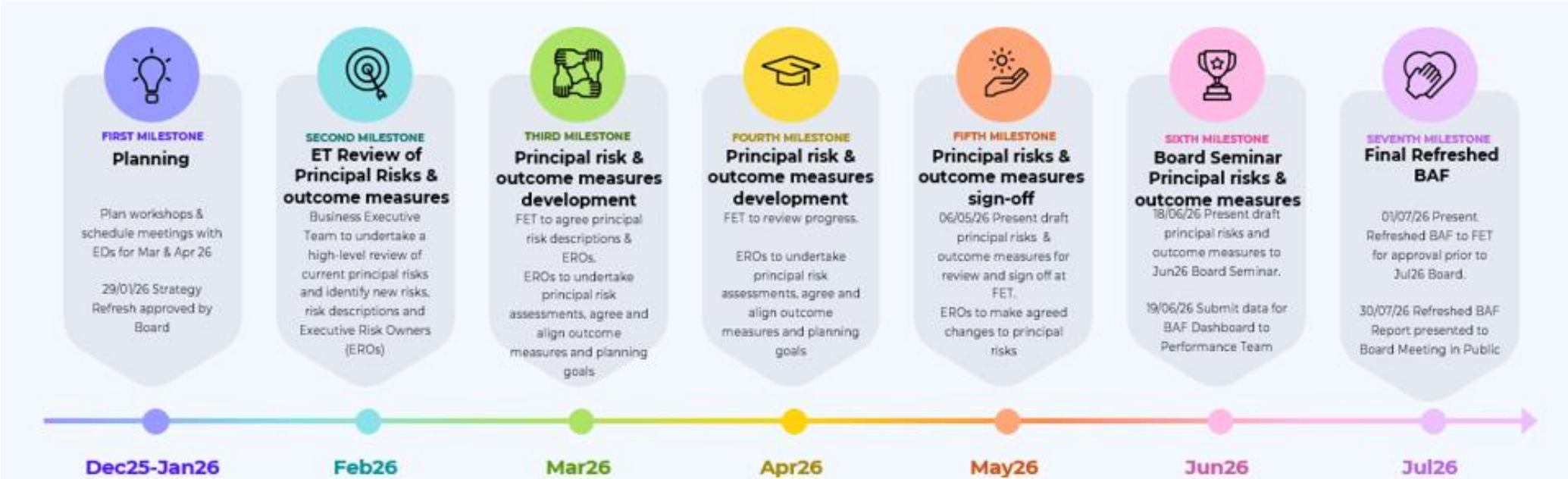
The Board’s Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (for example where the risk appetite is exceeded, or there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

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



Principal Risks

As a result of the Strategy Refresh, presented to Board in January 2026, the plan is to present a refreshed Board Assurance Framework (BAF) to Board in July 2026. A review of principal risks will be undertaken as part of the BAF refresh, in addition to the supporting planning goals and outcome measures per the timeline below.



Refreshed principal risks will be discussed at Board seminar in June 2026 ahead of presentation to the Board in July 2026.

Each principal risk will be aligned to a Board Committee and will be reported via the Assurance and Risk Report to ensure that they are being managed appropriately, taking in to account gaps in control, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Operational Risks assigned to FPC

20 operational risks on Datix are aligned to FPC, all of which are within review date.

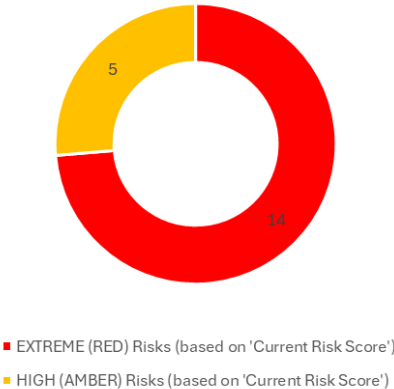
Of these, 19 have been identified as reportable to FPC based on the following criteria:

- FPC has been selected by the risk lead as the ‘Assuring Committee’ on Datix;
- Risks have been identified at operational level (previously Service and Directorate level) on Datix risk module;
- The current risk score is ‘extreme’ or ‘high’; and
- The current risk score is either equal to or exceeds the target risk score.

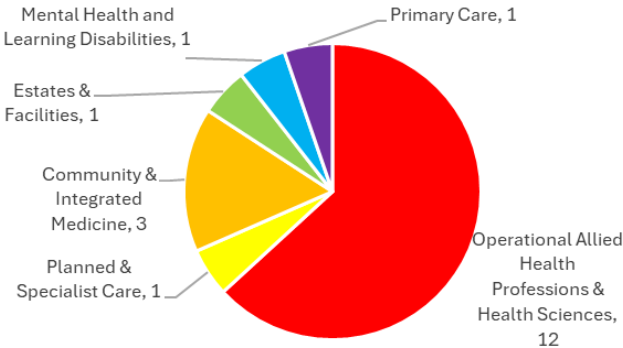
Total Number of Open Risks meeting criteria for reporting	19
New Risks since last reported to FPC	4
Closed Risks since last reported to FPC	0
Increase in Risk Score since last reported to FPC	2
Decrease in Risk Score since last reported to FPC →	0
No Change in Risk Score since last reported to FPC ↑	13
EXTREME (RED) Risks (based on ‘Current Risk Score’) ↑	14
HIGH (AMBER) Risks (based on ‘Current Risk Score’) ↑	5

The following slides summarise the operational risks aligned to FPC as of 29 January 2026.

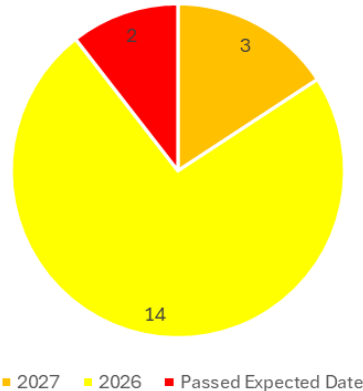
Current Level of Risks assigned to FPC



Risks split per Clinical Care Group/Executive Function



Risks by Target Risk Score Expected Date (Year)



New Operational Risks Reportable to FPC



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2242 - Budget cost pressure of £100k due to unfunded weekend physiotherapy services	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	4	31/03/2026	29/12/2025
2184 - Risk that budget code 1962 will have a cost pressure of £180K from April 2026	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16	6	31/03/2027	29/12/2025
2202 - Risk to overspend and reduced performance due to the Outpatient Insourcing contract	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	12	6	30/04/2026	17/12/2025
1869 - Risk of NHS Dental Services not achieving Patient Charge Revenue Income targets due to lower activity/income at practices*	Primary Care	Chief Operating Officer	12	8	31/03/2026	25/11/2025

* Risk 1869 realigned from Quality, Safety and Experience Committee (QSEC)



Changes in Risk Score since last reported to FPC

Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2107 - Risk of physiotherapy financial overspend due to unfunded respiratory on call services.	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20 ↑ (Previous Risk Score 16)	4	31/03/2026	29/12/2025
975 - Risk of failure to remain within allocated budget due to financial constraints (Estates & Facilities).	Estates & Facilities	Director of Allied Health Professions and Health Sciences	16 ↓ (Previous Risk Score 20)	10	31/03/2026	23/01/2026

No Change in Risk Score since previous report



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2167 - There is a risk that increasing non-pay cost pressures in Podiatry will impact on effective patient care	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	5	31/03/2026	14/01/2026
2132 - Risk of overspend due to cost pressures related to variable pay	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	20	31/03/2027	17/12/2025
2110 - Risk of not achieving savings targets for 2025/26 due to significant, strategic change required across whole CCGs	Community & Integrated Medicine	Chief Operating Officer	20	16	31/10/2025	25/09/2025
1631 - If the delegation of budget manager responsibilities are unmet then finances will be adversely affected	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	15	31/03/2026	29/12/2025
2148 -Risk of significant financial pressures impacting on service delivery due to reliance on RIF funding for key clinical roles	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/03/2027	29/12/2025
2131 - Risk of overspend due to cost pressures related to Everlight radiology	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	15	31/03/2026	17/12/2025

No Change in Risk Score since last reported to FPC



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1906 - Risk of not achieving savings targets within our annual plan due to ongoing service demand	Community & Integrated Medicine	Chief Operating Officer	16	12	31/03/2027	02/01/2026
1892 - Risk of not achieving savings targets due to continued expenditure without mitigating savings plans	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16	12	31/03/2026	17/12/2025
971 - Risk of failure to remain within allocated budget over the medium term due to financial constraints (MH&LD)	Mental Health and Learning Disabilities	Chief Operating Officer	16	3	31/03/2026	11/12/2025
2040 - Risk of decommissioning of current FCP Physio Primary care service due to funding uncertainty from April 2026	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	15	4	31/03/2026	29/12/2025
2124 - Risk of being unable to identify recurrent savings required due to spend on ad-hoc pay and non-pay	Planned & Specialist Care	Chief Operating Officer	12	4	31/03/2026	28/11/2025
1951 - Risk of overspend against Specialist Palliative Care budget due to potential withdrawal of funding for permanent posts	Community & Integrated Medicine	Chief Operating Officer	12	4	31/03/2026	02/12/2025
1646 - Risk of cost pressure (external test service level agreements PHW) due to increased workload/costs	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	8	8	23/04/2025	02/01/2026

Risk owners can allocate themes to their risks, which allows the Health Board to share risk information on specific areas with relevant experts as part of the second line of defence. Risks are allocated to a committee based on their main impact on reporting. Risk Themes are assigned based on any additional impacts or contributory factors, with each theme aligned to the appropriate committee for oversight. Risk Themes provide assurance that a holistic approach to risk management is undertaken and enables the Health Board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk.

Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board’s control framework, and to determine whether further action is required to prevent risks from materialising.



The following themes are currently aligned to FPC as of January 2026:

Risk Theme	Definition	Number of risks
Finance	Risks associated with the possibility of financial loss and uncertainty	86

Implementation of Welsh Health Circulars (WHCs)



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There are 2 open WHCs aligned to FPC as of January 2026, both issued since the previous report to Committee.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each WHC is assigned a status category.. To provide a more accurate reflection of WHC progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are included in the table below, and the number of WHCs aligned to these categories.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	0
Unable to Complete (NEW)	The WHC 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 WHC 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 WHC is overdue or not whilst decision pending.	0
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	1
Reliant on External Factors	The WHC 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 WHC and are currently awaiting formal approval to close.	1
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	0

Oversight of the delivery of WHCs has been included in new Clinical Care Group Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

Welsh Health Circulars assigned to FPC



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WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	RAG Status	Progress Update
055-25 2026-27 Health Board allocation	22/12/2025	Finance	Director of Finance	March 2026	In Progress	The Health Board allocation is reflected in the 2026/27 planning framework which is being incorporated into the three-year planning cycle. This will be taken through Finance and Performance Committee in February 2026, and Public Board in March 2026.
045-25 Revisions to the Standing Orders for the NHS Wales Joint Commissioning Committee	28/10/2025	Corporate Governance	Director of Corporate Governance	December 2025	Complete Pending Formal Approval	NHS Wales Joint Commissioning Standing Orders were presented to the Board for approval in November 2025.

Recommendations



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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.

WELSH HEALTH CIRCULARS

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.



DIOGEL | CYNALIADWY | HYGURCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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2 - ESCALATION OVERVIEW

2.1

10:05 AM, 15 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 24 February 2026.pdf](#)

Escalation Assessment with Prophet Forward Look Analysis

Finance and Performance Committee, 24 February 2026

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

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

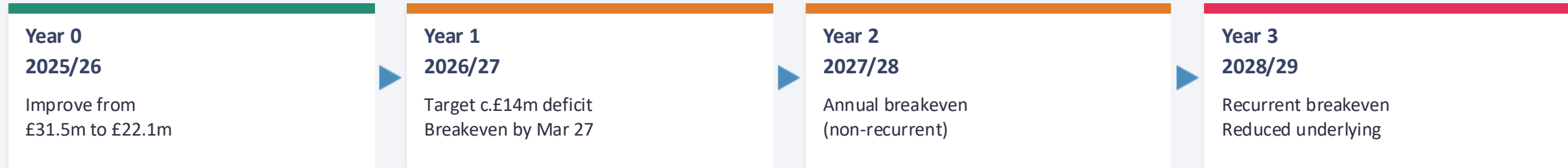
Alert / Advise / Assure Assessment

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

Three-Year Financial Roadmap



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

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)

Probability of Achieving De-escalation Target by Quarter
Prophet Time Series Forecast (80% Confidence Interval)

R1 Ophthalmology [Criterion: MD5]	0%	0%	0%	0%	0%
Delayed Follow-Ups [Criterion: MD15]	0%	0%	0%	0%	0%
Pathways of Care Delays [Criterion: MD9]	0%	0%	0%	0%	0%
Ambulance Handovers [Criterion: MD6]	16%	21%	56%	67%	37%
12-Hour ED Waits [Criterion: MD7]	2%	81%	71%	84%	70%
Diagnostic Endoscopy [Criterion: MD17]	99%	97%	88%	95%	95%
	Q4 25/26 (Feb-Mar 26)	Q1 26/27 (Apr-Jun 26)	Q2 26/27 (Jul-Sep 26)	Q3 26/27 (Oct-Dec 26)	Q4 26/27 (Jan-Mar 27)

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.

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 (September – 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

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.

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.

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.

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. It 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.

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.

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.

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 as they 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.

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.

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

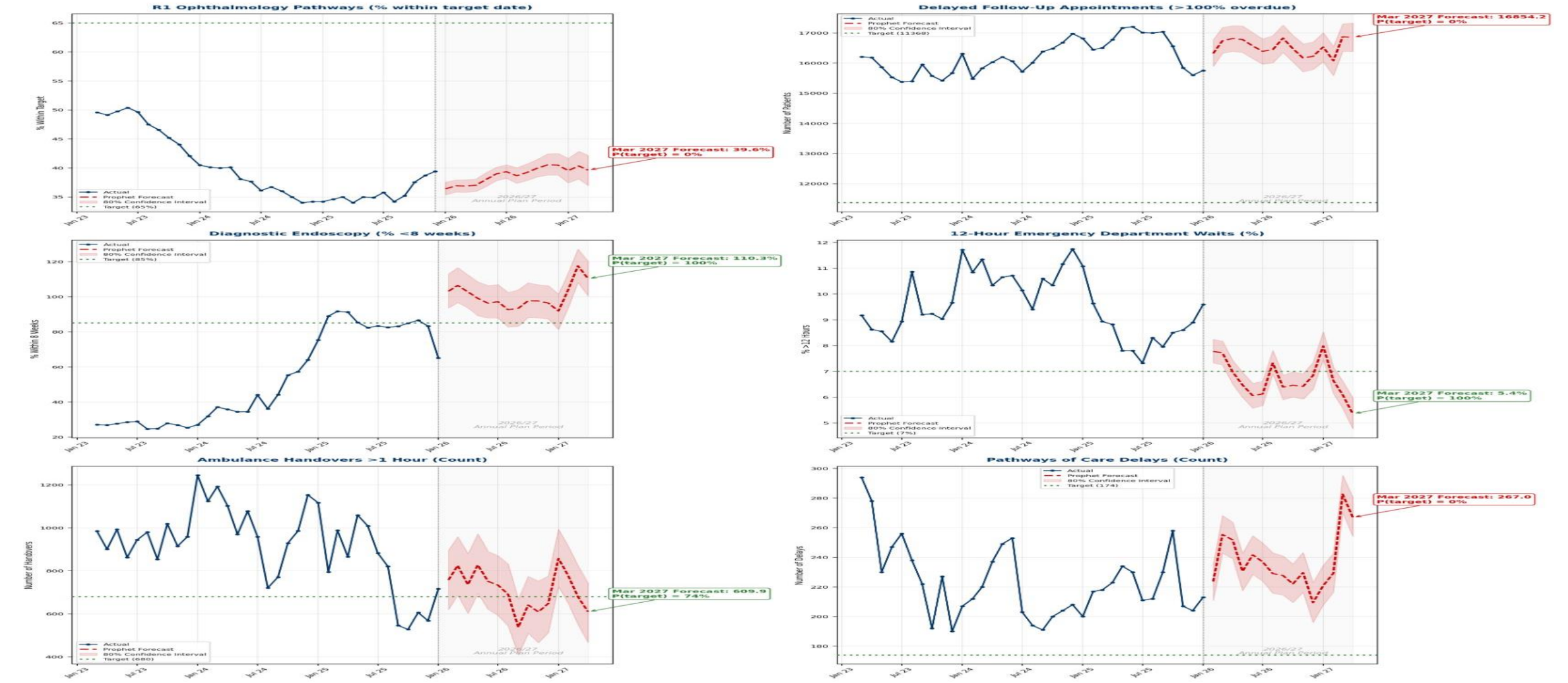
Radiology capacity is the binding constraint on multiple planned care and cancer metrics simultaneously. The diagnostic deficit directly constrains cancer pathway velocity (urology, lower GI, lung, gynaecology) and planned care referral to treatment (RTT) performance. Histopathology (169 cancer requests/week 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

HDUHB De-escalation Prophet Forecast Analysis
Forward Projection to March 2027 (26/27 Annual Plan Period)



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

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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)

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



GIG
CYMRU
NHS
WALES

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)..



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

3 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

3.1

10:20 AM, 30 Mins

**3.1 - DEMAND AND CAPACITY PLANNING
2026/27 (INCLUDING RECOVERY OF
THERAPIES AND REFERRAL TO
TREATMENT)**

***Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)***

| For assurance

Attachments

[Demand and Capacity Assessments 2026-27 FPC 24 February 2026.pdf](#)





- The Finance and Performance Committee is requested to **NOTE** progress to date in developing of demand and capacity (D&C) plans and related forecast performance trajectories for 2026/27
- Slides reflect progress to date against Planned Care (referral to treatment), Single Cancer Pathway (SCP), Diagnostics (8 weeks), Therapies (14 weeks) and Urgent and Emergency Care (UEC) metrics
- The Mental Health and Learning Disabilities (MHLD) Clinical Care Group (CCG) is currently progressing performance trajectories for 2026/27 (outcomes not reflected in this paper).
- D&C modelling remains work in progress, to take account of continuing refinement of CCG plans, interdependencies between CCG plans and assessment of CCG Annual Plan submissions and associated delivery assumptions / requirements
- Slides also provide an illustrative assessment of the likely financial cost of recovery / closure of forecast delivery gaps versus the respective NHS Wales Performance Framework metrics for 2026/27 – confirmation of the forecast financial cost of recovery will be detailed in the draft Annual Plan for 2026/27 to be considered at the February 2026 Board Seminar



Planned Care (Referral to Treatment)



- **2026/27 NHS Wales Performance Framework**

- Maximum 104-week waiting time for Total Pathway
- Maximum 26-week waiting time for Stage 1 (first outpatient appointment) – the previous maximum 52-week target wait has been removed

- **Baseline modelling based on core activity / capacity and derived demand in previous 12 months**

- CCG review of forecast budgeted / funded capacity for 2026/27 undertaken December 2025/January 2026 – excludes any non-funded / recovery funded activity assumptions
- Assumes forecast RTT performance as at March 2026
- Illustrative 3% allowance for (removals other than treatment (ROTT) assumptions
- Outpatient Transformation efficiency improvements assumed re-referral / demand management (see Supporting Appendices slides)
- Confirmation required of CCG delivery assumptions re further optimisation and productivity improvements relating to progress towards Getting It Right First Time (GIRFT) standards and theatre optimisation)
- Further assessment required of assumptions re regional capacity benefits which may emerge during 2026/27 from regional programmes re orthopaedics and ophthalmology

Planned Care (Referral to Treatment) Headlines



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- Forecast additional cost of achievement of Stage 1 (26 weeks) and Total Pathway (104 weeks) est **£8.61m** as below:
- **26-week Outpatient Department (OPD)** forecast achievement by March 2027 in all but 5 specialties. Potential 9,316 forecast delivery gap. Will require additional delivery solutions with a potential cost of **1.12m**
- **Maintenance of former 52-week OPD** maximum wait will require reprioritisation of existing resources between specialties to mitigate forecast delivery gaps in Rheumatology and Ear, Nost and Throat (ENT). Will also necessitate continued reliance on insourcing for Dermatology (£376k) funded as part of core CCG budget
- **104-week RTT** forecast potential delivery gap range of up to 5,507 breaches (worst case) or circa 4,465 breaches (if theatre cancellations can be mitigated and theatre optimisation improvements achieved). Worst case forecast would necessitate additional recovery solutions with a potential additional cost of circa **£7.49m**
 - £0.41m Urology
 - £1.3m Orthopaedics
 - £0.84m ENT
 - £4.6m Ophthalmology
 - £0.24m Dermatology

Planned Care (Referral to Treatment) Stage 1 (26 weeks) – Initial Assessment



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- No maximum 52 week wait target for 2026/27
- 52-week compliance requires additional solutions in Rheumatology and ENT (total £150k).
- Without recovery support for Ophthalmology, ENT, Dermatology, Neurology, Rheumatology , potential 9,316 patients waiting > 26 weeks by March 2027
- Efficiency (demand management) assumptions already assumed

26 Week OPD	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
100 - General Surgery	0	0	0	0	0	0	0	0	0	0	0	0
101 - Urology	0	0	0	0	0	0	0	0	0	0	0	0
103 - Breast	0	0	0	0	0	0	0	0	0	0	0	0
104 - Colorectal	0	0	0	0	0	0	0	0	0	0	0	0
107 - Vascular	0	0	0	0	0	0	0	0	0	0	0	0
110 - Trauma & Orthopaedics	0	0	0	0	0	0	0	0	0	0	0	0
120 - ENT	42	83	125	167	208	250	292	333	375	417	458	500
130 - Ophthalmology	135	271	406	541	677	812	947	1083	1218	1353	1489	1624
191 - Pain Management	0	0	0	0	0	0	0	0	0	0	0	0
300 - General Medicine	0	0	0	0	0	0	0	0	0	0	0	0
301 - Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0
302 - Endocrinology	0	0	0	0	0	0	0	0	0	0	0	0
303 - Clinical Haematology	0	0	0	0	0	0	0	0	0	0	0	0
307 - Diabetic Medicine	0	0	0	0	0	0	0	0	0	0	0	0
314 - Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0
320 - Cardiology	0	0	0	0	0	0	0	0	0	0	0	0
330 - Dermatology	433	867	1300	1733	2167	2600	3033	3467	3900	4333	4767	5200
361 - Nephrology	0	0	0	0	0	0	0	0	0	0	0	0
340 - Respiratory Medicine	0	0	0	0	0	0	0	0	0	0	0	0
400 - Neurology	102	204	306	407	509	611	713	815	917	1018	1120	1222
401 - Clinical Neurophysiology	0	0	0	0	0	0	0	0	0	0	0	0
410 - Rheumatology	64	128	193	257	321	385	449	513	578	642	706	770
420 - Paediatrics	0	0	0	0	0	0	0	0	0	0	0	0
430 - Geriatric Medicine	0	0	0	0	0	0	0	0	0	0	0	0
502 - Gynaecology	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory 2026/27 Without Funding	776	1553	2329	3105	3882	4658	5434	6211	6987	7763	8540	9316

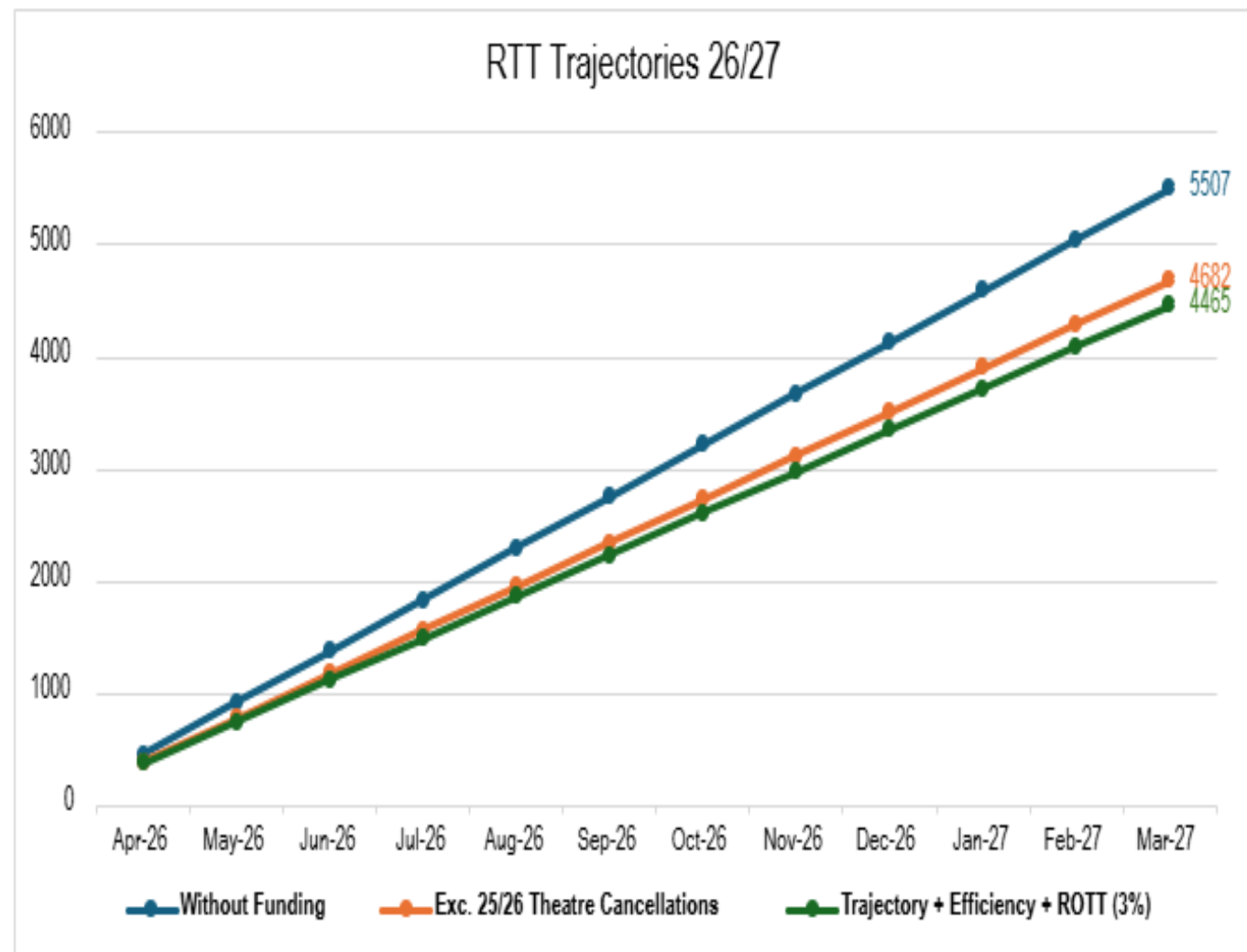
Trajectories 104-Week Referral To Treatment



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- Worst case trajectory N=5,507
- Subspecialty breakdown on following slide
- Mid trajectory for visualisation purposes demonstrates breach position without theatre cancellations
- Third trajectory includes efficiency and ROTT
 - Urology x 20
 - Dermatology x 32
 - Orthopaedic 24 included in D&C plan
 - ENT & Cataracts > 85% utilisation
 - ROTT @3% included for illustrative purposes



Planned Care (Referral to Treatment) Stage 4 / Total Pathway (104 weeks) - Initial Assessment



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- Without recovery support for Urology, T&O, ENT, Ophthalmology and Dermatology, potential for 5,507 patients waiting < 104 weeks by March 2027
- Trajectory in ENT likely Zero if Glangwili Hospital (GGH) sessions ran
- Each of the above specialties have required additional solutions (WLI / insource / outsource) during 2025/26
- ROTT / productivity assumptions / regional capacity and recovery resource assumptions yet to be applied

104 Week	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
100 - General Surgery	0	0	0	0	0	0	0	0	0	0	0	0
101 - Urology	39	78	116	155	194	233	271	310	349	388	426	465
103 - Breast	0	0	0	0	0	0	0	0	0	0	0	0
104 - Colorectal	0	0	0	0	0	0	0	0	0	0	0	0
107 - Vascular	0	0	0	0	0	0	0	0	0	0	0	0
110 - Trauma & Orthopaedics	39	79	118	157	197	236	275	315	354	393	433	472
120 - ENT	31	62	94	125	156	187	218	249	281	312	343	374
130 - Ophthalmology	301	601	902	1202	1503	1804	2104	2405	2705	3006	3306	3607
191 - Pain Management	0	0	0	0	0	0	0	0	0	0	0	0
300 - General Medicine	0	0	0	0	0	0	0	0	0	0	0	0
301 - Gastroenterology	0	0	0	0	0	0	0	0	0	0	0	0
302 - Endocrinology	0	0	0	0	0	0	0	0	0	0	0	0
303 - Clinical Haematology	0	0	0	0	0	0	0	0	0	0	0	0
307 - Diabetic Medicine	0	0	0	0	0	0	0	0	0	0	0	0
314 - Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0
320 - Cardiology	0	0	0	0	0	0	0	0	0	0	0	0
330 - Dermatology	49	98	147	196	245	295	344	393	442	491	540	589
361 - Nephrology	0	0	0	0	0	0	0	0	0	0	0	0
340 - Respiratory Medicine	0	0	0	0	0	0	0	0	0	0	0	0
400 - Neurology	0	0	0	0	0	0	0	0	0	0	0	0
401 - Clinical Neurophysiology	0	0	0	0	0	0	0	0	0	0	0	0
410 - Rheumatology	0	0	0	0	0	0	0	0	0	0	0	0
420 - Paediatrics	0	0	0	0	0	0	0	0	0	0	0	0
430 - Geriatric Medicine	0	0	0	0	0	0	0	0	0	0	0	0
502 - Gynaecology	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory 2026/27 Without Funding	459	918	1377	1836	2295	2754	3212	3671	4130	4589	5048	5507

Planned Care (Referral to Treatment)

Critical Next Steps:



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- **Key next steps to refine RTT performance trajectories for 2026/27**
 1. Further review of ROTT assumptions by specialty for 2026/27 to inform reasonable planning assumption for next 12 months
 2. Confirmation of CCG plans re further optimisation and productivity improvements by specialty for 2026/27 (to include OP Transformation, progress towards GIRFT standards and Theatre optimisation) with quantification of additional capacity/activity benefits and/or reduced demand
 3. Agreement of planning assumptions re regional capacity benefits which may emerge during 2026/27 from regional programmes re orthopaedics and ophthalmology
 4. Agreement of plans for application of recurrent planned care recovery funding available to the Health Board to part mitigate potential breach volumes.



Single Cancer Pathway



- **2026/27 NHS Wales Performance Framework**

- 75% of patients to receive their first definitive cancer treatment within 62 days from point of suspicion

- **Modelling Assumptions:**

- Assumes forecast SCP performance as of March 2027 (partly driven by non-recurrent Urology/diagnostic pathway actions/investments during Q4 2025/26)
- **Current position:** 65.8% SCP (December 2025). Target: 75%. Gap: 9.2 percentage points. Backlog: 628 patients (+17.8% YoY).
- **Key challenge:** Three tumour sites (Urology, Lower GI, Lung) account for 73.9% of the backlog. All three are diagnostically constrained. The Health Board already spends £3.53m a year on Radiology variable pay and outsourcing (plus circa £1.35m on Dermatology additional capacity) to enable current in-year performance improvement, but does not represent sustainable solutions
- **Important note:** Modelling is drawn from multiple / individual CCG planning submissions, demand and capacity analyses, and financial returns. SCP assumptions and costs for Radiology diagnostic capacity cannot be viewed independently from overall Radiology diagnostic pathway requirements (8 weeks) given the critical and complex interrelationship between both pathways



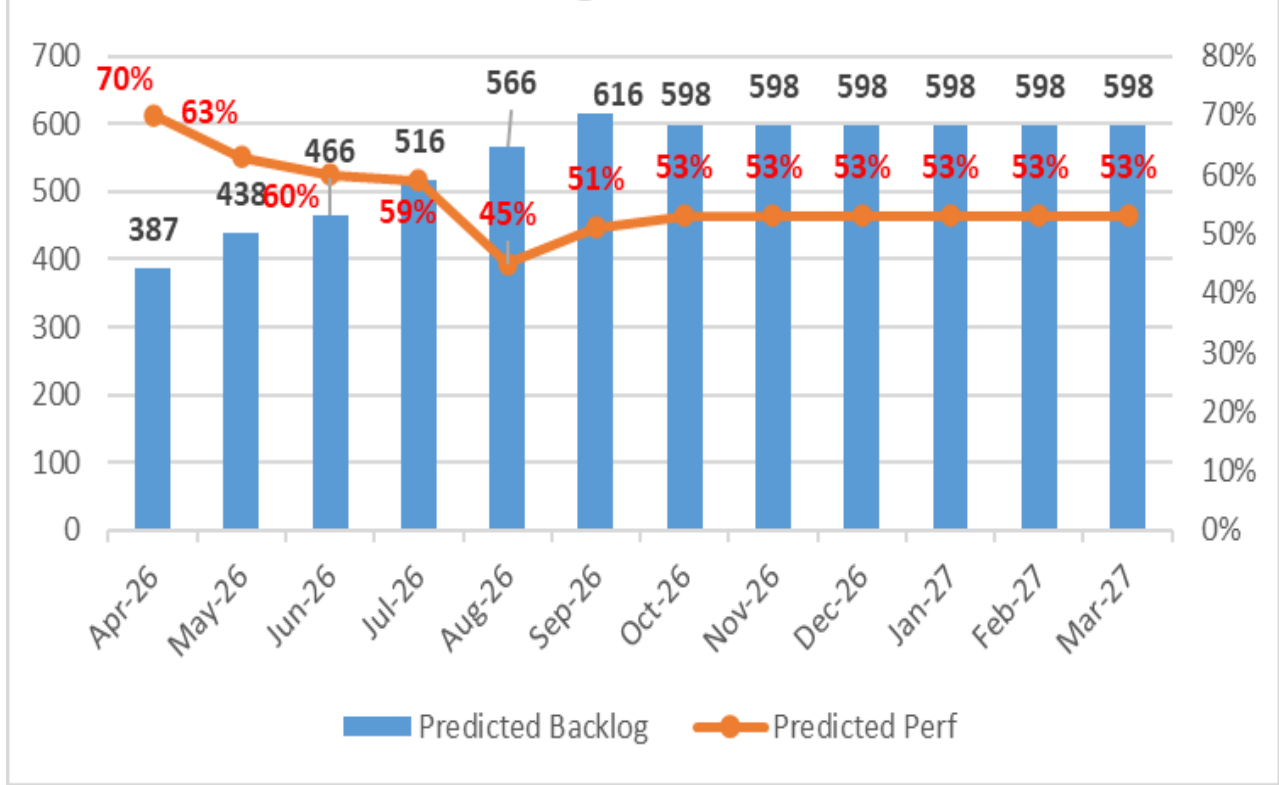
- **4 potential scenarios:**

- **Do Nothing** - Assumes no investment decisions are taken, and all current non-recurrent investments will cease. Performance deteriorates to circa 49%-53% by mid-year. The backlog does not reduce; it grows. Targeted Intervention (TI) de-escalation criteria cannot be met for cancer performance.
- **Status Quo** – continuation of current non-recurrent investments (including the **£3.53m** on Radiology diagnostic capacity, circa **£1.35m** on additional Dermatology capacity but **excluding** additional non-recurrent actions during Q4 2025/26). Assuming temporary improvement to circa 70% by March 2026, performance is expected to plateau around 65–66% by Q2 2026/27. The backlog does not reduce; it grows to the low 400 range by end of Q2 2026/27.
- **Reasonable** – assumes total system spend of **£8.62m** across two CCGs, including the current £3.53m reflected in the ‘Status Quo’ option above to enable performance improvement to circa 74%. Further gains require histopathology and pathway transformation elements reflected in the Stretch scenario below. This is the recommended option.
- **Stretch Improvement** – as per ‘Reasonable’ delivery scenario plus additional radiology immediate recovery actions plus additional histopathology capacity (costs awaited). Assumes Urology reaching 54 -60% and Lower GI reaching 70–75% simultaneously – levels neither service has ever achieved. Included for consideration given the NHS Performance Framework target of 75%. Would necessitate an additional investment of £2.08m radiology recovery cost plus histopathology to delivery forecast performance of circa 78%.

Single Cancer Pathway

Forecast Trajectory 2026/27 - Do Nothing

Predicted Backlog & Performance 26/27



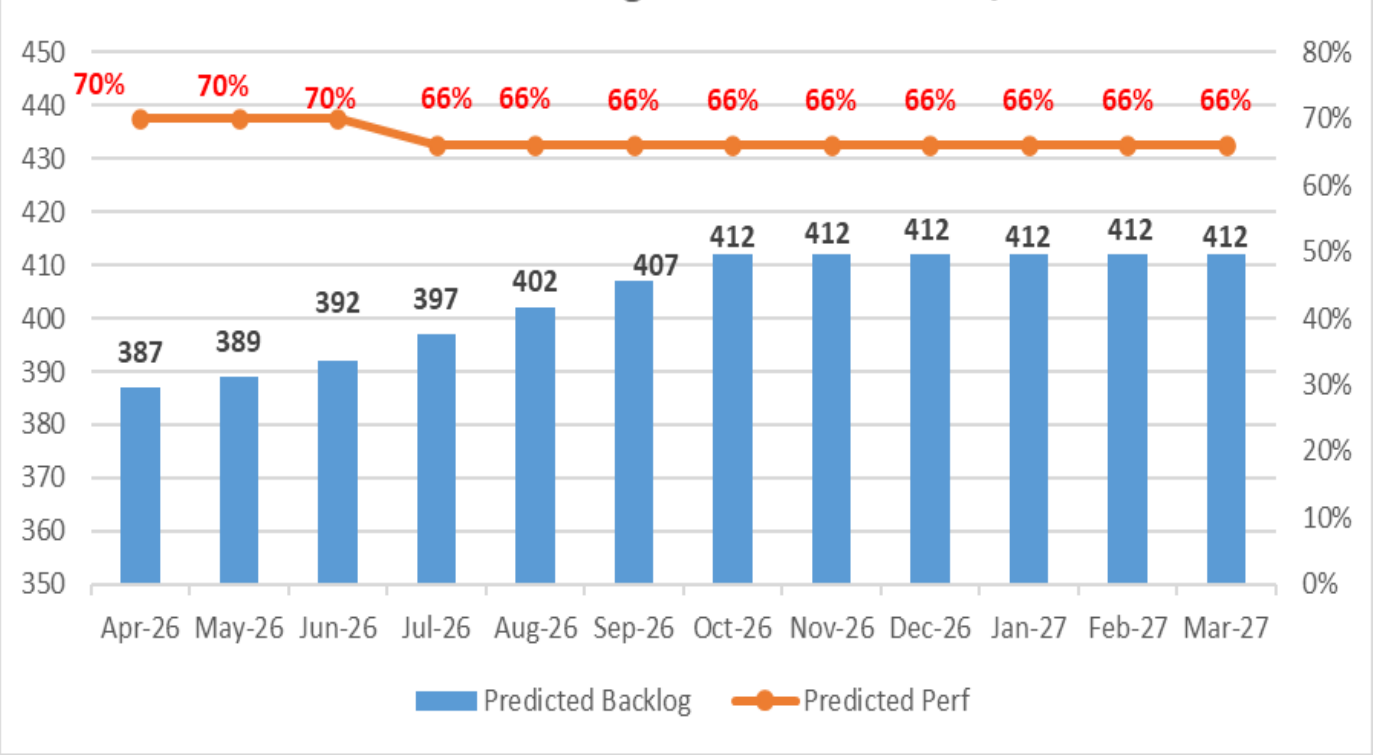
This trajectory assumes that all investment insourcing/outourcing and variable pay applied in 25/26 across all CCGs ceases (3.53/yr) and £1.35m of additional activity delivered within dermatology to meet the increased demand across (May – September 2026). To note, Histopathology is to be confirmed.

The combined impact would be growth in the 62-day backlog and a corresponding decrease in cancer performance to lowest point of 47% in August 26 which plateaus at 53% from October to March 2027 (assumes Dermatology performance decreases between May – September 2026 as additional activity to meet increased demand ceases)

Single Cancer Pathway

Forecast Trajectory 2026/27 - Status Quo

Predicted Backlog & Performance 26/27



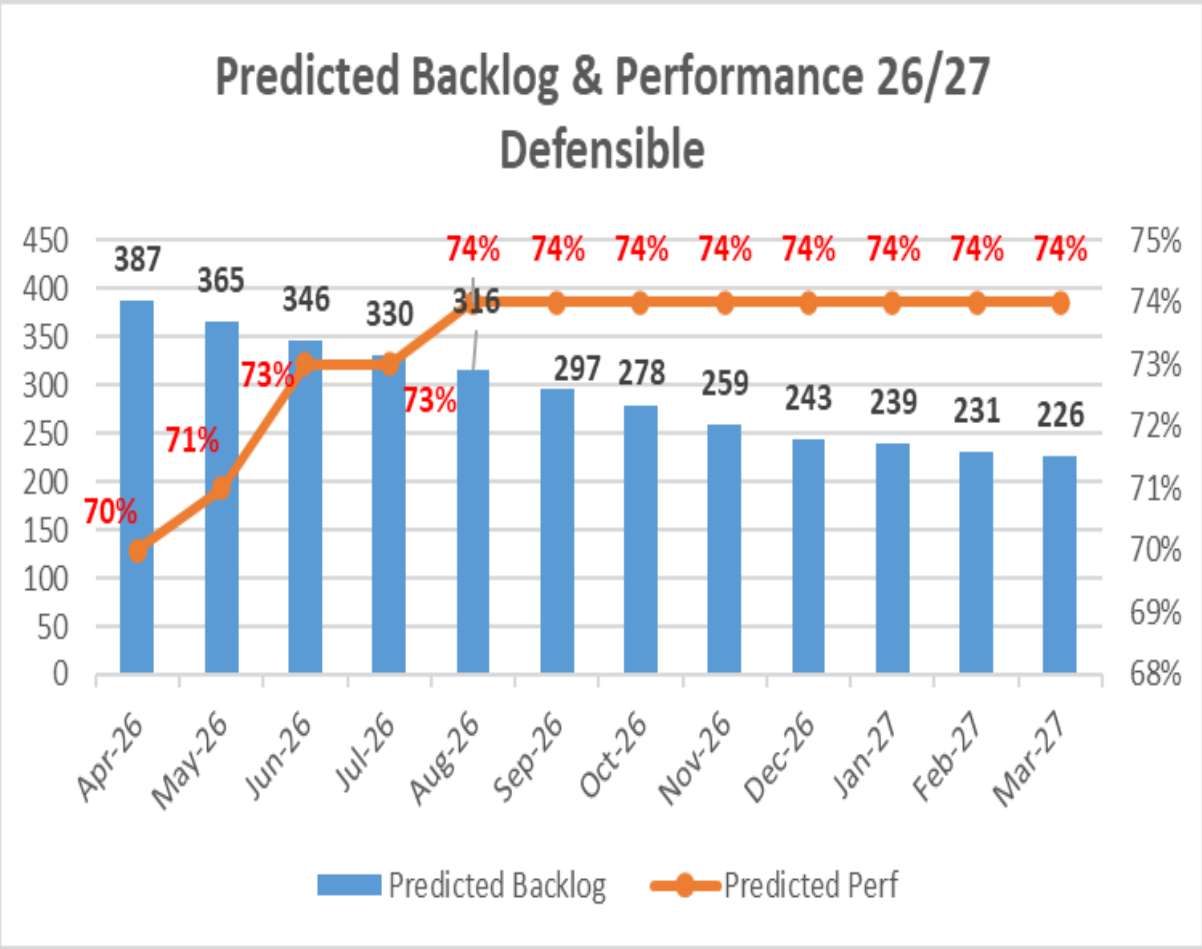
This trajectory assumes that all investment insourcing/outourcing and variable pay applied in 25/26 across all CCGs continues (3.53/yr) and £1.35m of additional activity delivered within dermatology to meet the increased demand across (May – September 2026). To note, Histopathology is to be confirmed.

Performance plateaus at 66% from July 2026 in the absence of any additional investments agreed.

It is critical that Dermatology performance is maintained above 90% which requires additional activity to be delivered May – September 2026 in times of increased demand.

Single Cancer Pathway

Forecast Trajectory 2026/27 – Reasonable Scenario

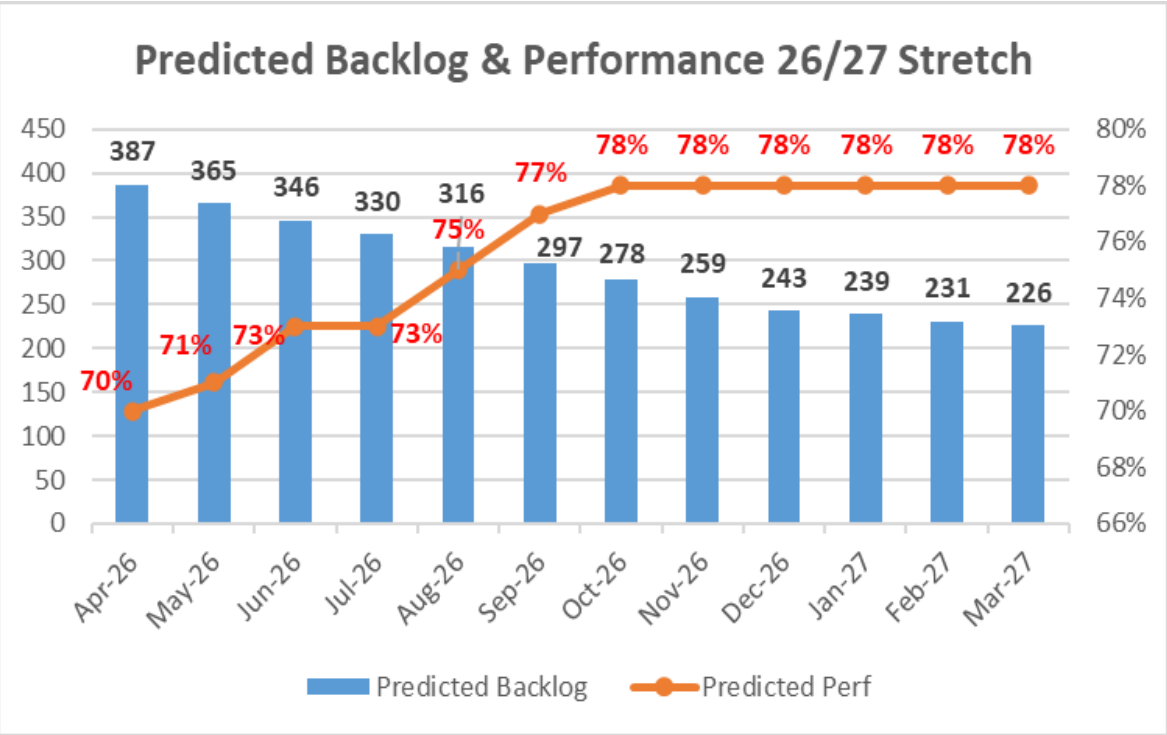


Delivering the Reasonable trajectory (74%) requires total system spend of £8.62m across two CCGs, of which £3.53m is already incurred during 2025/26.

This also requires Planned and Specialist Care (P&SC) CCG new investment of £2.18m plus £1.35m dermatology sustainability and the AHP&HS CCG diagnostic investment is £1.56m (cancer radiology). Histopathology is to be confirmed.

It is critical that Dermatology performance is maintained above 90% which requires additional activity to be delivered May – September 2026 in times of increased demand.

Single Cancer Pathway Forecast Trajectory 2026/27 – Stretch Improvement



The Stretch (78%) scenario adds a further £2.08m radiology recovery plus To note, Histopathology is to be confirmed.

The Stretch trajectory (78%) additionally assumes Urology reaches 54–60% (contributing approximately +14–17pp) and Lower GI reaches 70–75% (+5–6pp). Neither service has historically achieved these levels.

Single Cancer Pathway

Key Considerations:



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- Cancer performance improvement and radiology capacity improvement are interlinked. No plan that treats them separately is credible.
- The total system cost to deliver 74% is approximately £8.6m. Of this, £3.5m is already being spent for no sustainable improvement. The incremental decision is approximately £5.1m across two CCGs.
- Urology is the single highest-value intervention. It accounts for 60% of the improvement potential and consumes the most diagnostic resource.
- Maintenance of Dermatology performance is critical to overall outcome. Losing skin cancer performance costs approximately 2pp off the aggregate – roughly equivalent to the total combined gain from Lung, Gynaecology, Upper GI, Haematology, Head and Neck, and Breast improvements.
- Clarity regarding histopathology impacts and associated costs must be resolved before the Stretch trajectory can be confirmed
- The 'Status Quo' cost is £3.53m/yr (plus £1.35m) to effectively standstill. If this is reduced, then so too is the SCP Performance. This is not a zero-cost option.



Diagnostics

Diagnostics: Endoscopy (GI and Urology)



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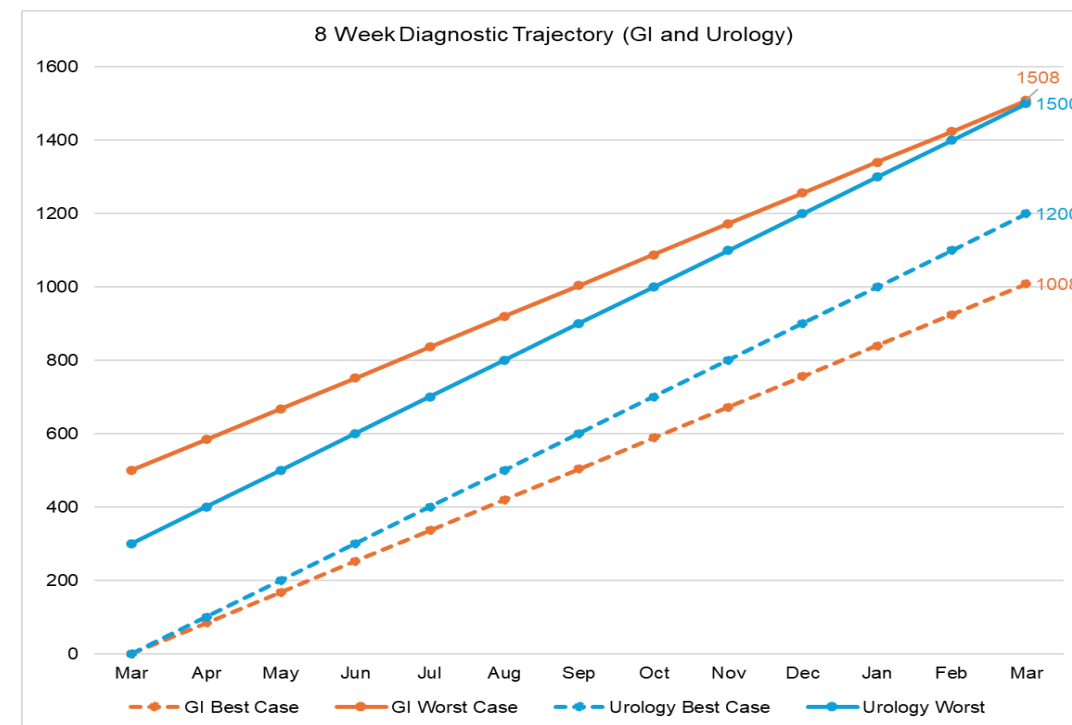
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Based on demand modelling projections for 2026/27:

- GI endoscopy demand is projected to grow by 5% in 2026/27, equating to an additional 21 patients per week (1,092 over the year). This equates to 3 additional endoscopy lists required per week, to maintain the 8-week diagnostic standard, surveillance compliance, and USC access. The D&C modelling for GI endoscopy is based on 7 patients per list (equating to 10-12 points as per endoscopy JAG guidelines) and also factors in ROTT (given all endoscopy referrals are vetted by a lead GI endoscopist to manage demand and appropriate prioritisation).
- Urology endoscopy demand is anticipated to equal 25 additional patients per week (1,300 over the year).

Using the demand growth projections summarised above, the GI and urology endoscopy modelling for 2026/27 is based on 2 scenarios (as reflected in the graph below):

- Scenario 1** (*best case scenario*) assumes both the GI and urology backlog (diagnostic conversions generated on the back of the WG Stage 1 outpatient initiative) is cleared by the end of March 2026.
- Scenario 2** (*worst case scenario*) assumes that the GI and urology backlog remains beyond March 2026 (worst case scenario patient figures have been included given the insourcing arrangement to accommodate these patients is still being mobilised) .



Diagnostics: Endoscopy (GI and Urology)

Proposed Recovery Solution



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Assuming the patient backlog is cleared in both specialties, to address the recurrent capacity gap projected across GI and urology in 2026/27 (to sustain delivery of the Urgent Suspected Cancer (USC), surveillance and 8-week diagnostic standard), plans to increase baseline capacity include:

Plan A - Stop delivering urology (flexible cystoscopy) sessions in GGH endoscopy (interdependency with the roll-out of the Galeas bladder service in urology) - to release capacity in endoscopy theatres to uplift GI endoscopy capacity by 3 lists per week.

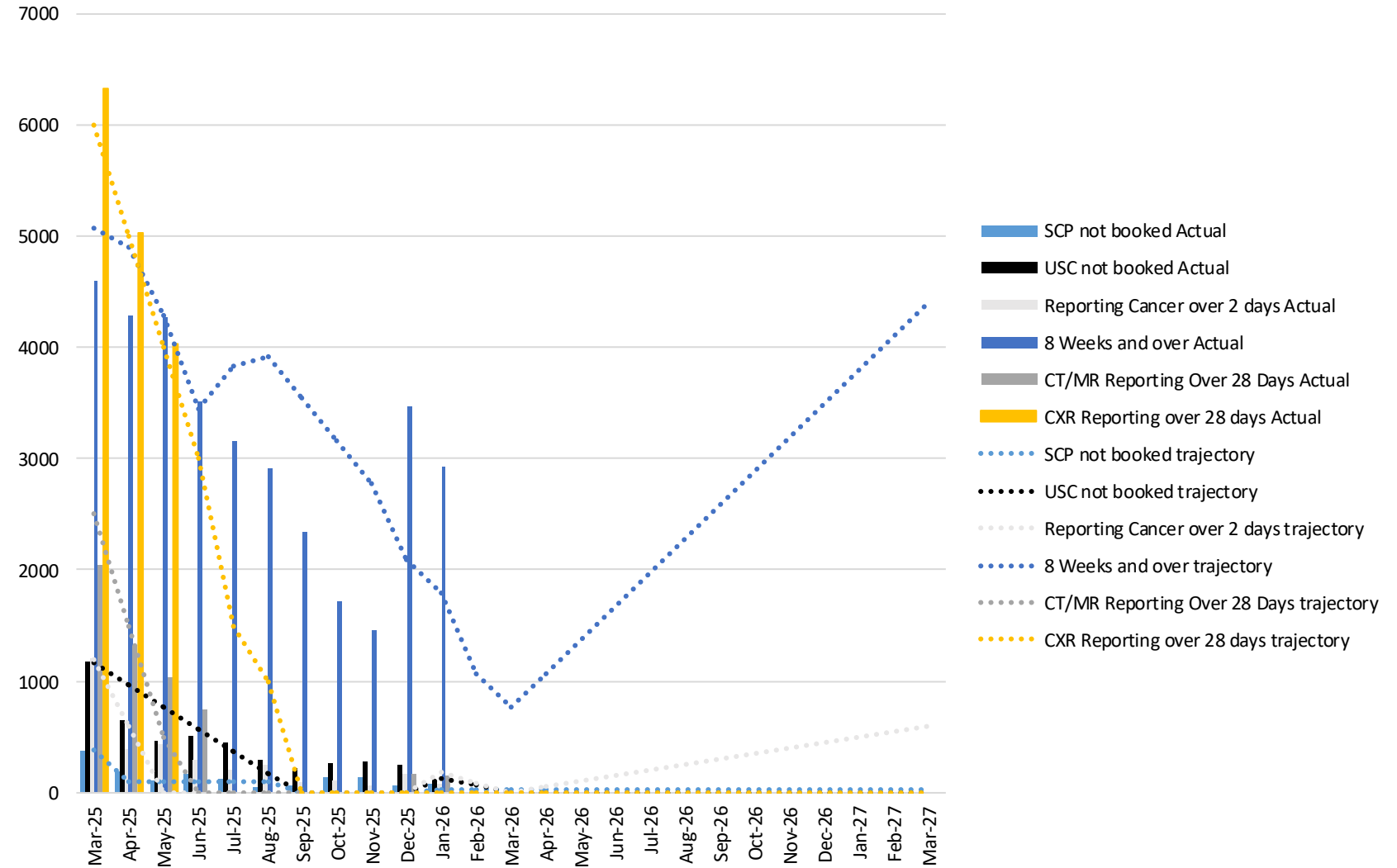
Plan A	Patient Volumes	Annual Cost
GI: Redeploy nursing staff currently utilised to deliver 3 urology endoscopy sessions in GGH - to support delivery of 3 new GI endoscopy sessions. Additional investment required to uplift the nursing/endoscopist establishment (by 6.58 WTE) in order to deliver GI sessions as opposed to urology sessions (staffing model is different)	21/week (1,092/yr)	£372k (already referenced in Single Cancer Pathway cost assumptions)
Urology: Roll-out of the Galeas bladder service (£283/patient)	25/week (1,300/yr)	£367,900k
Total:		£739,900k

Plan B - The alternative would be to increase endoscopy nursing establishment at GGH (by 3 sessions for GI and 4 sessions for Urology) to support the delivery of both GI and urology endoscopy demand growth, using weekend/evening theatre capacity (given Monday-Friday capacity is fully utilised). This would sustain delivery of USC, surveillance and the 8-week diagnostic standards.

Plan B	Patient Volumes	Annual Cost
Urology and GI - Expand endoscopy capacity to include evening and weekend activity - which involves increasing the nursing establishment at GGH (by 14.29WTE) to enable delivery of increased urology and GI endoscopy sessions.	21/week (1,092/yr)	£1,209m
	25/week (1,300/yr)	

The cost difference between Plan A and Plan B equates to £469,100k. Patient volumes delivered through both plans are equal (1,092/year for GI and 1,300/year for urology). Plan A is the preferred option.

- **Historical and forecast 5% increase in demand per annum**
- **8-week wait improved position by March 2026, supported by £3.4m recurrent stabilisation funding and £1.4m non-recurrent investment**
- **Without continuation of non-recurrent funding support, forecast increase in 8-week breaches during 2026/27 to circa 4,407 breaches by March 2027 and forecast deterioration in reporting cancer over 28 days**
- **MRI MSK pathway changes to meet national guidance will require potential movement of Radiology funding to Physiotherapy services (impact on trajectories being analysed)**





Therapies

2026/27 NHS Wales Performance Framework

- Maximum 14 week wait for Therapy referrals

CCG D&C Modelling for 2026/26 accounts for:

- Historical pattern of 14-week breaches in most of the therapy pathways post pandemic.
- During 2025/26, Therapy direct access (max 14-week wait) breaches have steadily deteriorated year to date rising from 2,216 breaches in March 2025 to 2,966 breaches in August 2025. Recent improvement noted during Q3 2025/26 with reduction of overall breaches to 2,719 in December 2025.
- The overall increasing trend in breach performance reflects significant increases in demand across the majority of therapy services pathways and limited scope to increase capacity within current agreed CCG financial limits
- Occupational Therapy (OT) has identified productivity opportunities in the Paediatric OT service (the majority of the OT breaches during 2025/26 sit with this team)
- Nutrition and Dietetics - significant increased referrals re selective eating. Previous recovery funded mitigation has not been successful due to increasing risk of harm to patients identified.
- Orthotics and Podiatry - new patient referrals have increased by circa 40% since 2019
- Physiotherapy - performance deterioration during 2025/26 driven by increasing referral demand across CMATS, Community and ICT, MSK and Paediatric teams since the COVID pandemic and has now increased above pre-pandemic levels.

Therapies

Direct Access (14 weeks) – Initial Assessment

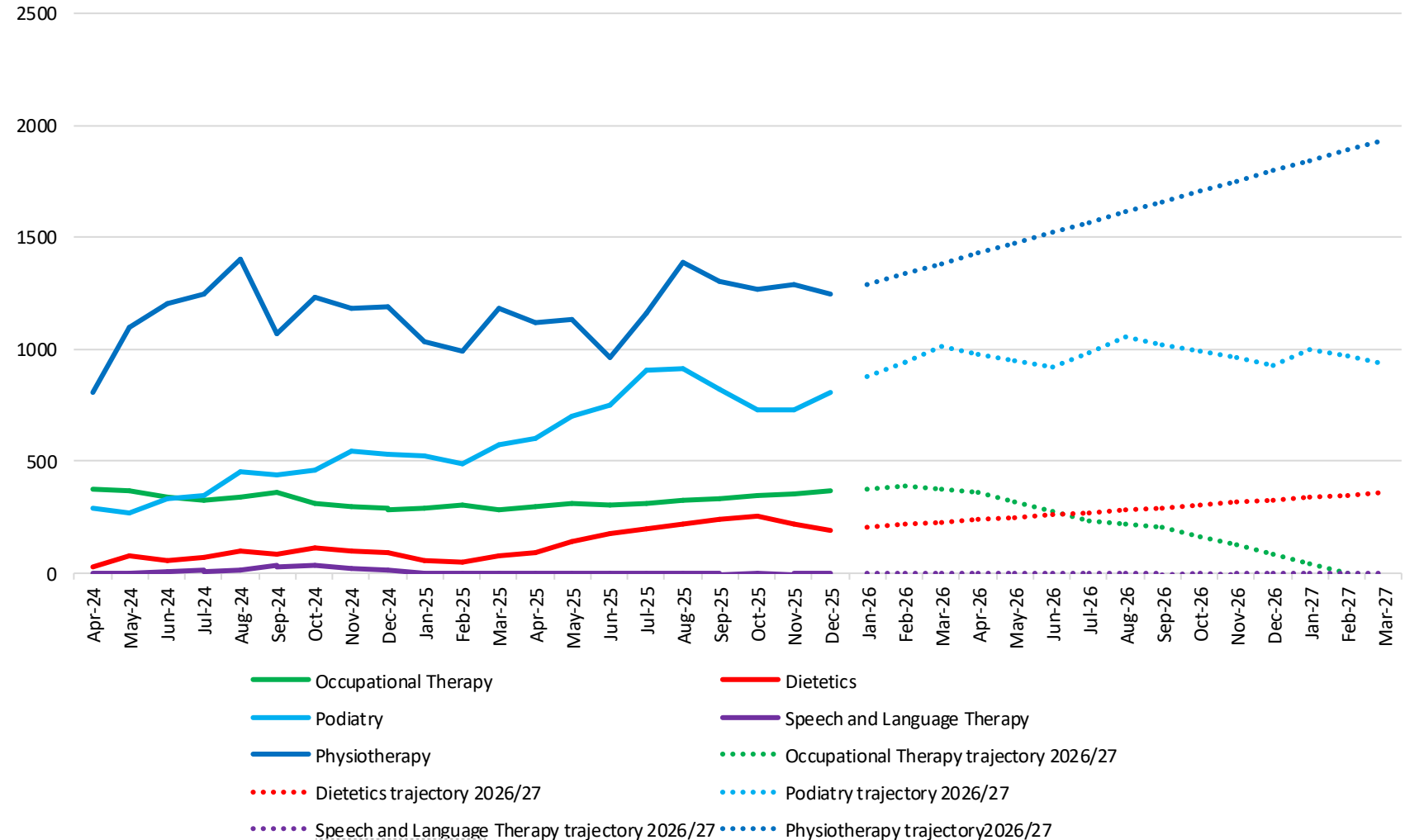


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- **SALT and Occupational Therapy forecast achievement of max 14-week wait**
- **Potential growth to circa 3,229 total breaches by March 2027 as below (without support for workforce expansion in each of the following):**
 - **Physiotherapy (1,934)**
 - **Podiatry (936)**
 - **Nutrition & Dietetics (359)**
- **Recovery to target performance by March 2027 will require 15 WTE with forecast additional £839k cost (see slide in supporting appendices)**

14 Week breaches trajectory 2026/27 - AH and HS CCG Therapies





Urgent and Emergency Care



- Modelling remains work in progress and the model currently addresses four critical urgent and emergency care (UEC) performance metrics monitored under the TI framework: ambulance handovers exceeding one hour, 12-hour emergency department waits, clinical assessment times, and pathway of care delays.
- Further work required re max 45 min ambulance handover requirement, % ambulance handovers < 15 mins, % patients who spend < 4hrs within ED
- Modelling utilises 4 separate statistical methods, combined and probability tested, taking account of historical and seasonal variations and trend analyses
- Key delivery assumptions include implementation of the UEC Business Case components of 7 Day Clinical Streaming (assumed implementation June 2026) and expanded SDEC model at WGH (assumed implementation July 2026)
- Key observations to date:
 - UEC Business Case is critical but not sufficient to enable achievement of all current TI de-escalation targets by March 2027
 - 68% probability of achieving the 1-hour TI ambulance handover target but low probability of achieving other metrics
- Additional site/system specific interventions required to improve performance forecasts

MARCH 2027 PROJECTIONS VS TI TARGETS

Metric	TI Target	Do-Nothing / Status Quo	Post Implementation of UEC Business Case	Confidence Level (Likelihood of achievement)	Assessment
Ambulance Handovers >1hr	680	620	590	68.3%	TARGET ACHIEVABLE (moderate-high confidence)
12hr ED Waits (%)	7.0%	9.96%	8.73%	20.4%	GAP REMAINS (low confidence)
Clinical Assessment (mins)	60	74.5	71.8	18.2%	GAP REMAINS (very low confidence)
PoCD Delays	174	206	199	7.6%	GAP REMAINS (very low confidence)

RESIDUAL GAPS REQUIRING ADDITIONAL INTERVENTION

Metric	Target	BC Projection	Residual Gap	Primary Driver	Required Action
12hr ED Waits	7.0%	8.7%	+1.7pp	WGH (17.2% baseline)	SDEC expansion + pathway redesign
Clinical Assessment	60 mins	71.8 mins	+11.8 mins	GGH (78.8 mins baseline)	ED triage redesign
PoCD Delays	174	199	+25	WGH (63.9 baseline)	D2A acceleration, social care

STRATEGIC CONCLUSIONS

- **DO-NOTHING IS NOT VIABLE** — Performance deteriorates on all metrics without intervention
- **BUSINESS CASE IS NECESSARY BUT NOT SUFFICIENT** — Material improvement but gaps remain
- **SITE-LEVEL TARGETING IS CRITICAL** — WGH for 12-hour waits/Pathways of Care Delays, GGH for Clinical Assessment
- **3-MONTH CHECKPOINT REQUIRED** — If actual trajectory tracks better than projections, **revise upward**

Demand and Capacity Planning 2026/27

Current illustrative Cost of Recovery



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- illustrative assessment of the likely additional financial cost of recovery / closure of forecast delivery gaps versus the respective NHS Wales Performance Framework metrics for 2026/27
- Confirmation of the forecast financial cost of recovery will be detailed in the draft Annual Plan for 2026/27 to be considered at the February 2026 Board Seminar
- Does not include MHLDD and other non-direct D&C delivery priorities / costs highlighted within CCG Plans

Metric	Element	Forecast Recovery Cost
Planned Care RTT	Stage 1 (26 week max wait)	£1.12m
	Total Pathway (104 week max wait)	£7.49m
Single Cancer Pathway	Reasonable Scenario	£8.62m
Diagnostics	Endoscopy (Urology Galeas Bladder)	£0.37m
	Radiology	£1.40m
Therapies	14 week recovery	£0.84m
UEC	Current costs assumed within HB 2026/27 financial plan	nil
Sub Total		£19.84m



Supporting Appendices

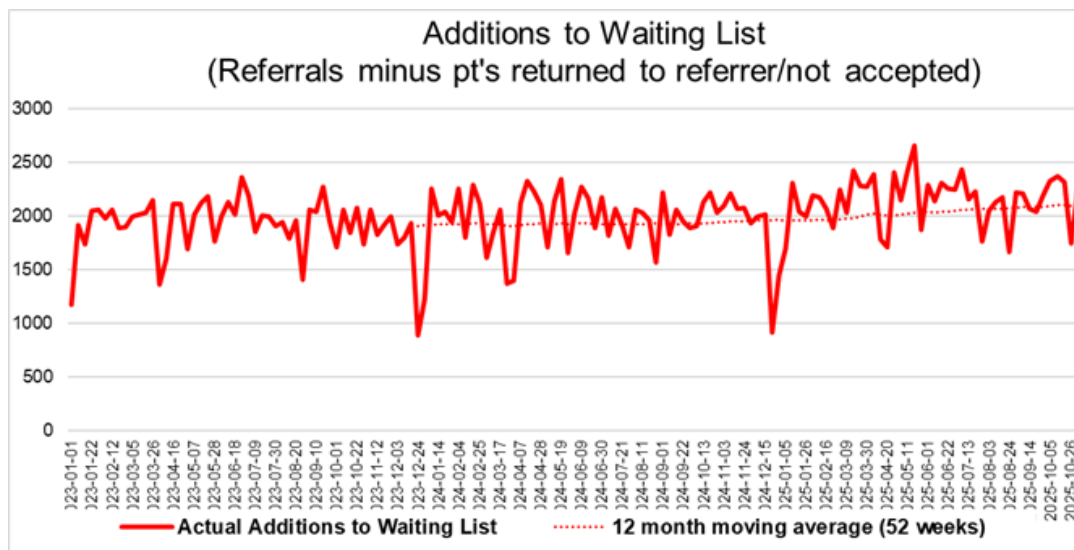
Planned Care Referral To Treatment Stage 1 Efficiency



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Attended									
Main specialty	Future Appointment	Future Appointment %	SOS/PIFU	SOS/PIFU %	Discharged	Discharged %	SOS/PIFU + Discharged	SOS/PIFU + Discharged %	Total Attendance
100 - General Surgery	1	5.00%	11	55.00%	8	40.00%	19	95.00%	20
101 - Urology	16	64.00%	1	4.00%	8	32.00%	9	36.00%	25
103 - Breast	18	22.22%	0	0.00%	63	77.78%	63	77.78%	81
104 - Colorectal	7	41.18%	2	11.76%	8	47.06%	10	58.82%	17
107 - Vascular	0	0.00%	0	0.00%	4	100.00%	4	100.00%	4
110 - Trauma & Orthopaedics	112	42.91%	89	34.10%	60	22.99%	149	57.09%	261
120 - ENT	63	38.65%	17	10.43%	83	50.92%	100	61.35%	163
130 - Ophthalmology	159	65.98%	7	2.90%	75	31.12%	82	34.02%	241
191 - Pain Management	12	54.55%	5	22.73%	5	22.73%	10	45.45%	22
300 - General Medicine	8	47.06%	0	0.00%	9	52.94%	9	52.94%	17
301 - Gastroenterology	23	47.92%	4	8.33%	21	43.75%	25	52.08%	48
302 - Endocrinology	9	81.82%	0	0.00%	2	18.18%	2	18.18%	11
303 - Clinical Haematology	20	86.96%	0	0.00%	3	13.04%	3	13.04%	23
307 - Diabetic Medicine	13	86.67%	0	0.00%	2	13.33%	2	13.33%	15
320 - Cardiology	12	52.17%	1	4.35%	10	43.48%	11	47.83%	23
328 - Stroke Medicine	2	16.67%	0	0.00%	10	83.33%	10	83.33%	12
330 - Dermatology	46	34.07%	10	7.41%	79	58.52%	89	65.93%	135
340 - Respiratory Medicine	14	42.42%	1	3.03%	18	54.55%	19	57.58%	33
361 - Nephrology	4	100.00%	0	0.00%	0	0.00%	0	0.00%	4
400 - Neurology	15	34.88%	4	9.30%	24	55.81%	28	65.12%	43
410 - Rheumatology	26	83.87%	2	6.45%	3	9.68%	5	16.13%	31
420 - Paediatrics	11	44.00%	3	12.00%	11	44.00%	14	56.00%	25
430 - Geriatric Medicine	10	76.92%	1	7.69%	2	15.38%	3	23.08%	13
502 - Gynaecology	47	33.33%	29	20.57%	65	46.10%	94	66.67%	141
Total	648	46.02%	187	13.28%	573	40.70%	760	53.98%	1,408



- 54% avoid future appointment
 - Discharged (40.7% / 760 pts)
 - SOS/PIFU (13.28% / 187 pts)
- Referral Management
 - 31% Referrals returned after vetting
- My Health Pathways
 - 271 published / 50k page views
- OPD Activity +12% vs pre-Covid
 - 6,742 (19/20 average)
 - compared to 7,848 up to September 2024 to 2025

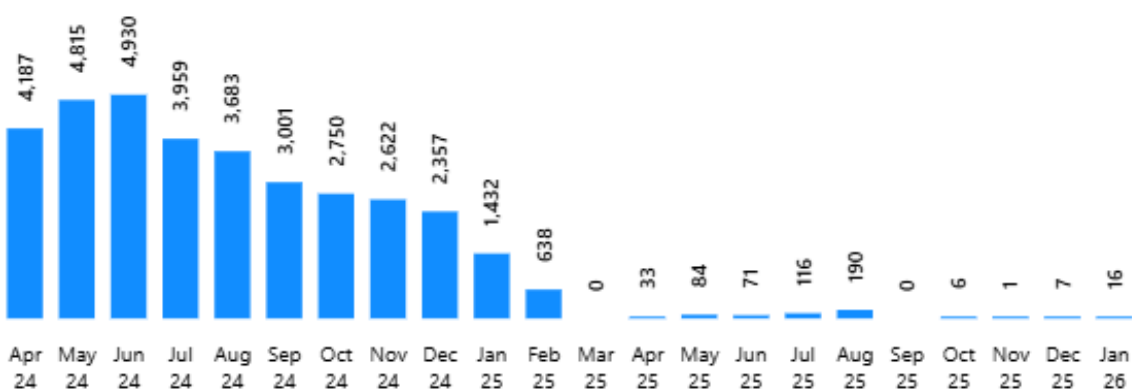
Planned Care (Referral to Treatment) Former Stage 1 52-week Maximum Wait

52-week Outpatient target will be held with the following budget realignments/continuations:

- **ENT** Consultant Locum (20k pa)
- **Rheumatology** Locum (130k pa)
- **Dermatology** continuing with S1 insourcing (214k pa)
- **Neurology** continuing with insourcing (£162k p/a)

Continuation of insourcing (~ 376k resourced from P&SC budget)

Patients waiting over 52 weeks



*16 breaches in January are non-planned care specialties
Care group anticipate no breaches by March 2027*

Of lists delivered during 2025/26:

- **ENT** Theatre utilisation 93%
- **Ophthalmology** Theatre utilisation 89.5% (*8 eyes a list including bi-laterals*)
- **Orthopaedic** theatre utilisation 84.9%. 2 additional surgeons working towards 4 joints a list (*24 joints included in 26/27 D&C plan*). 4 joints a list at BGH unachievable due to environment. Increasing all surgeons to 4 per list requires consultant Anaesthetic cover, regular theatre teams, early team brief (with anaesthetist) and improved turnaround times. Consultant ability (& speed) varies.
- **Urology** utilisation @ GGH >200% (*complex nephrectomy*) main theatre PPH 83% (*most activity*). If 85% utilisation implemented at PPH Main = 20 additional patients could be treated across the year.
- **Dermatology** utilisation 77.1%. If increased to 80% an extra 32 patients could be treated. DSU mandate number of patients booked. Calculation includes DSU follow sessions.

Cancelled Sessions

- If Theatre sessions were not cancelled in GGH there would be 825 fewer RTT projected breaches in 26/27
- ENT would have had minimal breaches if 337 patients were not cancelled

Planned Care Referral To Treatment Theatre Cancellations (2025)



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Month / Specialty	Ophthalmology	ENT	Gynaecology	Obstetrics	General Surgery	Pain Management	Urology	Cardiology	Trauma & Orthopaedics	Dermatology	Paediatric Plastic Surgery	Gastroenterology	Community Paediatric Service	Colorectal	Grand Total
2025															
Jan	44	34	31	6	19	5	1	1	1		1				143
Feb	43	23	25	4	4	21	9	5	7					1	142
Mar	24	54	15	4	4		17	7	3						128
Apr	45	27	7	3	14	4	10	5			4				119
May	23	23	20	11	15	4	2	1							99
Jun	46	34	23	30	8	7	3	1	2	1					155
Jul	27	19	15	19	8	6	1	3		10					108
Aug	26	23	17	20	11	6	4	7	1		1	1			117
Sep	44	35	22	22	15	12	3	2			3		1		159
Oct	34	26	21	19	9	10	2		1						122
Nov	20	14	9	14	3	6	1	2	3						72
Dec	26	25	13	25	2		3	6		1					101
Grand Total	402	337	218	177	112	81	56	40	18	12	9	1	1	1	1465

- Table includes all GGH cancellations in 2025 (N=825)
 - Ophthalmology = 402
 - ENT = 337
 - Urology = 56
 - Orthopaedics = 18
 - Dermatology = 12

Single Cancer Pathway (SCP) Delivery Scenarios – Forecast Cost Summary



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Cost Category	Status Quo (66%)	Defensible (74%)	Stretch (78%)	Validation Status
Already committed (AHP)	£3.53m	£3.53m	£3.53m	Confirmed
P&SC Tier 1 Essential	–	£2.18m	£2.18m	Costed
P&SC Dermatology sustainability	£1.35m	£1.35m	£1.35m	Funding source TBC
AHP Cancer Radiology (Option 1)	–	£1.56m	£1.56m	AHP CCG decision
AHP Radiology Recovery (one-off)	–	–	£2.08m	Costed (V7)
Histopathology	–	–	TBC	Cost TBC
TOTAL SYSTEM COST	£3.53m	£8.62m	£10.70m+	
of which: already being spent	£3.53m	£3.53m	£3.53m	

Single Cancer Pathway (SCP) Delivery Scenarios – Forecast Cost (Key Components)



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Component	Cost	CCG Owner	Type	New / Existing	What It Buys
ALREADY COMMITTED (cost of inaction)					
Variable pay (radiology)	£1.90m	AHP	Recurrent	Existing	Sustains current 65–66%. No improvement.
Outsourced reporting	£1.63m	AHP	Recurrent	Existing	28,840 reports/yr at 4.4x internal cost. No pathway gain.
P&SC CCG TIER 1 – ESSENTIAL (new investment)					
Cancer Trackers & CNS (24 WTE)	£963k	P&SC	Recurrent	NEW	SCP data accuracy, pathway coordination. Enables all other improvements.
Urology Cancer Diagnostics	£848k	P&SC	Recurrent	NEW	Addresses 40.9% of backlog. Urology 19.2%→40%+.
Endoscopy Plan A (6.58 WTE)	£372k	P&SC	Recurrent	NEW	Prevents 888 diagnostic breaches. Enables LGI + UGI pathways.
P&SC CCG – DERMATOLOGY SUSTAINABILITY					
Derm insourcing (£964k) + seasonal (£382k)	£1.35m	P&SC	Recurrent + seasonal	RE-BASE needed	Protects Skin at 93.9%. Without it, aggregate drops ~2pp. Currently partly funded through recovery.
AHP CCG – CANCER RADIOLOGY					
Cancer Radiology Option 1 (Agency)	£1.56m	AHP	Recurrent	NEW	Closes 96 scan/wk cancer gap. CT + MRI capacity. Enables 72–74%.
STRETCH ADDITIONS					
Radiology Immediate Recovery	£2.08m	AHP	One-off + bridge	NEW	CXR backlog clearance, SCP reporting TAT, NOUS recovery. Enables 74–76%.
Histopathology baseline + capacity	TBC	AHP/Path	Unknown	TBC	169 cancer requests/wk. Prerequisite for 78%. Currently unknown constraint.

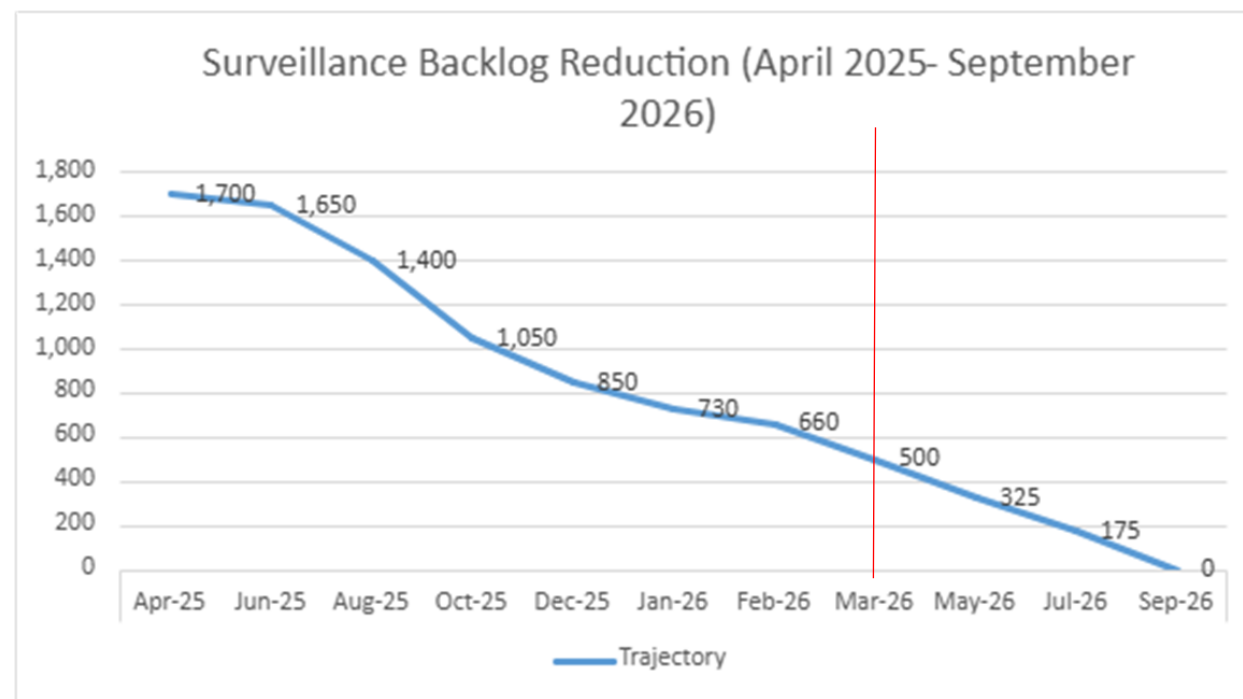
Diagnostics: Endoscopy (GI Surveillance)



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- The surveillance backlog for GI endoscopy is on trajectory to reduce to 500 patients by the end of March 2026 (as per plan submitted in 2025/26).
- £179k already allocated in 2026/27 to clear the remaining 500 patients, however this plan was based on the continued use of the planned additional activity rates being used via internal waiting list initiatives.
- Due to the cessation of the Planned Additional Activity Rate (PAAR) beyond end of March 2026 – the plan to accommodate the remaining 500 surveillance patients by September 2026 will need to be re-considered.
- A paper including an options appraisal is currently being drafted. In the event of potential reduced staff take up of internal WLI sessions, alternative solutions include mobilising an insourcing arrangement (in place of the waiting list initiatives proposed, using PAAR).
- A WLI (inc. PAAR) equates to £3,200k per list. An insourcing list equates to circa £5,600k per list.



Therapies - Summary Assessment of Potential Recovery Opportunities

Recovery of waiting times to the 14-week target level will not be achieved without significant levels of additional workforce support:

- Successful recruitment of temporary external workforce solutions in Nutrition & Dietetics and Orthotics and Podiatry is considered unlikely due to previous experience
- Conversely, there is moderate confidence in successful recruitment of temporary workforce solution Physiotherapy (both temporary and substantive solutions are provided as requested)

	Staff WTE	AfC	Cost Recurrent	Zero breach predicted
Nutrition and Dietetics	3.0	7	186k	Dec 2026
Orthotics and Podiatry	3.0	6	152k	Feb 2027
	1.0	7	62k	
Physiotherapy	5.0	6	253k	Jan 2027
	3.0	7	186k	
Total	15	-	839k	End of 2026/27

Table 1 - Summary additional workforce requirements highlighted by AH&HS CCG

- **Orthotics & Podiatry** recovery to **zero** breach performance is achievable in **February 2027** if successful substantive recruitment and start in post May 2026
- **Nutrition & Dietetics** recovery to **zero** breach performance can be achieved by **December 2026** in if successful substantive recruitment and start in post June 2026
- Recovery in **Physiotherapy** if successful phased recruitment of temporary or substantive workforce solutions **zero** breach position by **January 2027**

This basic D&C analysis will be refreshed through the full demand and capacity service review underway across these specialities and will provide a refined position once complete.

3.2 - SAVINGS IDENTIFICATION 2026/27 FOR OPERATIONAL TEAMS

***Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer), James
Severs (Hywel Dda
UHB - Executive
Director of Allied
Health Professions
and Health Science)***

| For assurance

Attachments

[Ops and CCG Savings Identification 2026-27 FPC 24 February 2026.pdf](#)



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Operational Team and Clinical Care Group Savings 2026/27

Finance and Performance Committee, 24 February 2026



- The Finance and Performance Committee is requested to note progress achieved to date in the identification of Operations function / Clinical Care Group (CCG) savings plans and proposals for 2026/27
- This paper summarises:
 - Progress to date across the Operations function
 - Headline summaries by CCG
 - Next Steps agreed with CCGs to further develop additional opportunities under consideration with supporting PIDs / QIAs
 - Supporting information re CCG proposed savings proposals and further Red / Blue / Black opportunities under consideration (as applicable to individual CCGs)

Operations / CCG Savings Identification 2026/27

Summary progress to end January 2026



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- Operations / CCG provisional 2026/27 savings target of £33,685m (includes carry forward 2025/26 recurrent savings gap and additional 2% requirement for 2026/27)
- Cash releasing savings proposals / plans identified to date total £7.91m in-year (24%) and £8.783m FYE (26%)
- Additional non-cash releasing opportunities identified to date total £2.52m in year / £4.21m FYE
- Finance teams working with CCGs to confirm continuation of 2025/26 non-recurrent savings into 2026/27 above proposals currently identified by CCG
- Each CCG has identified additional Red / Blue / Black proposals currently under consideration
- Agreed Next Steps:
 - 21 February 2026 - All CCGs (except Community and Integrated Medicine) to develop RAG rates PIDs and QIAs for additional opportunities under consideration and mitigations for unresolved cost pressures
 - 21 February 2026 - Community and Integrated Medicine to develop plans to address additional 2026/27 2% savings requirements
 - 5 March 2026 – Community and Integrated Medicine to develop RAG rates PIDs and QIAs for undelivered 2025/26 savings requirement and any unresolved cost pressures

FY26.27 Savings Identified to Date - Cash Releasing Only

Delegated Officer (£'000)	Provisional FY26.27 Target*	FY26.27 Saving Plans Identified to date								
		Blue	Red	Amber	Green	Total In Year	In Year Variance	In Year Recurrent	In Year Non-Recurrent	Total Full Year Effect
Chief Operating Officer	33,685	2,130	5,480	300	0	7,910	-25,775	6,318	1,592	8,783
Chief Operating Officer Management	1,103	0	0	0	0	0	-1,103	0	0	0
Community and Integrated Medicine	12,440	368	0	300	0	668	-11,772	368	300	491
Mental Health and Learning Disabilities	6,542	0	1,393	0	0	1,393	-5,150	100	1,292	100
Operational Allied Health and Health Sciences	4,884	160	568	0	0	728	-4,157	728	0	1,334
Planned and Specialist Care	8,409	1,602	3,520	0	0	5,121	-3,288	5,121	0	6,857
Primary Care	306	0	0	0	0	0	-306	0	0	0



- Allied Health Professions and Health Sciences (AHP&HS) CCG 2026/27 savings target of £4.87m (includes carry forward 2025/26 recurrent savings gap of £3.3m and additional £1.56m (2%) requirement for 2026/27)
- Cash releasing savings proposals / plans identified to date total £0.728mm in-year (15%) and £1.334m FYE (27%)
- In respect of mitigating actions to support a balanced position, non-cash releasing saving proposals / plans identified to date total £0.097m and £0.129m FYE
- 2026/27 critical cost pressures totalling £10.77m, identified mitigation schemes categorised by likelihood of delivery:
 - Highly probable £4.07m
 - Probable £4.11m
 - Unlikely £2.24m
 - Gap £0.35m



- Planned and Specialist Care (P&SC) CCG 2026/27 savings target of £8.4m (includes carry forward 2025/26 recurrent savings gap of £4.2m and additional £4.2m (2%) requirement for 2026/27)
- Cash releasing savings proposals / plans identified to date total £5.121m in-year (61%) and £6.857m FYE (82%)
- In respect of mitigating actions to support a balanced position, non-cash releasing saving proposals / plans identified to date total £0.123m and £0.184m FYE
- Potential 2026/27 Theatres cost pressure (subject to current review)
- Further Red / Blue / Black savings opportunities under consideration (detail to be confirmed)



- Community and Integrated Medicine (C&IM) CCG 2026/27 savings target of £12.440m (includes carry forward 2025/26 recurrent savings gap of £7.6m and additional £4.9m (2%) requirement for 2026/27)
- Cash releasing savings proposals / plans identified to date total £0.668m in-year (5%) and £0.491m FYE (4%). In-year split; amber £0.3m, blue schemes £0.368m.
- In respect of mitigating actions to support a balanced position, non-cash releasing saving proposals / plans identified to date total £2.300m and £3.900m FYE
- Carry forward cost pressure from 2025/26 of £4.3m (predominantly workforce pressure related)
- Further Black savings opportunities under consideration (value to be confirmed)



- Mental Health and Learning Disabilities (MHLD) CCG 2026/27 savings target of £6.54m (includes carry forward 2025/26 recurrent savings gap of £4.5m and additional £2.0m (2%) requirement for 2026/27)
- Cash releasing red savings proposals / plans identified to date total £1.393m in-year and FYE (21%) and £0.100m FYE (2%)
- CCG currently assessing mitigating actions to support a balanced position, i.e. non-cash releasing saving proposals / plans under review
- Further Red / Blue / Black savings opportunities under consideration (value to be confirmed)



- Primary Care CCG 2026/27 savings target of £0.306m (includes carry forward 2025/26 recurrent savings gap of £0.82m and additional £0.224m (2%) requirement for 2026/27)
- Cash releasing savings proposals / plans awaiting confirmation as at end January 2026
- Potential cash releasing opportunities within Dental budget (£0.253m) under review – would equate to 83% of in-year target.
- Further Red / Blue / Black savings opportunities under consideration (value to be confirmed)



Supporting information regarding CCG proposed savings proposals and further Red / Blue / Black opportunities under consideration (as applicable to individual CCGs)

Allied Health and Health Sciences CCG

Savings and Opportunities Summary

Savings Summary £'m	Year 1 2026/27			Year 2 2027/28			Year 3 2028/29			Total Three-Year		
	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total
C/Fwd recurrent savings gap/(surplus)	3.326			3.423		3.423	4.983		4.983			
Additional 2% savings requirement	1.560			1.560		1.560	1.560		1.560			
Total Savings Target	4,886			4.983		4.983	6.543		6.753			
In-Year Green and Amber												
In-Year Red and Blue	0.824											
In-Year Delivery	0.824											
Full Year Effect Green and Amber												
Full Year Effect Red and Blue	1.463											
Full Year Effect Delivery	1.463											
Gap/(Surplus) C/Fwd to Next Year	3.423			4.983		4.983	6.543		6.543			

Allied Health and Health Sciences CCG Opportunities: Red and Blue Schemes



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Scheme Name	Rec / Non-Rec	Red / Blue	Start Date	In-Year £'m	FYE £'m	Scope of opportunity and complexity detail
In house preparation to manufacture 75% Azacitidine doses & Biosimilar switches	Rec	Red	July	0.278	0.371	Low complexity, reliant on pharmacy staffing appointment
Overseas recruitment and impact on agency consultant costs	Rec	Red	Sept	0.440	0.880	
Radiology out of hours	Rec	Blue	Sept	0.106	0.212	
Total				0.824	1.463	

Allied Health and Health Sciences CCG

Break Even 2026/27



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AHP&HS CCG opening position:

- Cost pressure £10.77m

Mitigation schemes (categorised by likelihood of delivery):

- Highly probable £4.07m
- Probable £4.11m
- Unlikely £2.24m
- Gap £0.35m

Area	Cost Pressures	2026/27	Likelihood
Radiology	Radiology-Agency - AHP	£692,407	Highly Probable
Radiology	Radiology-Variable Pay - AHP	£636,519	Highly Probable
Radiology	Radiology-Variable Pay - Medical	£553,237	Highly Probable
Radiology	Radiopharmacy SLA (Escalated Jan 26)	£210,000	Highly Probable
Radiology			
Radiology			
Podiatry	Podiatry-Variable Pay	£7,492	Highly Probable
Podiatry	Podiatry-VBHC Funding for B7 post - provided non recurrently in 25/26	£69,960	Highly Probable
Podiatry	Podiatry-Podiatry Consumables	£197,795	Highly Probable
Physio	Physio-Agency	£235,214	Highly Probable
Physio	Physio-Variable Pay	£90,445	Highly Probable
Physio	Physio-On-call	£81,120	Highly Probable
Physio	Physio - Cluster posts no longer supported by Primary Care	£600,000	Highly Probable
Physio	Physio-Rheidol service charges	£20,000	Highly Probable
Physio			
Physio			
Pathology	Pathology-Agency - HS	£272,588	Highly Probable
Pathology	Pathology-Agency - Medical	£832,897	Highly Probable
Pathology	Pathology-Variable Pay - HS	£1,638,668	Highly Probable
Pathology	Pathology-Variable Pay - Medical	£415,554	Highly Probable
Pathology	VBHC - Heart Failure Decommissioning. Staff will be a pressure as recruited permanently and the service will have to be absorbed or stop	£150,000	Highly Probable
Pathology			
Pathology			
Occupational Therapy	Occupational Therapy-Agency	£31,816	Highly Probable
Occupational Therapy	Occupational Therapy-Variable Pay	£13,805	Highly Probable
Occupational Therapy	Prehab and Optimisation Prog - 3P's - Funding to cease and staff will be a pressure as recruited permanently and service will need to be absorbed or stop	£200,000	Highly Probable
Occupational Therapy	Occupational Therapy-SLA's for Neuro support and cellulitis	£77,215	Highly Probable
Occupational Therapy			
Occupational Therapy			
Dietetics	Dietetics-Agency	£61,518	Highly Probable
Dietetics	Dietetics-Variable Pay	£80,260	Probable
Dietetics	Dietetics Vacancy lag (Band 5 overrecruitment)	£109,446	Highly Probable
Other			
Other	Medical locum (Radiology and Pathology)	£1,000,000	Highly Probable
Other	RIF	£2,500,000	Highly Probable

	Page 142	£10,777,956	
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Allied Health and Health Sciences CCG Planning Cycle Critical [risk 25] Priorities



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Investment Description (£'m)	Recurrent	Non-Recurrent	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	CSG and Justifications
Radiology Ultrasound and Everlight (as per SBAR investment Apr 25)	£1.710m	£0.600m	£2.310m	£2.700m	0	Risk (797) to the ability to deliver ultrasound services across all Sites and impact on patient care and urgent cancer diagnosis. Continuation of the SBAR recommendations to maintain a resilient and sustainable workforce.
Dietetics Paediatric Service	£0.225m		£0.225m	0	0	Risk (1603) of delayed response and breach of waiting time targets due to increased referrals for children with selective eating disorders over and above funded baseline
Dietetics Adult Service	£0.500m		£0.500m	0	0	Risk (2169) of reduced quality, effectiveness of services for those with complex obesity with associated delay in subsequent treatment pathways.
Podiatry Consumables	£0.200m		£0.200m	0	0	Risk (2041) of harm to service users of Podiatry & Surgical Appliances due to inability to see new patients in a timely way.
Total	£2.635m	£0.600m	£3.235m	£2.700m	0	

Planned and Specialist Care CCG Savings and Opportunities Summary

Savings Summary £'m	Year 1 2026/27			Year 2 2027/28			Year 3 2028/29			Total Three-Year		
	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total
C/Fwd recurrent savings gap/(surplus)	4.2		4.2	1.4		1.4	5.6		5.6			
Additional 2% savings requirement	4.2		4.2	4.2		4.2	4.2		4.2			
Total Savings Target	8.4		8.4	5.6		5.6	9.8		9.8			
In-Year Green and Amber												
In-Year Red and Blue	5.2		5.2									
In-Year Delivery	5.2		5.2									
Full Year Effect Green and Amber												
Full Year Effect Red and Blue	7.0		7.0									
Full Year Effect Delivery	7.0		7.0									
Gap/(Surplus) C/Fwd to Next Year	1.4		1.4	5.6		5.6	9.8		9.8			

Planned and Specialist Care CCG Opportunities: Red and Blue Schemes

Scheme Name	Rec / Non-Rec	Red / Blue	Start Date	In-Year £'m	FYE £'m	Scope of opportunity and complexity detail
Drug – opportunities with new Biosimilar drugs identified - Recurrent	Rec	Red	April	2.021	2.658	Medium complexity. Requirement for potential pharmacy investment (some resource already accounted for with a net position outlined in the figures of potential saving opportunity). Companies to provide training, patient information leaflet, consent
OOH Nursing rota in WGH & PPH within Endoscopy	Rec	Red	April	0.192	0.192	Low complexity. Work on going, currently mitigating other cost pressures in 2025/26
Medical / Nursing – variable pay linked to AdHoc / WLI / vacancies	Rec	Red	April	3.031	4.191	A mixture of cash releasing and run rate spend reduction as initial opportunities. £0.7m in year and full year effect of £1.4m highly complex reliant on employment engagement discussions around work patterns and job requirements
Total						

Community and Integrated Medicine CCG

Savings and Opportunities Summary

Savings Summary £'m	Year 1 2026/27			Year 2 2027/28			Year 3 2028/29			Total Three-Year		
	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total	Rec	NR	Total
C/Fwd recurrent savings gap/(surplus)	7.6	0.0	7.6	8.6	0.7	9.3	13.2	0.7	13.9			
Additional 2% savings requirement	4.9	0.0	4.9	4.9	0.0	4.9	4.9	0.0	4.9			
Total Savings Target	12.5	0.0	12.5	13.5	0.7	14.2	18.1	0.7	18.8			
In-Year Green and Amber	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0			
In-Year Red and Blue	2.3	0.5	2.8	1.0	0.0	1.0	2.8	0.0	2.8			
In-Year Delivery	2.3	0.7	3.0	1.0	0.0	1.0	2.8	0.0	2.8			
Full Year Effect Green and Amber	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0			
Full Year Effect Red and Blue	3.9	0.5	4.4	1.0	0.0	1.0	2.8	0.0	2.8			
Full Year Effect Delivery	3.9	0.7	4.6	1.0	0.0	1.0	2.8	0.0	2.8			
Gap/(Surplus) C/Fwd to Next Year	8.6	0.7	9.3	12.5	0.7	13.2	15.3	0.7	16.0			

Community and Integrated Medicine CCG

Savings: Green and Amber Schemes

Scheme Name	Rec / Non-Rec	Green / Amber	Start Date	In-Year £'m	FYE £'m	Scheme description
Delay of PPH MIU Model	Non-Rec	Amber	01/04/26	0.2	0.2	Delay of implementation of new MIU/SDEC model in PPH
Delay of BBC recruitment	Non-Rec	Amber	01/04/26	0.1	0.1	Delay of therapy recruitment into BCC
Total		0.2				

Community and Integrated Medicine CCG Opportunities: Red and Blue Schemes

Scheme Name	Rec / Non-Rec	Red / Blue	Start Date	In-Year £'m	FYE £'m	Scope of opportunity and complexity detail
UEC Streaming Hub	Rec	Red	01/07/26	1.1	1.5	7 day clinical streaming
UEC WGH SDEC	Rec	Red	01/10/26	1.2	2.4	7 day SDEC in WGH
Total						

Community and Integrated Medicine CCG Opportunities: Medicines Management

Scheme Name	Rec / Non-Rec	Red / Blue	Start Date	FYE £'m	Scope of opportunity and complexity detail
Omalizumab - switch	Rec	Blue	N/A	0.03	Switch in
IDB - Gastroenterology	Rec	Blue	N/A	0.13	Invest to save in IBD team going through V&S
Ferric Carboxymaltose	Rec	Black	N/A	0.02	Loss of Exclusivity
Denosumab	Rec	Black	N/A	0.03	Loss of Exclusivity
Nintedanib - Respiratory	Rec	Black	N/A	0.34	Loss of Exclusivity
Total				0.52	

Community and Integrated Medicine CCG Opportunities: Black Schemes



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Scheme Name	CSG	Rec	Saving Type	BRAG	FYE £m	Scope of opportunity
Rehabilitation Pathways	Carms	Rec	Cash Releasing	Opportunity		Reviewing the operating model of community hospitals
Interim Care Beds	Carms	Rec	Cash Releasing	Opportunity		Investigating the Ceredigion model to bring into Carmarthenshire
Medical model review	All	Rec	Cash Releasing	Opportunity		Speciality Service Review (Fragility matrix & Safe Care Pathways)
Optimise utilisation of Community Estate	Pembs	Rec	Cash Releasing	Opportunity		Closing local sites to relocate to WGH
Orthogeriatrics	All	Rec	Cash Releasing	Opportunity		Prevention and reduction of LoS
CHC review	All	Rec	Cash Releasing	Opportunity		Use of core services instead of providers
Equipment Store efficiency	All	Rec	Cash Releasing	Opportunity		Review of equipment stores - stock and efficiency on flow
Switch from IV to oral anitbiotics	All	Rec	Cash Releasing	Opportunity		VBHC project - Switch from IV to oral anitbiotics
Use of Ward 6 PPH	All	Non-rec	Cash Releasing	Opportunity		Use of Ward 6 PPH by Planned care
Total						

Community and Integrated Medicine

2025/26 – 2026/27 Carry Forward Cost Pressures

Key Driver Description (£'m)	Carms	Cered	Pembs	UEC	CCG Total	Explanations
Service Capacity	0.0	0.0	0.0	0.0	0.0	
Clinical Activity	0.0	0.0	0.0	0.0	0.0	
Workforce - Vacancies	(1.1)	(0.8)	(1.6)	(0.6)	(4.1)	84 WTE vacancies across the CCG (<i>mainly A&C 38, Nursing 21, ACS 17, Add Prof 5</i>)
Workforce - Over Establishment	0.6	0.1	0.5	0.0	1.2	Loss of VBHC and Neighbourhood Nursing funding (20 WTE)
Workforce - Variable & Premium Pay	1.0	1.5	1.7	0.0	4.2	Medical rota gaps requiring agency and locum and agency nurses. Currently have 24.3WTE Agency Docs and 57WTE Nurses, month 4 was the CCG lowest nurse agency usage at 47WTE
Continuing Healthcare	0.1	(0.3)	0.7	0.0	0.5	
Drugs & Prescribing	0.0	0.0	0.0	0.0	0.0	
Non-Pay Contracts & Consumables	1.3	1.1	0.2	0.0	2.5	Clinical Supplies & Services, Premises and Equipment Stores
Income Over / Under Achievement	(0.1)	(0.1)	0.1	(0.0)	(0.2)	
Total	1.7	1.4	1.6	(0.6)	4.3	

Mental Health and Learning Disabilities

Further Opportunities Under Consideration



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Opportunity	Value	RAG Status
Review provision of LD Residential Service Begelly & Greville Court	TBC	TBC
Adult & Childrens ND review and remodelling	TBC	TBC
Review of A&E Liaison Service –Removal of non-medical overnight in A&E ,centralised hwb model,	TBC	TBC
Review of third sector Commissioning services , consider performance and duplication of provision with GP clusters and LA's	TBC	TBC
Reduction in Primary Care Services (Adults and CAMHS) Review primary care liaison, IPTS – shift to One At A Time Approach.	TBC	TBC
Mainstream SIF funded services eg Perinatal, Early Intervention in Psychosis, Eating Disorder	TBC	TBC
Enlli Ward closure	TBC	TBC
Reduction in private OOA bed use through increase in local beds by 1 (Bryngofal) and 1 (St Caradog).	TBC	TBC
Removal of Medical Agency contracts.	TBC	TBC
CHC Efficiency- Repatriation of patients back to LSU beds.	TBC	TBC
Support to review current text messaging service – feel there could be cheaper options	TBC	TBC
Redesign of CMHT model and workforce, Revised pathway – extended use of 111 option 2.	TBC	TBC
Options for income generation – LSU beds	TBC	TBC

Primary Care CCG

Further Opportunities Under Consideration



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Opportunity	Value	RAG Status
Potential for Meddygfa'r Sarn to be returned to independent contractor which would reduce overspend on MP budget	TBC	TBC
Re-adjustment of Managed Practice budgets to align them to practices of similar weighted list size; where there are over allocations there will need to be a spending reduction plan agreed over the next 12 months	TBC	TBC
Potential to re-tender service provision at Ash Grove Surgery (subject to review)	TBC	TBC
Consideration of staff travel expenses with a view to moving to reducing to essential travel only and moving to more online meetings	TBC	TBC
Potential as part of OCP to move to three locality leads from seven and giving up B7 PCSM vacancy and replacing with B5 contracts manager	TBC	TBC
Increase in salaried clinicians in managed practices and Out of Hours reducing locum expenditure (workforce planning ongoing across both at present)	TBC	TBC

4 - FINANCE

4.1 - FINANCIAL PERFORMANCE ASSURANCE REPORT

*Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance), Jennifer
Thomas (Hywel Dda
UHB - Head of
Corporate Reporting
and Planning)*

| For assurance

Attachments

[Financial Performance Assurance Report M10 2025-26 FPC 24 February 2026.pdf](#)

[Appendix 1 Month 10 2025026 Financial Performance Assurance Report.pdf](#)

[Appendix 2 2025-26 Strategic Cash Welsh Government Response Letter.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Performance Assurance Report – Month 10 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 deficit of £1.3m, which is an improvement against the £2.5m in-month deficit plan due to a core operational underspend of £(1.4)m.
- The savings target of £3.9m has been under identified by £0.2m; the £3.7m savings identified have been fully delivered in-month.
- The financial run rate is on track to achieve the forecast position of £22.1m with no mitigating actions included in the forecast.
- 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	25.0	30.0
Unidentified / (Identified) savings gap / (improvement)	0.2	(5.2)	(3.9)
Under / (Over) delivery of savings schemes	0.0	0.3	0.3
Core operational variation	(1.4)	(4.0)	(4.3)
Gross Forecast	1.3	16.1	22.1
Future Mitigating Actions	0.0	0.0	0.0
Reported Position	1.3	16.1	22.1

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 which need to be mitigated, the key themes being:

- **Shift Supply and Demand** – Demand-led pressures and absence pressures have led to an increasing number of shifts being requested but market supply has not fulfilled the demand. Medical and Nursing agency demand led increases in WGH, BGH and GGH and Pathology. Further increases are anticipated with surge beds having opened in January 2026 and approved recruitment plans in BGH Emergency Department. This is a risk to the start of the new financial year.
- **Medical Pay** – there is continued use of additional medical cover in the form of premium pay across several sites, in particular BGH, Planned Care and Mental Health. An urgent update is required for timelines on Medical Stabilisation Programme.
- **Nurse Agency usage** – a 11% increase has occurred between July and January, with no improvement yet made from the latest cohort of newly qualified nurses. Roster compliance remains varied.

- **Sickness absence** is a steady increasing trend, impacting on clinical variable and agency pay increases. This is being reviewed as part of the People, Organisation Development and Culture Committee.

Escalation Response

For a continued period, there have been several Clinical Care Groups in Level 3 escalation for Finance, as well as other domains. The Level 4 escalation level has yet to be used as it is pending finalisation with the Executive Team. This highlights a key risk where appropriate responses to the escalation framework have not materialised in a sufficient time period, and that continued escalation highlights ineffective actions.

Recurrent Savings Delivery and Impact on Underlying Deficit

- The underlying deficit as part of the financial planning cycle is £58.5m, which assumes £19.0m of recurrent savings delivery. As at Month 10, the full year recurrent savings gap has reduced to £0.6m, along with recurrent funding for Real Living Wage £(2.3)m and Bank £(0.4)m being confirmed in the WG allocation letter for 2026-27 funding, offset by offset by the recognition of the National Insurance shortfall in funding of £2.0m being a recurrent pressure following the recent pay matrix exercise, resulting in an underlying deficit of £58.4m.
- 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 misbalance across service areas with Executive functions over delivering by £11.0m and CCG's under delivering by £7.1m.
- As planning discussions are underway for the 2026-29 planning cycle, it is recognised that the organisation must change the savings approach, the Health Board has already delivered **£28.8m** of non-recurrent savings to Month 10 primarily through underspend conversions. To ensure a clearer and more transparent financial approach for 2026/27, the Executive Team has agreed to the removal of non-recurrent savings from budgets, or the conversion of these into recurrent schemes where appropriate. Quantification of these values will be shared once all responses are received.

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.

Capital

- There is a 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. Due to the significant amount of expenditure forecast for the 2 remaining months of the year, there is a risk to overall delivery of the Capital Resource Limit, in addition to risk of underspends against All Wales funded schemes including, Carmarthen Hwb £0.2m, Aseptic Unit £0.15m and

Gamma Camera Upgrade £0.2m. Close monitoring of these risks will be necessary with reallocation of funds where required.

- Close monitoring of these risks will be necessary with reallocation of funds where required.
- Reactive savings planning and underspend conversion – Further to the initial amber savings scheme created in Month 5 of £6.0m, £1.0m of green assumed savings remain as a balance covering Month 11 and Month 12. The underspend conversion rate in-month is £0.9m.

Assure (to note)

There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Cash

- Confirmation has been received by Welsh Government that the strategic cash request of £22.1m has been approved, refer to **Appendix 2**, confirmation letter received from the Director of Finance, Health, Social Care, and Early Years Group, and therefore eliminates the risk around insufficient cash to enable payment of creditors at the end of the year.

In-Year Savings Delivery Achievement

- Of the annual savings target of £46.4m, £50.3m has been identified on an in-year basis resulting in a £(3.9)m over-identification, however £50.0m are forecast to deliver, leaving a £(3.6)m savings delivery over-achievement.
- Run rate management of year-to-date savings of £1.0m are now in the savings forecast to deliver in future months.

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. This is due to be implemented on the 1 April 2026.

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.

Although there has been positive action evidenced towards achieving a 30% reduction in on-contract agency expenditure, Month 9 saw an increase in on-contract agency spend due to pressures within the sites. However, off-contract use is 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.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **RECOGNISE** that the Health Board's forecast deficit has remained as £22.1m with no further mitigating actions required, assuming all expected actions deliver in full.
- **SCRUTINISE** the top priority alerts for urgent remedial action plans, especially given the risks these could cause to the start of the new financial year.
- **ACKNOWLEDGE** that the in-year savings delivery target has been over-achieved, supported significantly by non-recurrent actions.

- **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** that the strategic cash request of £22.1m has been approved by Welsh Government and the in-year risk will be reduced to reflect this.

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 MHLDD – 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



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2025/26 Financial Performance Report

Finance and Performance Committee

Month 10 January 2025/26

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

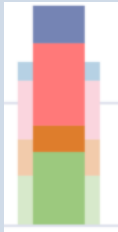
Key

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



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Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 3

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 remains at £22.1m in line with the revised Target Control Total, with prior mitigating actions of £2.4m now identified.

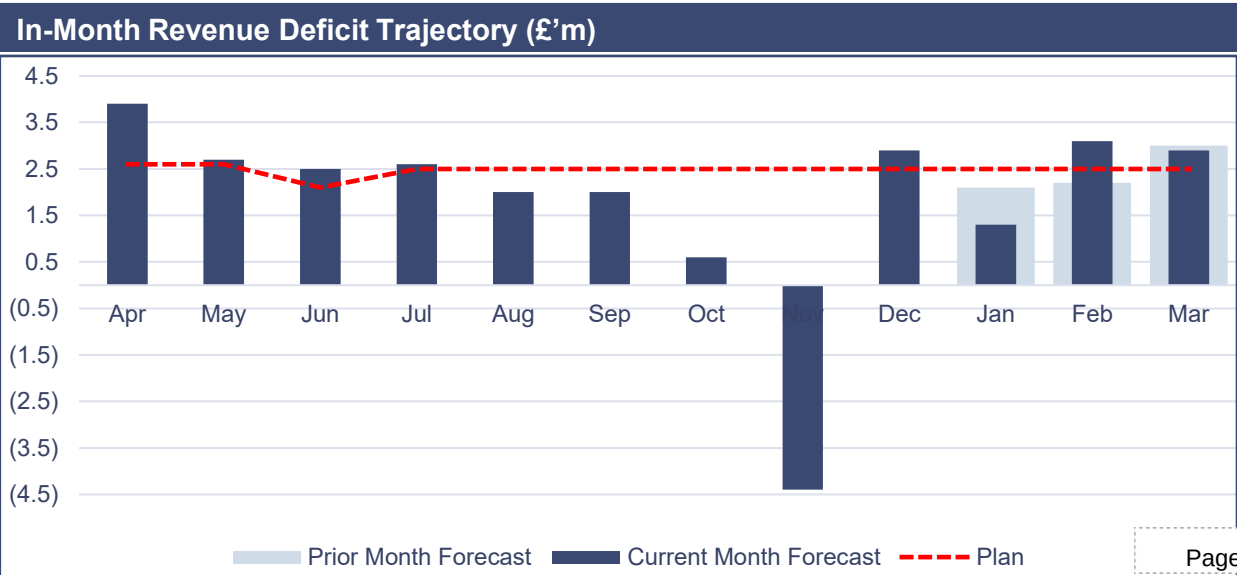
The in-month financial position is a deficit of £1.3m, which is an improvement against the £2.5m in-month deficit plan due to a core operational underspend of £(1.4)m. The savings target of £3.9m has been under identified by £0.2m; the £3.7m savings identified have been fully delivered in-month.

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	25.0	30.0	30.0
Unidentified / (Identified) savings gap / (improvement)	(0.6)	0.2	(5.2)	(3.4)	(3.9)
Under / (Over) delivery of savings schemes	0.0	0.0	0.3	0.3	0.3
Core operational variation	1.0	(1.4)	(4.0)	(2.4)	(4.3)
Gross Forecast	2.9	1.3	16.1	24.5	22.1
Future Mitigating Actions	0.0	0.0	0.0	(2.4)	0.0
Reported Position	2.9	1.3	16.1	22.1	22.1

Core Operational Variation	Risk #2086 5 x 3 = 15	The in-month core underspend of £(1.4)m is largely driven by a reduction in Oncology drugs price, Estates utilities reduction in expenditure following realignment of expenditure in line with NWSSP schedule and lower vaccinations uptake than plan.
Cash		A strategic cash request of £22.1m has been approved by Welsh Government, this has been forecasted to be received in March 2026.
Savings		Of the annual savings target of £46.4m, £50.3m has been identified on an in-year basis resulting in a £(3.9)m over-identification, however £50.0m are forecast to deliver, leaving a £(3.6)m savings delivery overachievement. Run rate management of year-to-date savings of £1.0m are now in the savings forecast to deliver in future months.
Capital	Risk #2204 3 x 4 = 12	Delivery against the capital programme remains at a medium risk. Due to the significant amount of expenditure forecast for the two remaining months of the year, there is a underspend to the Capital Resource Limit, in addition to risk of underspends against All Wales funded schemes including, Carmarthen Hwb £0.2m, Aseptic Unit £0.15m and Gamma Camera Upgrade £0.2m. Close monitoring of these risks will be necessary with reallocation of funds where required.
Underlying Deficit	Risk #1199 5 x 5 = 25	£18.4m of recurrent full year effect schemes have been identified, with recurrent funding for Real Living Wage £(2.3)m and Bank £(0.4)m being confirmed, offset by the National Insurance shortfall in funding £2.0m, resulting in an underlying deficit of £58.4m. This does not support the organisations required trajectory to achieve financial breakeven by 2027/28. In addition, there are a number of financial and led pressures which 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)	(0.6)	0.2	0.8
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	1.0	(1.4)	(2.4)
Gross Forecast	2.9	1.3	(1.6)
Future Mitigating Actions	0.0	0.0	0.0
Reported Net Position	2.9	1.3	(1.6)



Unidentified Savings Gap (£'m)	Change
Continuing Healthcare accountancy gain saving in prior month	0.9
Additional pay underspend savings identified in-month	(0.1)
Movement in Unidentified Savings Gap	0.8

Core Operational Variation (£'m)	Change
Pharmacy & Medicines Management latest prescribing report	(0.7)
Medical locum retrospective backdated claims	(0.5)
Estates & Facilities Utilities gas realignment of end of year costs	(0.3)
Community & Integrated Medicine infection prevention control disposables	(0.2)
Primary Care Community Pharmacy year to date contract uplift	0.4
Mental Health Continuing Healthcare year to date funding to cover costs	0.4
Prior Month Impacts	(0.9)
Cancer Oncology Drugs reduction in costs against planning assumptions	(0.6)
Estates & Facilities year to date Profit Share income alignment	(0.3)
Workforce Certificate of Sponsorship reduction in expenditure	(0.3)
Public Health lower vaccinations uptake of Health Protection programmes	(0.3)
Current Month Impacts	(1.5)
Movement in Core Operational Variation	(2.4)

Position Overview – Change from Prior Forecast



GIG
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NHS
WALES

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University Health Board



Executive Summary

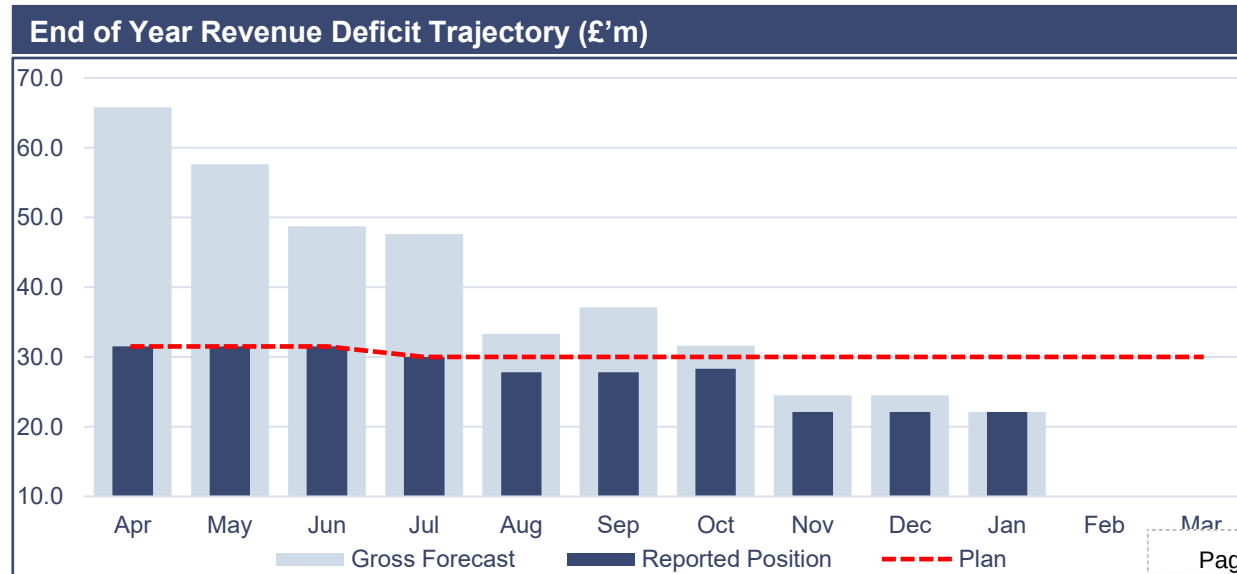
Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 5

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)	(3.4)	(3.9)	(0.5)
Under / (Over) delivery of savings schemes	0.3	0.3	0.0
Core Operational Variation	(2.4)	(4.3)	(1.9)
Gross Forecast	24.5	22.1	(2.4)
Future Mitigating Actions	(2.4)	0.0	2.4
Reported Net Position	22.1	22.1	0.0



Unidentified Savings Gap (£'m)	Change
Additional in-month underspend savings identified	(0.5)
Movement in Unidentified Savings Gap	(0.5)

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
Primary Care GMS contract uplifts lower than anticipated in-year	(1.1)
Estates & Facilities Utilities reduction in NWSSP forecast expenditure	(0.5)
Workforce Certificate of Sponsorship reduction in expenditure	(0.4)
Estates & Facilities Profit Share income increase	(0.2)
Continuing Healthcare backdated high-cost Local Authority package	0.3
Movement in Core Operational Variation	(1.9)

Actionable Insights – Top Priority Alerts



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 6

Action / Decision	Description	Owner	Status	Due Date
Shift Supply and Demand	Demand-led pressures and absence pressures have led to an increasing number of shifts being requested but market supply has not fulfilled the demand across Medical and Nursing agency in Withybush, Bronglais and Glangwili and Pathology. Further increases are anticipated following the opening of surge beds in January and approved recruitment plans in Bronglais Emergency Department. This is a risk to the start of the new financial year.	Executive Directors, CCG Directors	Increased shift demand not wholly available with market supply.	Overdue
Reactive savings planning and underspend conversion Conversion of remaining schemes to Green	Further to the initial amber savings scheme created in M5 of £6.0m, £1.0m remains as a balance covering M11-M12. The underspend conversion rate in month is £0.9m.	Executive Directors and Deputies	Recognition to convert Amber scheme to Green based on evidenced track record	Overdue
Confirmation of Non-Recurrent savings conversion required as part of 26/29 Financial Plan	Consistent with the principles agreed at Executive Team, each Executive Director and delegated budget holder is asked to confirm agreement with the total projected non-recurrent savings in FY26/27. Without justification for nonagreement, alternative rebuttable proposals are required.	Executive Directors and Deputies	Under urgent review in conjunction with Finance Business Controllers	13 February 2026
Medical pay Additional cover at premium costs	Continuing use of additional medical cover, including premium locum and agency in BGH, Planned Care and Mental Health.	Medical Director	Urgent update required on Medical Stabilisation	Overdue
Nurse agency usage Additional cover at premium costs	A 11% increase due to ongoing breaches within roster management outside of our standard operating procedure.	CIM CCG Director and Nursing	Further controls required to mitigate increased spending and clinical variation	Overdue

Financial Summary



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 7

In-Month Actual

£113.4m



Variance to Plan £(1.2)m

YTD Actual

£1,093.9m



Variance to Plan £(8.9)m

EOY Forecast

£1,327.1m



Variance to Plan £(7.9)m

3-Year Growth

16.9%

2022-23 Outturn £1,135m*

In-Year Growth

0.8%

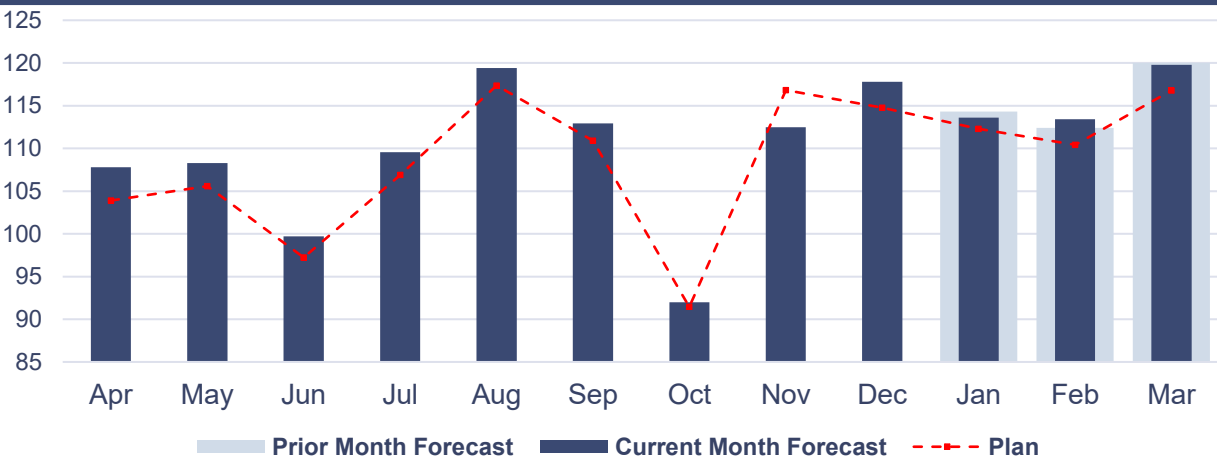
2024-25 Outturn £1,317m*

YTD Extrapolation

£1,312.6m

Risk / (Opp) £(14.4)m

Net Income and Expenditure (Before Allocations) (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay	58.0	58.9	57.0	570.9	685.0	685.7		(0.7)
Administration and Estates	11.7	12.2	11.6	116.0	139.2	139.1		0.1
Allied Health, Scientists and Other	7.2	7.3	7.2	71.6	85.9	85.9		(0.1)
Medical and Dental	13.4	13.9	13.0	133.2	159.8	160.1		(0.3)
Nursing, Midwifery and Clinical Support	25.7	25.5	25.2	250.2	300.2	300.6		(0.4)
Non Pay	61.6	66.1	63.8	587.8	705.3	721.5		(16.2)
Clinical Services and Supplies	4.4	4.8	4.5	43.0	51.6	51.7		(0.1)
Commissioned Healthcare Services	36.9	38.1	36.5	358.4	430.1	431.4		(1.4)
Drugs and Prescribing	11.7	13.8	13.3	122.7	147.2	149.8		(2.6)
Other Non-Pay	8.6	9.3	9.4	63.7	76.4	88.6		(12.2)
Income	(7.0)	(7.2)	(7.3)	(64.8)	(77.7)	(80.2)		2.5
Net Income and Expenditure	112.5	117.8	113.4	1,093.9	1,312.6	1,327.1		(14.4)
Allocations	116.9	114.9	112.1	1,077.7	1,293.3	1,305.0		11.7
Reported Position	(4.4)	2.9	1.3	16.1	19.3	22.1		(2.8)

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 accountancy gain savings. Month 9, December, Primary Care drugs increase in price including an uptake of Mounjaro drugs, and year-to-date Primary Care Dental, Pharmacy and General Medical Services increase in pay uplift costs in line with funding. Month 12, March, £6.0m increase for Depreciation and Amortisation Impairment.

Month 10, January, reduction in Medical and Dental relating to reduction in retrospective claims from prior month and reduction in Medical Additional Duty Hours. Reduction in Commissioned Healthcare Services relating to reduction in Psychiatric Intensive Care Unit beds within Mental Health due to less patient demand, reduction in Continuing Healthcare utilisation and number of packages within Community and Integrated Medicine, and year-to-date Primary Care Dental, Pharmacy and General Medical Services increase in pay uplift included in prior month. Oncology drugs price reduction of 19% from planned levels and Public Health reduction in vaccination update.

*Outturn adjusted for Notional Pension costs 2024-25 c£40.3m, 2022-23 c£22.0m.

Financial Summary – Key Drivers vs Plan



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 8

In-Month

Reported Position

£1.3m



Planned Deficit **£2.5m**
Prior Month Forecast **£2.1m**

Savings Identification Gap

£0.2m



Savings Target **£3.9m**
Total Identified **£3.7m**

Savings Delivery Gap

£0.0m



Savings Delivery **£3.7m**
Prior Month Delivery **£4.5m**

Core Operational Variation

£(1.4)m



Prior Month Variation **£1.0m**

Year to Date

Reported Position

£16.1m



Planned Deficit **£25.0m**

Savings Identification Gap

£(5.2)m



Savings Target **£38.6m**
Total Identified **£43.8m**

Savings Delivery Gap

£0.3m



Savings Delivery **£43.5m**
Prior Month Delivery **£39.8m**

Core Operational Variation

£(4.0)m



Prior Month Variation **£(2.6)m**

End of Year

Reported Position

£22.1m



Planned Deficit = **£30.0m**
Prior Annual Forecast = **£22.1m**

Savings Identification Gap

£(3.9)m



Savings Target = **£46.4m**
Total Identified = **£50.3m**

Savings Delivery Gap

£0.3m



Savings Delivery = **£50.0m**
Prior Month Delivery = **£49.5m**

Core Operational Variation

£(4.3)m



Prior Month Variation = **£(2.4)m**

Gross Forecast

£22.1m



Prior Gross Forecast = **£24.5m**
Mitigating Actions = **£0.0m**

Net Risks / (Opportunities)

£1.8m



Prior Month = **£1.6m**

Capital Position

£42.1m



Annual Plan = **£42.1m**
Prior Annual Forecast = **£38.6m**

Underlying Deficit

£58.4m



Annual Plan = **£58.5m**
Recognised as Unsustainable

Total Pay Insights



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 9

In-Month Actual

£57.0m



Variance to Plan £(0.4)m

YTD Actual

£570.9m



Variance to Plan £(0.9)m

EOY Forecast

£685.7m



Variance to Plan £(1.6)m

3-Year Growth

25.7%

2022-23 Outturn £545.6m*

In-Year Growth

7.9%

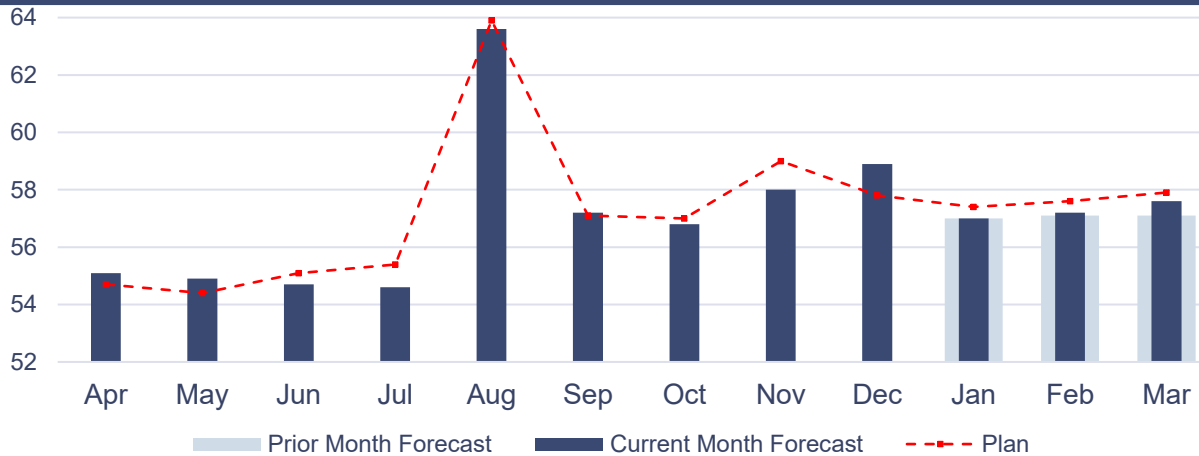
2024-25 Outturn £635.5m*

YTD Extrapolation

£685.0m

Risk / (Opp) £(0.7)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Substantive	52.9	52.8	52.3	518.9	622.6	623.3	●	(0.7)
Administration and Estates	11.3	11.8	11.3	112.6	135.1	135.0	●	0.1
Allied Health, Scientists and Other	7.0	7.0	7.0	68.9	82.7	82.8	●	(0.1)
Medical and Dental	10.9	10.8	10.8	107.4	128.8	129.0	●	(0.2)
Nursing, Midwifery and Clinical Support	23.6	23.2	23.3	230.0	276.0	276.6	●	(0.5)
Variable	4.3	5.0	3.6	43.6	52.3	52.1	●	0.2
Administration and Estates	0.3	0.4	0.3	3.4	4.1	4.1	●	(0.0)
Allied Health, Scientists and Other	0.2	0.2	0.1	1.5	1.8	1.8	●	0.0
Medical and Dental	2.1	2.5	1.6	22.1	26.5	26.4	●	0.1
Nursing, Midwifery and Clinical Support	1.7	1.9	1.6	16.6	19.9	19.8	●	0.1
Agency (Premium)	0.8	1.2	1.1	8.4	10.1	10.3	●	(0.2)
Administration and Estates	-	-	-	-	-	-	●	-
Allied Health, Scientists and Other	0.1	0.1	0.1	1.2	1.4	1.4	●	0.0
Medical and Dental	0.4	0.6	0.6	3.7	4.4	4.7	●	(0.3)
Nursing, Midwifery and Clinical Support	0.4	0.4	0.3	3.5	4.3	4.2	●	0.0
Total Expenditure	58.0	58.9	57.0	570.9	685.0	685.7	●	(0.7)
Plan	59.0	57.8	57.4	571.8	686.2	687.3		
Variance to Plan	(1.0)	1.1	(0.4)	(0.9)	(1.1)	(1.6)		

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 re-banding uplift expenditure £0.6m.

Month 9, December, variable & premium pay cost increases across both Medical and Dental and Nursing owing to recovery performance backlog within Scheduled Care, inclusive of arrears payments alongside an increased requirement for sickness cover.

Month 10, January, reduction in Medical and Dental and Nursing variable pay due to a reduction in retrospective claims in-month, in addition to a further reduction in Medical Additional Duty Hours. Increase in future anticipated Nursing expenditure due further recruitment within the Fracture Liaison Services.

*Outturn adjusted for Notional Pension costs 2024-25 c£40.3m, 2022-23 c£22.0m.

Substantive Insights



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 10

In-Month Actual

£52.3m



Variance to Plan £(3.2)m

YTD Actual

£518.9m



Variance to Plan £(33.7)m

EOY Forecast

£623.3m



Variance to Plan £(41.0)m

In-Year Growth

1.9%

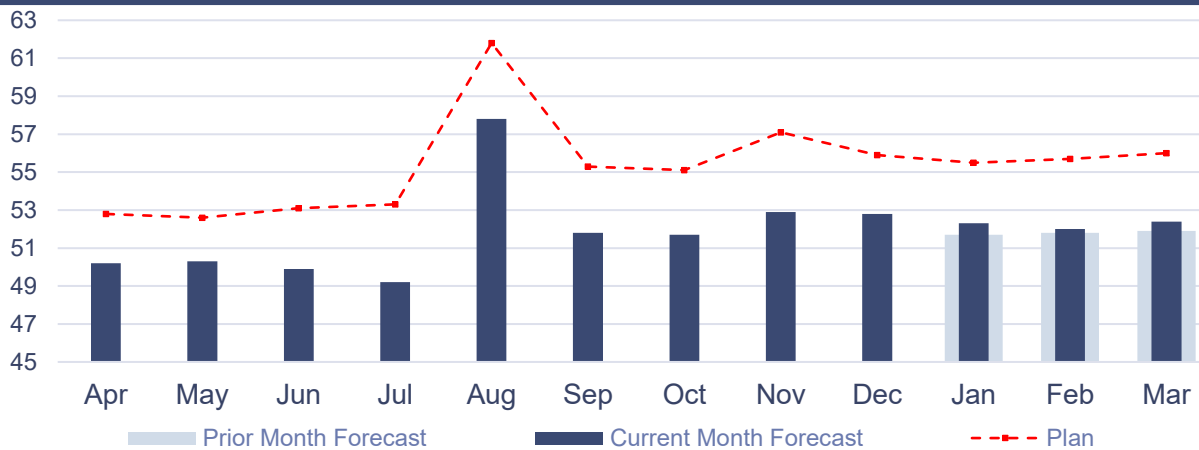
2024-25 Outturn £611.7m

YTD Extrapolation

£622.6m

Risk / (Opp) £(0.7)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	52.9	52.8	52.3	518.9	622.6	623.3		(0.7)
Administration and Estates	11.3	11.8	11.3	112.6	135.1	135.0		0.1
Allied Health, Scientists and Other	7.0	7.0	7.0	68.9	82.7	82.8		(0.1)
Medical and Dental	10.9	10.8	10.8	107.4	128.8	129.0		(0.2)
Nursing, Midwifery and Clinical Support	23.6	23.2	23.3	230.0	276.0	276.6		(0.5)
Functions	52.9	52.8	52.3	518.9	622.6	623.3		(0.7)
Chief Operating Officer Management	0.7	0.6	0.6	6.8	8.1	8.1		0.1
Community and Integrated Medicine	15.9	16.0	16.1	159.5	191.4	192.1		(0.7)
Mental Health and Learning Disabilities	5.8	5.8	5.9	57.2	68.6	69.2		(0.5)
Operational Allied Health and Health Sciences	5.5	5.6	5.6	54.9	65.8	66.0		(0.1)
Planned and Specialist Care	13.3	13.3	13.3	131.0	157.2	157.4		(0.2)
Primary Care	1.2	1.2	1.2	12.8	15.4	15.3		0.1
Executive Functions	10.4	10.2	9.7	96.8	116.1	115.3		0.8
Total Expenditure	52.9	52.8	52.3	518.9	622.6	623.3		(0.7)
Plan	57.1	55.9	55.5	552.6	663.1	664.3		
Variance to Plan	(4.2)	(3.2)	(3.2)	(33.7)	(40.4)	(41.0)		

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 from prior month as a result of additional year to date Band 2 to 3 pay award and rebanding uplift expenditure mainly relating to Healthcare Support Workers within Nursing £0.6m.

Increase in Nursing run rate relating to increased recruitment within Mental Health during the year across various services, and a further anticipated increase in recruitment within the Fracture Liaison Services within Community and Integrated Medicine.

Variable Insights



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 11

In-Month Actual

£3.6m



Variance to Plan £2.0m

YTD Actual

£43.6m



Variance to Plan £27.8m

EOY Forecast

£52.1m



Variance to Plan £33.1m

In-Year Growth

(16.4)%

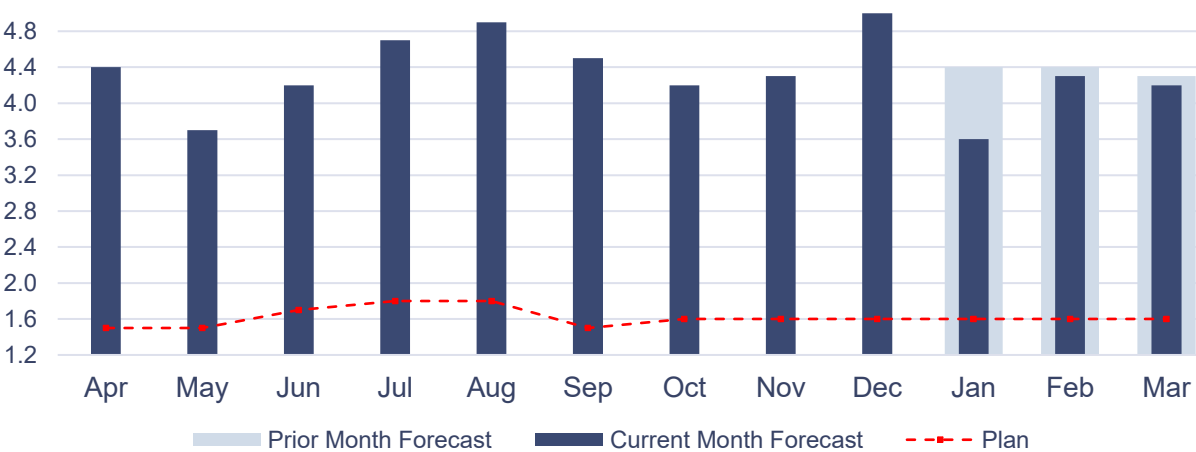
2024-25 Outturn £62.4m

YTD Extrapolation

£52.3m

Risk / (Opp) £0.2m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	4.3	5.0	3.6	43.6	52.3	52.1	0.2	0.2
Administration and Estates	0.3	0.4	0.3	3.4	4.1	4.1	0.0	(0.0)
Allied Health, Scientists and Other	0.2	0.2	0.1	1.5	1.8	1.8	0.0	0.0
Medical and Dental	2.1	2.5	1.6	22.1	26.5	26.4	0.1	0.1
Nursing, Midwifery and Clinical Support	1.7	1.9	1.6	16.6	19.9	19.8	0.1	0.1
Functions	4.3	5.0	3.6	43.6	52.3	52.1	0.2	0.2
Chief Operating Officer Management	-	-	-	0.1	0.1	0.1	0.0	0.0
Community and Integrated Medicine	1.7	1.7	1.5	16.6	20.0	19.7	0.3	0.2
Mental Health and Learning Disabilities	0.3	0.3	0.2	3.1	3.7	3.4	0.3	0.2
Operational Allied Health and Health Sciences	0.3	0.3	0.2	2.4	2.8	2.8	0.0	0.0
Planned and Specialist Care	1.3	1.9	1.2	13.7	16.4	16.6	(0.1)	(0.1)
Primary Care	0.6	0.6	0.5	5.3	6.4	6.5	(0.1)	(0.1)
Executive Functions	0.3	0.3	(0.1)	2.4	2.9	3.0	(0.0)	(0.0)
Total Expenditure	4.3	5.0	3.6	43.6	52.3	52.1	0.2	0.2
Plan	1.6	1.6	1.6	15.9	19.0	19.0		
Variance to Plan	2.7	3.4	2.0	27.8	33.3	33.1		

Key Information

Month 9, December, variable pay cost increases across both Medical & Dental and Nursing as a result of recovery performance backlog within Scheduled Care, including Waiting List Initiative payments, in addition to backdated retrospective claims. Nursing increases due to cover for vacancies and sickness.

Month 10, January, reduction from prior month due to Medical and Dental retrospective claims included in prior month. Improvement from forecast due to further reduction in Medical Additional Duty Hours across areas, Planned and Specialist Care reduction in Medical variable cover required and Community and Integrated Medicine Nursing variable reduction due to unfilled shifts.

Future months are anticipated to increase due to the one-off reduction in Medical Additional Duty Hours in-month not anticipated to continue.



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

In-Month Actual

£1.1m



Variance to Plan £0.7m

YTD Actual

£8.4m



Variance to Plan £5.0m

EOY Forecast

£10.3m



Variance to Plan £6.2m

In-Year Growth

(38.7)%

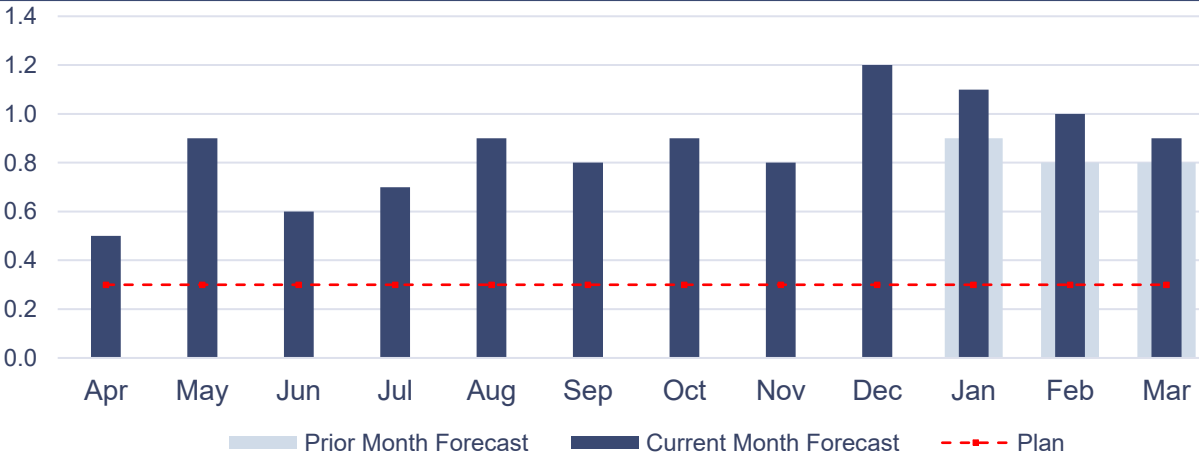
2024-25 Outturn £16.8m

YTD Extrapolation

£10.1m

Risk / (Opp) £(0.2)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	0.8	1.2	1.1	8.4	10.1	10.3		(0.2)
Administration and Estates	-	-	-	-	-	-		-
Allied Health, Scientists and Other	0.1	0.1	0.1	1.2	1.4	1.4		0.0
Medical and Dental	0.4	0.6	0.6	3.7	4.4	4.7		(0.3)
Nursing, Midwifery and Clinical Support	0.4	0.4	0.3	3.5	4.3	4.2		0.0
Functions	0.8	1.2	1.1	8.4	10.1	10.3		(0.2)
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	0.4	0.6	0.6	4.3	5.1	5.4		(0.3)
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.9	1.1	1.0		0.0
Operational Allied Health and Health Sciences	0.1	0.3	0.2	1.9	2.3	2.3		(0.0)
Planned and Specialist Care	0.2	0.2	0.2	1.3	1.6	1.6		0.0
Primary Care	-	-	-	-	-	-		-
Executive Functions	-	-	-	-	-	-		-
Total Expenditure	0.8	1.2	1.1	8.4	10.1	10.3		(0.2)
Plan	0.3	0.3	0.3	3.4	4.1	4.1		
Variance to Plan	0.5	0.8	0.7	5.0	6.0	6.2		

Key Information

Month 9, December, premium pay cost increases across both Medical and Dental and Nursing as a result of recovery performance backlog within Scheduled Care, inclusive of arrears payments alongside an increased requirement for sickness cover. Anaesthetics continued use of the premium card.

Month 10, January, saw a decrease in agency expenditure due Community and Integrated Medicine being unable to fill shifts, and a reduction in agency reliance within Operational Allied Health, anticipated to continue in future months. Increase in Medical and Dental agency reliance against forecast in-month and anticipated to continue in future months due to Planned and Specialist Care anticipated increase in recovery activity.

Clinical Services and Supplies Insights

In-Month Actual

£4.5m

Variance to Plan £0.6m

YTD Actual

£43.0m

Variance to Plan £2.8m

EOY Forecast

£51.7m

Variance to Plan £3.7m

3-Year Growth

27.3%

2022-23 Outturn £40.6m

In-Year Growth

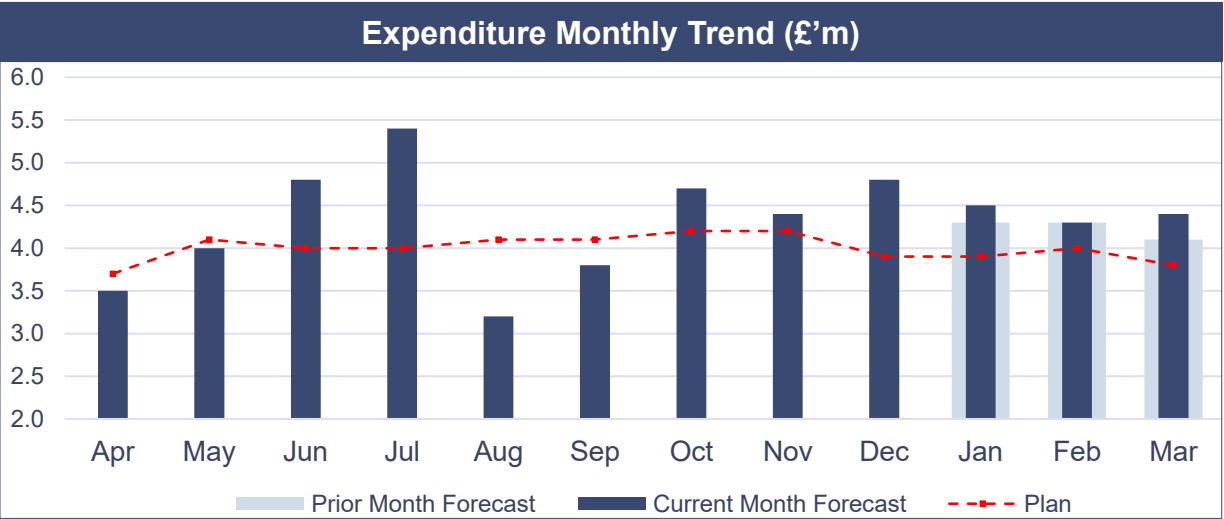
9.1%

2024-25 Outturn £47.4m

YTD Extrapolation

£51.6m

Risk / (Opp) £(0.1)m



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	4.3	4.7	4.5	43.0	51.6	51.7		(0.1)
Chief Operating Officer Management	-	-	-	0.2	0.2	0.2		-
Community and Integrated Medicine	1.3	1.2	1.3	11.5	13.9	13.8		-
Mental Health and Learning Disabilities	-	-	-	0.2	0.3	0.3		-
Operational Allied Health and Health Sciences	1.1	1.4	1.2	11.5	13.8	13.9		(0.1)
Planned and Specialist Care	1.8	2.2	1.9	18.7	22.5	22.5		-
Primary Care	-	(0.1)	0.1	0.3	0.4	0.4		-
Executive Functions	0.1	-	0.1	0.5	0.6	0.6		-
Total Expenditure	4.3	4.7	4.5	43.0	51.6	51.7		(0.1)
Plan	4.2	3.9	3.9	40.2	48.2	47.9		0.3
Variance to Plan	0.1	0.9	0.6	2.8	3.4	3.7		(0.3)

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.
- Month 9, December, includes an increase in lab equipment within Pathology, increased disposables in line with Infection Prevention Control, Sleep Service and insulin consumables within Community and Integrated Medicine, and Planned and Specialist Care insourced activity within Operating Theatres.
- Month 10, January, increased expenditure than anticipated due to purchase of Heart Monitors within Community and Integrated Medicine.
- Month 12, March, increased consumables and insourcing anticipated within Planned and Specialist Care in line with anticipated increase in recovery activity.

Commissioned Healthcare Services Insights

In-Month Actual

£36.5m



Variance to Plan £(0.3)m

YTD Actual

£358.4m



Variance to Plan £0.8m

EOY Forecast

£431.4m



Variance to Plan £0.1m

3-Year Growth

21.9%

2022-23 Outturn £353.8m

In-Year Growth

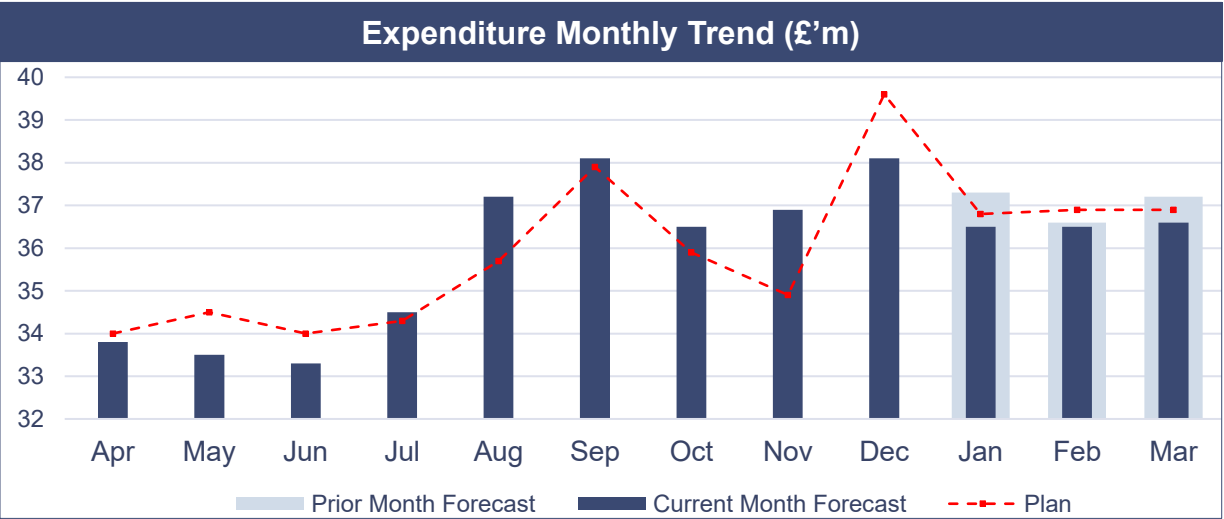
6.3%

2024-25 Outturn £405.7m

YTD Extrapolation

£430.1m

Risk / (Opp) £(1.3)m



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	36.9	38.1	36.5	358.4	430.1	431.4		(1.3)
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	2.6	3.0	2.4	25.8	30.9	30.8		0.1
Mental Health and Learning Disabilities	3.9	4.0	3.9	37.9	45.4	45.4		-
Operational Allied Health and Health Sciences	0.4	0.4	0.5	4.4	5.3	5.3		-
Planned and Specialist Care	1.3	(0.4)	1.0	7.1	8.6	9.3		(0.8)
Primary Care	10.3	13.4	10.6	103.6	124.4	124.7		(0.3)
Executive Functions	18.3	17.7	18.2	179.6	215.5	215.9		(0.4)
Total Expenditure	36.9	38.1	36.5	358.4	430.1	431.4		(1.3)
Plan	34.9	39.6	36.8	357.6	429.1	431.4		(2.2)
Variance to Plan	1.9	(1.5)	(0.3)	0.8	0.9	0.1		0.9

Key Information

- Month 5, August, year-to-date reclassification of Theatre outsourcing activity from Clinical Services and Supplies and backdated retrospective Continuing Healthcare uplifts.
- Month 6, September, year-to-date Joint Commissioning Committee expenditure in line with funding relating to Pay Award Matrix and Vertex, all of which totalling £3.4m.
- Month 9, December, year-to-date Primary Care Dental, Pharmacy and General Medical Services increase in pay uplift costs in line with funding.
- Month 10, January, relating to reduction in Continuing Healthcare utilisation and number of packages within Community and Integrated Medicine and less patient demand for Psychiatric Intensive Care Unit beds within Mental Health.
- Reduction in future forecast expenditure due to Primary Care General Medical Services contract uplifts being lower than anticipated.

Drugs and Prescribing Insights



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 15

In-Month Actual

£13.3m



Variance to Plan £(0.6)m

YTD Actual

£122.7m



Variance to Plan £(5.3)m

EOY Forecast

£149.8m



Variance to Plan £(4.1)m

3-Year Growth

6.5%

2022-23 Outturn £140.6m

In-Year Growth

(3.3)%

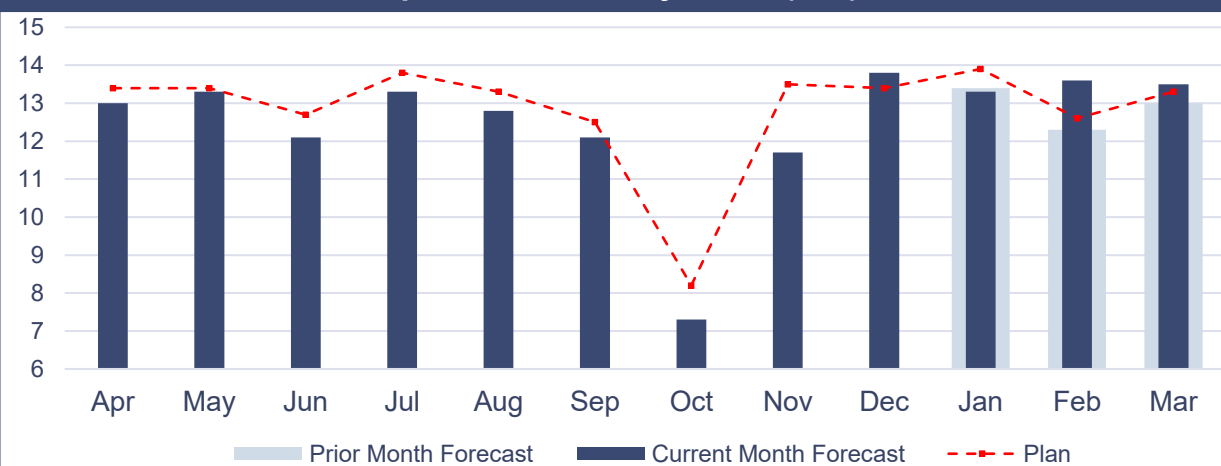
2024-25 Outturn £154.9m

YTD Extrapolation

£147.2m

Risk / (Opp) £(2.6)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	11.7	13.8	13.3	122.7	147.2	149.8		(2.6)
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	1.4	1.5	1.4	14.5	17.4	17.4		(0.1)
Mental Health and Learning Disabilities	0.1	0.1	0.1	1.0	1.2	1.2		-
Operational Allied Health and Health Sciences	0.4	0.6	0.5	5.1	6.1	6.1		-
Planned and Specialist Care	2.9	3.3	2.9	30.6	36.7	37.1		(0.4)
Primary Care	-	-	-	0.2	0.2	0.2		-
Executive Functions	6.8	8.4	8.4	71.4	85.7	87.8		(2.1)
Total Expenditure	11.7	13.8	13.3	122.7	147.2	149.8		(2.6)
Plan	13.5	13.4	13.9	128.0	153.6	153.9		(0.3)
Variance to Plan	(1.8)	0.4	(0.6)	(5.3)	(6.4)	(4.1)		(2.3)

Key Information

Month 7, October, reduction of £6.1m as a year-to-date recognition of Aseptic Unit System accountancy gain saving alignment.

Month 9, December, increase relating to September Prescribing Audit Report, sighting an increased price per item of £0.09p in addition to volume increase. A proportion of the increase in cost per item relates to Mounjaro drugs being purchased in-month, with the step-up expected to continue in future months.

Month 10, January, reduction in Cancer Oncology Drugs from prior month due to in-month price per patient decrease of 19%.

Future increase anticipated above prior month forecast relating to Primary Care prescribing due to increased Mounjaro drugs uptake, offset by Velindre rebate income overachievement.

Other Non-Pay Insights



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 16

In-Month Actual

£9.3m



Variance to Plan £2.8m

YTD Actual

£63.7m



Variance to Plan £22.6m

EOY Forecast

£88.6m



Variance to Plan £32.7m

3-Year Growth

(20.3)%

2022-23 Outturn £111.1m

In-Year Growth

(37.4)%

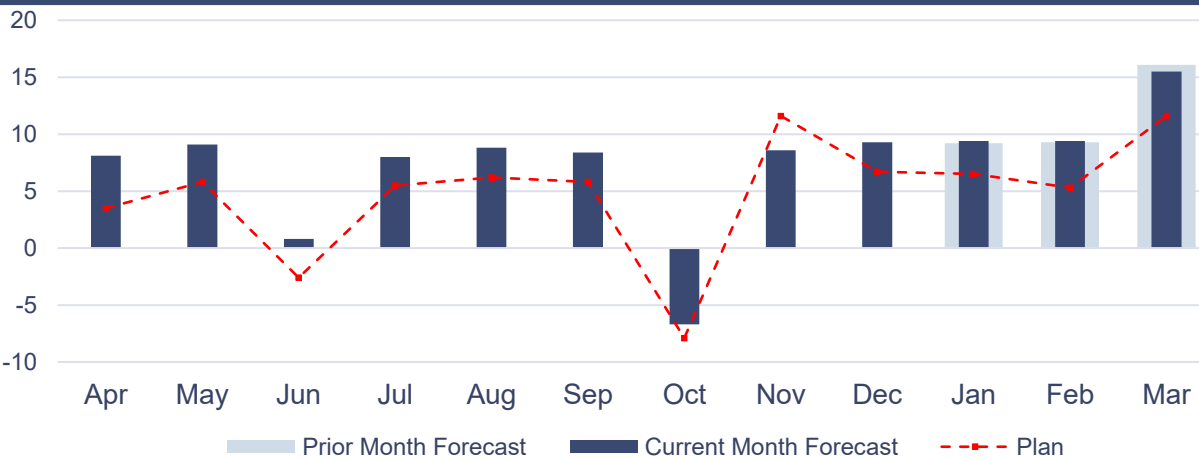
2024-25 Outturn £141.5m

YTD Extrapolation

£76.4m

Risk / (Opp) £(12.2)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	8.6	9.3	9.3	63.7	76.4	88.6		(12.2)
Chief Operating Officer Management	-	0.2	-	0.8	1.0	1.0		-
Community and Integrated Medicine	1.0	0.8	1.2	9.1	10.9	11.0		(0.1)
Mental Health and Learning Disabilities	0.2	0.2	0.3	2.2	2.6	2.6		0.1
Operational Allied Health and Health Sciences	0.2	0.1	0.1	1.4	1.7	1.7		-
Planned and Specialist Care	0.4	0.4	0.3	3.4	4.0	4.1		-
Primary Care	0.1	0.2	0.2	1.5	1.9	2.0		(0.1)
Executive Functions	6.8	7.5	7.3	45.2	54.2	66.2		(12.0)
Total Expenditure	8.6	9.3	9.3	63.7	76.4	88.6		(12.2)
Plan	11.6	6.7	6.5	41.1	49.3	57.9		(8.7)
Variance to Plan	(3.0)	2.7	2.8	22.6	27.1	30.7		(3.6)

Key Information

Month 3, June and Month 7, October Amortisation and revaluation and impairment adjustments of Capital Expenditure reduced by circa £8.0m and £16.2m respectively.

Month 10, January, increase in expenditure within Community and Integrated Medicine due to increased in Local Authority Home Based Care scheme and transport costs relating to discharges, offset by lower expenditure within Executive Functions relating to Workforce Certificate of Sponsorship.

Month 12, March, includes a £6.0m increase in relation to anticipated Depreciation and Amortisation Impairment increases.

Income Insights



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 17

In-Month Actual

£7.3m



Variance to Plan £0.9m

YTD Actual

£64.8m



Variance to Plan £3.8m

EOY Forecast

£80.2m



Variance to Plan £6.7m

3-Year Growth

10.9%

2022-23 Outturn £72.3m

In-Year Growth

2.3%

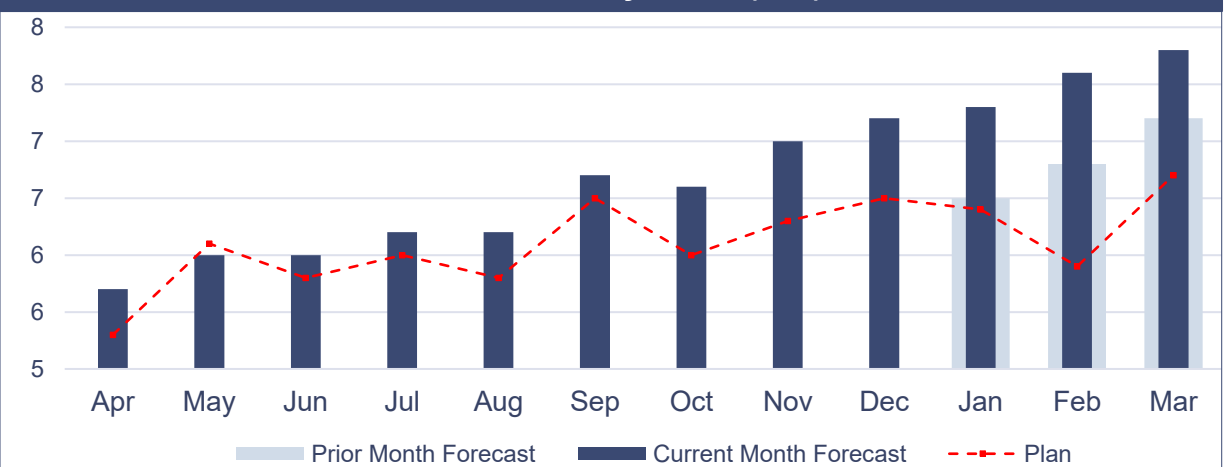
2024-25 Outturn £78.4m

YTD Extrapolation

£77.7m

(Risk) / Opp £(2.5)m

Income Monthly Trend (£'m)



Income Trajectory Analysis (£'m)	P08-26	P09-26	P10-26	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	7.0	7.2	7.3	64.8	77.7	80.2		(2.5)
Chief Operating Officer Management	-	-	-	0.3	0.4	0.4		-
Community and Integrated Medicine	0.5	0.6	0.4	3.5	4.2	4.1		0.1
Mental Health and Learning Disabilities	0.3	0.3	0.3	2.6	3.1	3.1		-
Operational Allied Health and Health Sciences	0.3	0.3	0.3	2.8	3.4	3.3		0.1
Planned and Specialist Care	0.4	0.6	0.5	5.1	6.2	6.1		-
Primary Care	0.3	0.2	0.3	2.3	2.7	2.8		-
Executive Functions	5.3	5.3	5.6	48.2	57.8	60.5		(2.7)
Total Income	7.0	7.2	7.3	64.8	77.7	80.2		(2.5)
Plan	6.3	6.5	6.4	60.9	73.1	73.5		(0.4)
Variance to Plan	0.7	0.6	0.9	3.8	4.6	6.7		(2.1)

Key Information

Month 10, December, includes an increase from forecast due to Estates Compass Profit Share income, Housing with Care Fund capital income, and Velindre drugs rebate income for Mounjaro.

Future increase anticipated above prior month forecast relating to Primary Care prescribing due to increased Mounjaro drugs uptake and a corresponding increase in Velindre rebate income.

End of Year – Key Drivers vs Plan



GIG
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NHS
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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



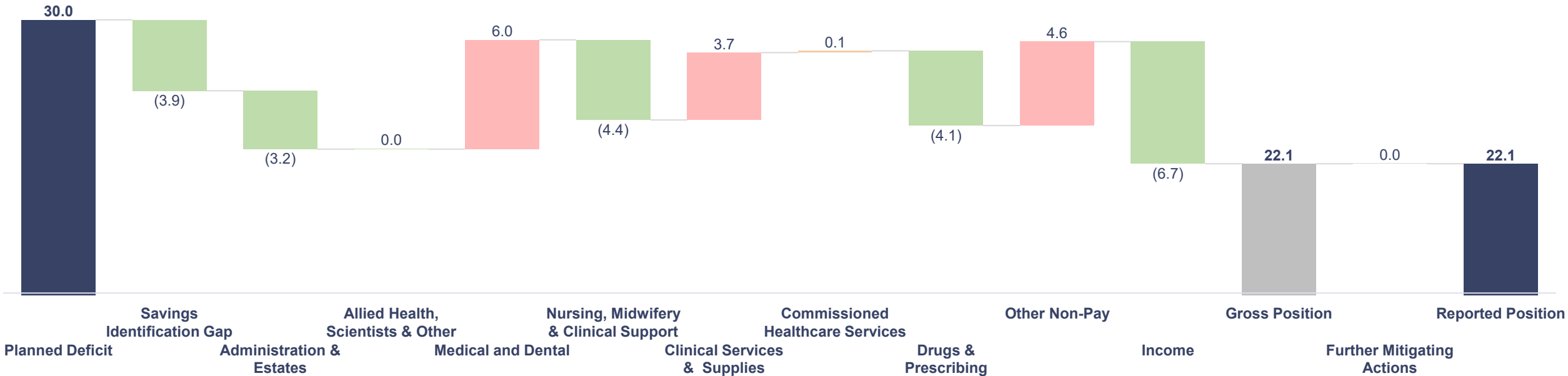
Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 18



Key Information

Medical and Dental – Premium locum usage to cover vacancies, sickness and surge capacity within Planned and Specialist Care, Community and Integrated Medicine and Mental Health.

Nursing and Midwifery – Vacancies within Community and Integrated Medicine and Mental Health £(1.8)m, in addition to Band 2 to 3 pay uplift funding £(2.0)m.

Drugs – Lower Oncology drugs prices and flu and Covid-19 vaccination uptake than planned, offset by high-cost drugs and Mounjaro uptake within Pharmacy and Medicines Management.

Other Non-Pay – Estates inflationary contract uplifts for maintenance, premises, energy and laundry £1.0m. Digital inflationary contract uplifts £0.8m. Community and Integrated Medicine premises rental and adaptation costs £0.6m, travel costs to support discharge, and prior year Patient Flow invoice £0.6m. Clinical Negligence losses claims for cases £0.6m.

Income – Pharmacy and Medicines Management Velindre drugs rebate largely relating to Mounjaro uptake £(2.6)m. Continued Bowel and Breast Screening and Wet Age-related Macular Degeneration income overachievement £(1.0)m. NWSSP income overachievement £(1.0)m and Flving Start and Health Education and Improvement Wales £(0.6)m. Cost Recovery Unit of large cases, Non-Contracted Activity, Powys and Betsi high-cost drugs income.

End of Year – Key Performance vs Plan



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 19

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	(0.6)	(0.7)	Clinical Care Group management structures due to ongoing recruitment processes and reduction in taxi expenditure.
Community and Integrated Medicine	3.9	0.0	1.6	5.7	Increases purchases of consumables for Infection Prevention control, premises costs, discharge travel costs and premium Medical costs.
Mental Health and Learning Disabilities	0.2	0.0	1.4	1.6	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	2.2	0.3	0.6	3.1	Oncology drugs lower than planned, income overachievement, offset by theatres insourcing and outsourcing and ongoing Medical locum usage.
Primary Care	(2.4)	0.0	(3.3)	(5.7)	Underspend relating to Dental contracts underperformance and General Medical Services supplementary services.
Executive Functions	(11.0)	0.0	(4.0)	(15.0)	Reduction in uptake of vaccinations within Public Health, Velindre rebate and Education income overachievement and reduction in Certificate of Sponsorship Workforce costs. .
Sub Total	(3.9)	0.3	(4.3)	(7.9)	
Gross Position				22.1	
Further Mitigating Actions				0.0	No further gap to reported position requiring mitigating actions
Reported Position				22.1	

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				24.5	
Chief Operating Officer Management	(0.2)	0.0	(0.1)	(0.3)	Additional pay underspends identified as savings in-month.
Community and Integrated Medicine	0.0	0.0	0.0	0.0	No material deviation.
Mental Health and Learning Disabilities	(0.1)	0.0	(0.2)	(0.3)	Confirmation of funding to cover Continuing Healthcare 6.9% uplift costs.
Operational Allied Health & Health Sciences	0.0	0.0	(0.2)	(0.2)	Reduction in Pathology drugs and Radiology contract expenditure.
Planned and Specialist Care	0.0	0.0	0.1	0.1	Increase in Operating Theatres outsourcing to maintain the Ear, Nose and Throat and Ophthalmology sessions.
Primary Care	(0.3)	0.0	(0.9)	(1.2)	Primary Care General Medical Services contract uplifts lower than anticipated. Additional Dental underspend savings identified in-month.
Executive Functions	0.1	0.0	(0.6)	(0.5)	Estates reduction in NWSSP utilities forecast expenditure and increase in Compass Profit Share income. Workforce Certificate of Sponsorship reduction in expenditure.
Sub Total	(0.5)	0.0	(1.9)	(2.4)	
Gross Position				22.1	
Further Mitigating Actions				0.0	
Reported Position				22.1	

End of Year – Saving Delivery Performance



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 21

Savings

Savings Target

£46.4m

Recurrent = £19.0m
Non-Recurrent = £27.4m

In-Year Recurrent Gap

£4.6m

Target = £19.0m
Delivery = £14.4m



In-Year Non-Recurrent Gap

£(8.5)m

Target = £27.4m
Delivery = £35.9m



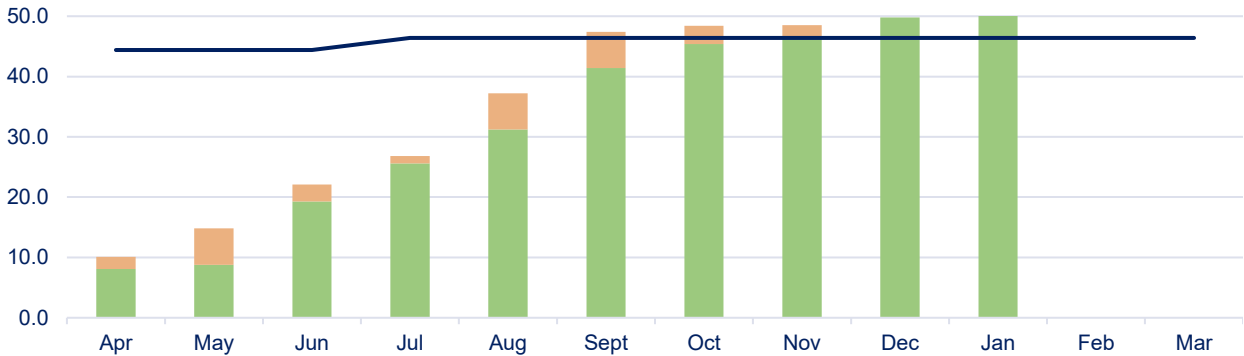
Full Year Recurrent Gap

£0.6m

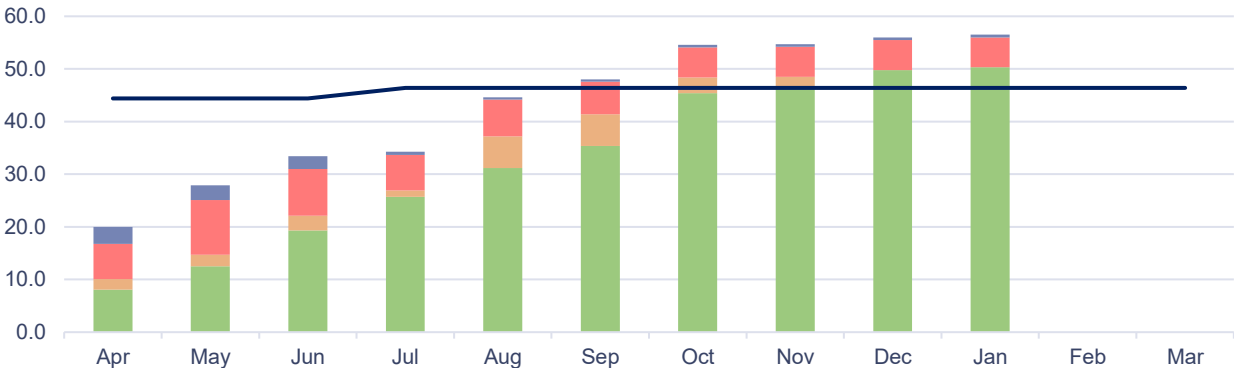
Target = £19.0m
Delivery = £18.4m



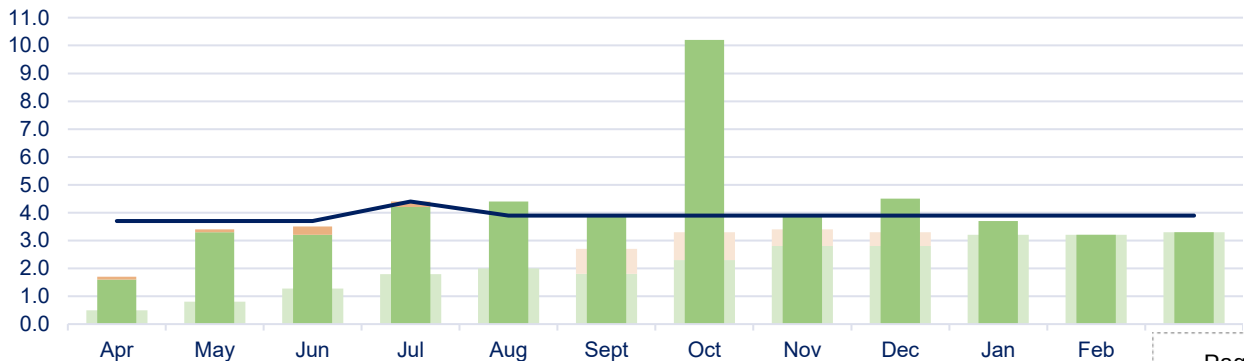
Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



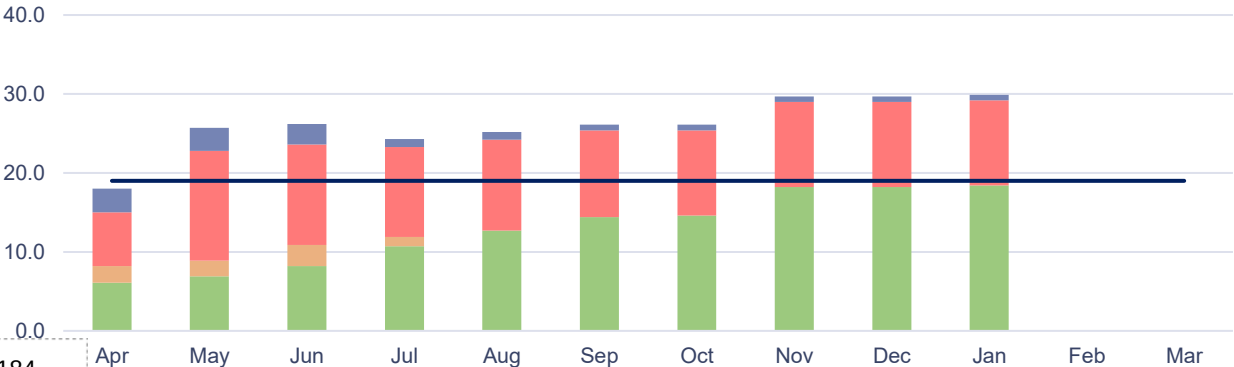
Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)



Monthly Profiled Risk-Assessed Savings Delivery (£'m)

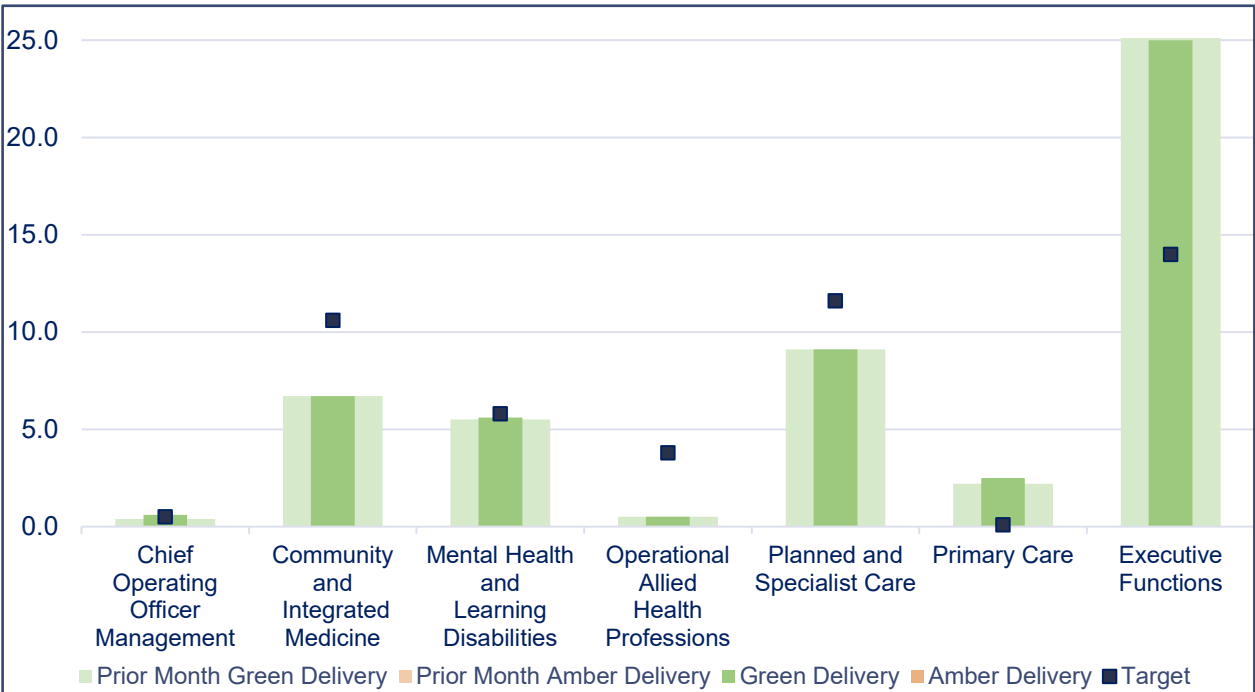


Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)



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	0.5	0.6	0.6	(0.1)
Community and Integrated Medicine	10.6	6.7	6.7	3.9
Mental Health and Learning Disabilities	5.8	5.6	5.6	0.2
Operational Allied Health and Health Sciences	3.8	0.5	0.5	3.3
Planned and Specialist Care	11.6	9.4	9.1	2.5
Primary Care	0.1	2.5	2.5	(2.4)
Executive Functions	14.0	25.0	25.0	(11.0)
Grand Total	46.4	50.3	50.0	(3.6)

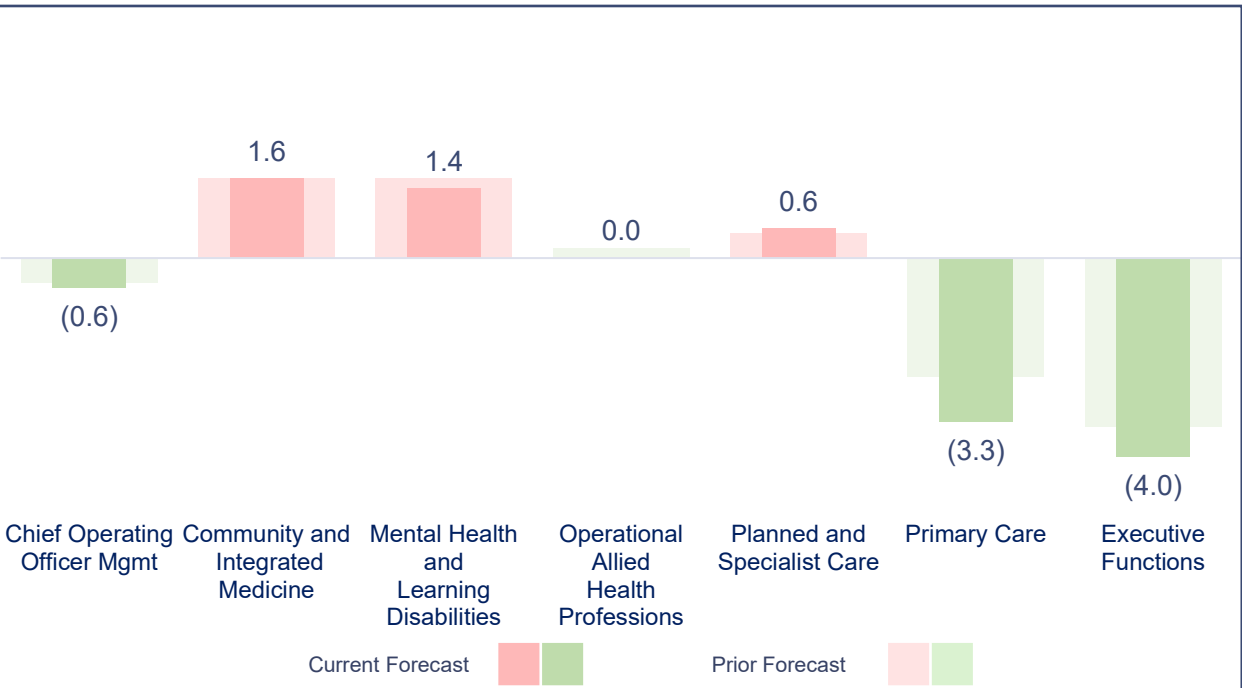
Key Information

Additional savings identified in-month relating to £0.5m conversions of Pay and Dental underspends, over and above the existing run rate management monthly assumption of year-to-date savings of £0.5m.

Continuation of run rate management of pay vacancy underspends are recognised as a green saving in future months of £1.0m.

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	(0.3)	(0.3)	0.0	(0.6)
Community and Integrated Medicine	(0.4)	2.6	(0.6)	1.6
Mental Health and Learning Disabilities	(0.3)	1.6	0.1	1.4
Operational Allied Health and Health Sciences	1.2	(0.4)	(0.8)	0.0
Planned and Specialist Care	2.0	(0.4)	(1.0)	0.6
Primary Care	0.4	(5.0)	1.3	(3.3)
Executive Functions	(4.5)	6.2	(5.7)	(4.0)
Total	(1.9)	4.3	(6.7)	(4.3)

Key Information

Community and Integrated Medicine Clinical supplies relating to incontinence products, disposable consumables due to increased infection prevention control and insulin pumps £1.2m, in addition to increased travel costs to support discharge, increased equipment stores costs, and prior year patient flow invoice £1.4m

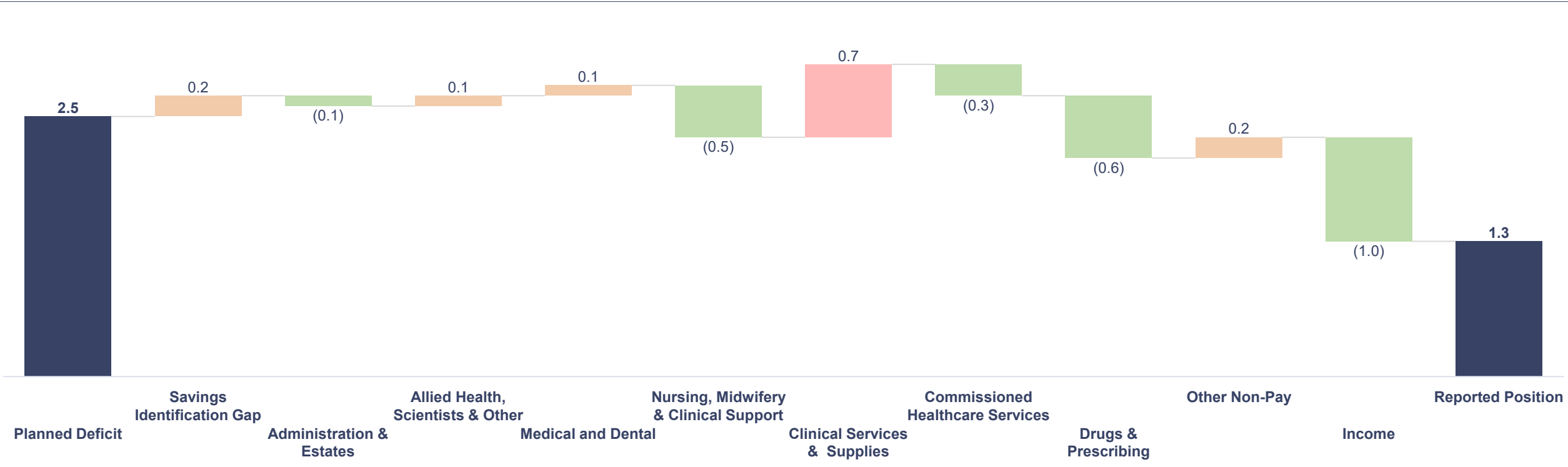
Mental Health Net increase of 23 Continuing Healthcare packages £0.6m, and purchase of Psychiatric Intensive Care Unit beds from independent sector £1.0m.

Planned and Specialist Care Medical variable pay within Anaesthetics, Orthopaedic and Urology £1.2m. Ophthalmology, Theatres and Orthopaedic outsourcing £2.3m, offset by delayed impact of new NICE Horizon funded Oncology drugs and reduction in drug prices £(3.3)m. Income overachievement for Bowel Screening and Wet Age-related Macular Degeneration.

Primary Care Dental contracts underperformance £(1.4)m, and General Medical Services supplementary services £(1.8)m, and contract uplifts lower than anticipated £(1.1)m.

Executive Functions Emergency activity Swansea Bay Long Term Agreements £1.7m, energy and maintenance contract uplifts £1.0m, Primary Care prescribing Mounjaro drugs £2.7m, offset by Velindre income rebates £(2.7)m, Band 2 to 3 pay uplift funding £(2.0m), Public Health of vaccinations £(0.6)m, and HEIW and Non-Contracted activity income.

In-Month – Key Drivers vs Plan



Key Information

Nursing and Midwifery – Increased underspend largely relating to Community and Integrated Medicine due to vacancies and sickness, and a failure to fill a significant number of shifts. Nurse agency usage in January also decreased by 11.3%, from 55WTE in December to 49WTE in January.

Clinical Services & Supplies – Planned & Specialist Care £0.2m insourced activity within Operating Theatres and Community & Integrated Medicine £0.2m increase in purchase of Heart Monitors.

Commissioned Healthcare Services – Primary Care underspend relating to Optometry due to reduced activity and GMS supplementary services £(0.2)m. Reduction in Continuing Healthcare patient acuity and demand and the number of packages in Pembrokeshire £(0.2)m.

Drugs and Prescribing – Oncology drugs price reduction of 19% from planned levels, and Public Health reduction in vaccination update.

Income – Pharmacy Prescribing Rebates largely relating to Mounjaro £(0.4)m, and Non-Activity £(0.2)m.

In-Month – Key Performance vs Plan



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 25

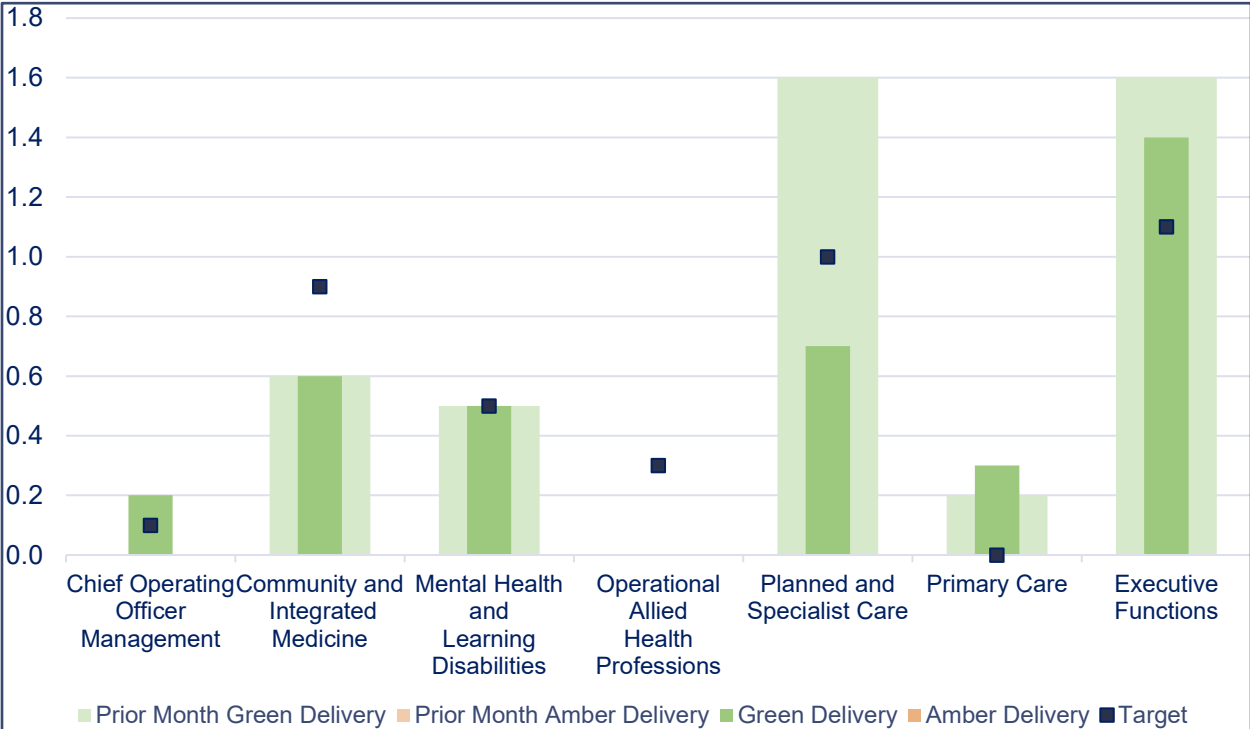
Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				2.5	
Chief Operating Officer Management	(0.1)	0.0	0.0	(0.1)	Over-achieved pay efficiency savings.
Community and Integrated Medicine	0.3	0.0	0.1	0.4	Local Authority Home Based Care and discharge transport expenditure, Medical locum usage offset by CHC packages ending.
Mental Health and Learning Disabilities	0.0	0.0	0.2	0.2	Continuing Healthcare expenditure relating to new Local Authority contract package.
Operational Allied Health & Health Sciences	0.3	0.0	0.0	0.3	Continuing under achievement of savings against target.
Planned and Specialist Care	0.3	0.0	(0.2)	0.1	Oncology drugs reduction in price of 19% compared to plan, offset by Theatres insourcing activity.
Primary Care	(0.3)	0.0	0.0	(0.3)	Overidentification of savings in relation to Dental and Pay underspends.
Executive Functions	(0.3)	0.0	(1.5)	(1.8)	Utilities reduction in expenditure in line with NWSSP forecast, Workforce Certificate of Sponsorship reduction, lower Health Protection and vaccination uptake, Mounjaro Velindre rebate income
Sub Total	0.2	0.0	(1.4)	(1.2)	
Gross Position				1.3	

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	(0.2)	0.0	0.0	(0.2)	Additional savings identified in relation to pay underspend savings.
Community and Integrated Medicine	0.0	0.0	(0.3)	(0.3)	Reduction in disposables consumables due to infection prevention control from prior month, and less Continuing Healthcare packages.
Mental Health and Learning Disabilities	0.0	0.0	0.8	0.8	Continuing Healthcare funding to cover 6.9% cost uplift in prior month, and additional Local Authority Continuing Healthcare costs.
Operational Allied Health & Health Sciences	0.0	0.0	(0.3)	(0.3)	Reduction in Medical due to retrospective claims included in prior month and reduction in lab equipment purchases.
Planned and Specialist Care	0.9	0.0	(1.3)	(0.4)	Continuing Healthcare accountancy gain saving, and Medical retrospective claims in prior month. Oncology drugs price reduction.
Primary Care	(0.1)	0.0	0.6	0.5	Community Pharmacy contract uplift funding in prior month.
Executive Functions	0.2	0.0	(1.9)	(1.7)	Medicines Management £0.8m latest prescribing price impact. Estates utilities year to date reduction in expenditure in line with NWSSP forecast, Workforce Certificate of Sponsorship reduction and lower Public Health Protection and vaccination uptake.
Sub Total	0.8	0.0	(2.4)	(1.6)	
Gross Position				(1.6)	

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	0.2	0.2	(0.1)
Community and Integrated Medicine	0.9	0.6	0.6	0.3
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	0.0	0.3	0.3	(0.3)
Executive Functions	1.1	1.4	1.4	(0.3)
Grand Total	3.9	3.7	3.7	0.2

Key Information

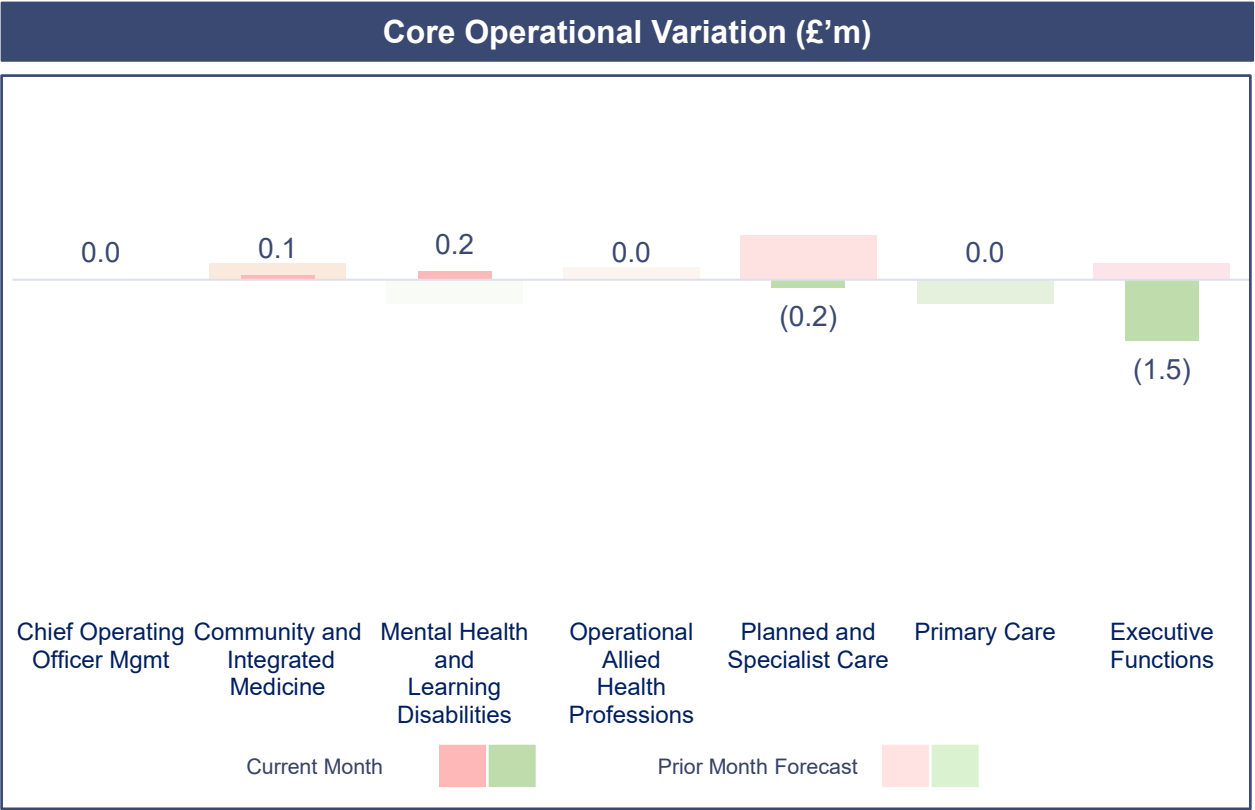
Overall savings delivery of £3.7m has been achieved, resulting in a £0.2m savings under-delivery against £3.9m target, with variations across Clinical Care Groups

Of the savings delivered in-month, £1.3m relate to recurrent schemes and £2.4m relate to non recurrent schemes.

Newly identified schemes relate to underspend conversion of £0.9m, compared to £0.7m in Month 9. £0.7m of underspends relate to pay and £0.2m relate to Dental.

Note a reduction in savings identified within Planned and Specialist Care in-month compared to Month 9. Gwlydd Continuing Healthcare saving being identified in prior month.

In-Month – Core Operational Variation



Core Operational Variation (£'m)				
Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.0	0.0	0.0	0.0
Community and Integrated Medicine	0.0	0.2	(0.1)	0.1
Mental Health and Learning Disabilities	0.0	0.2	0.0	0.2
Operational Allied Health and Health Sciences	0.1	0.0	(0.1)	0.0
Planned and Specialist Care	0.2	(0.3)	(0.1)	(0.2)
Primary Care	0.0	(0.1)	0.1	0.0
Executive Functions	(0.7)	0.0	(0.8)	(1.5)
Total	(0.4)	0.0	(1.0)	(1.4)

Key Information

Community and Integrated Medicine Additional costs from the Local Authority in relation to Homecare Based Scheme and transport costs relating to discharges.

Planned and Specialist Care Cancer Oncology Drugs in-month price per patient decrease of 19%, offset by continued use of Premium Medical Rate Card across specialities and Waiting List Initiative sessions to meet Welsh Government Waiting Times targets.

Executive Functions Medical Additional Duty Hours central accrual release, and income relating to Digital Connecting Care, Mounjaro Velindre drugs rebate and Non-Contracted Activity.

Year to Date – Key Drivers vs Plan



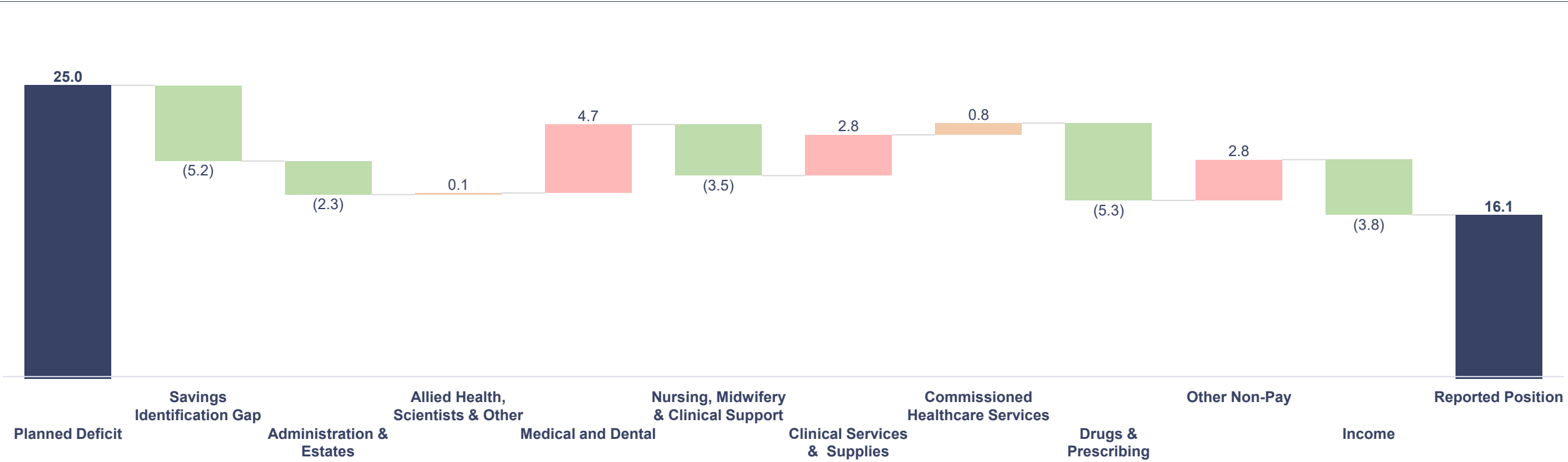
Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 29



Key Information

Medical & Dental – Planned and Specialist Care variable & premium pay cost increases as a result of recovery performance backlog, with continued use of the premium rate card and increased Waiting List Initiative payments. Increased requirement for sickness and vacancies cover within Mental Health and Community and Integrated Medicine.

Nursing and Midwifery – Confirmation of Band 2 to 3 pay uplift funding £(1.5)m, with continued Nursing vacancies across Community and Integrated Medicine.

Drugs & Prescribing – Oncology drugs underspend due to price increases being lower than planned, and delays in NICE treatments increases expected. Public Health drugs underspend with lower uptake for Shingles and Covid-19 vaccinations.

Income – Overachievement of Velindre rebate income driven by Mounjaro price increases within Pharmacy and Medicines Management. Bowel Screening, Wet age-related macular degeneration, Flying Start and HEIW income within Planned and Special

Year to Date – Key Performance vs Plan



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WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 30

Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				25.0	
Chief Operating Officer Management	(0.2)	0.0	(0.4)	(0.6)	Vacancies held within Management roles of the Directorate.
Community and Integrated Medicine	3.2	0.0	1.1	4.3	Continuing Healthcare packages and purchase of disposable consumables, incontinence products and heart monitors.
Mental Health and Learning Disabilities	(0.1)	0.0	1.4	1.3	Continuing Healthcare packages and purchase of Psychiatric Intensive Care Unit beds from independent sector.
Operational Allied Health & Health Sciences	2.7	0.0	(0.1)	2.6	Over-achievement of income and reduction in drug costs, offset by Physiotherapy and Occupational Therapy agency and variable pay.
Planned and Specialist Care	1.7	0.3	(0.4)	1.6	Income overachievement and Oncology drugs underspend, offset by Theatres insourcing and ongoing usage of Medical locums.
Primary Care	(2.3)	0.0	(1.7)	(4.0)	Underspend relating to Dental contracts, General Medical Services supplementary services and delay in cluster projects.
Executive Functions	(10.2)	0.0	(3.9)	(14.1)	Band 2 to 3 pay uplift funding and reduction in Public Health vaccination uptake, offset by Swansea Bay Long Term Agreement Emergency Activity and Estates energy and maintenance contracts.
Sub Total	(5.2)	0.3	(4.0)	(8.9)	
Gross Position				16.1	

Year to Date – Savings Performance Breakdown



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Hywel Dda
University Health Board



Executive Summary

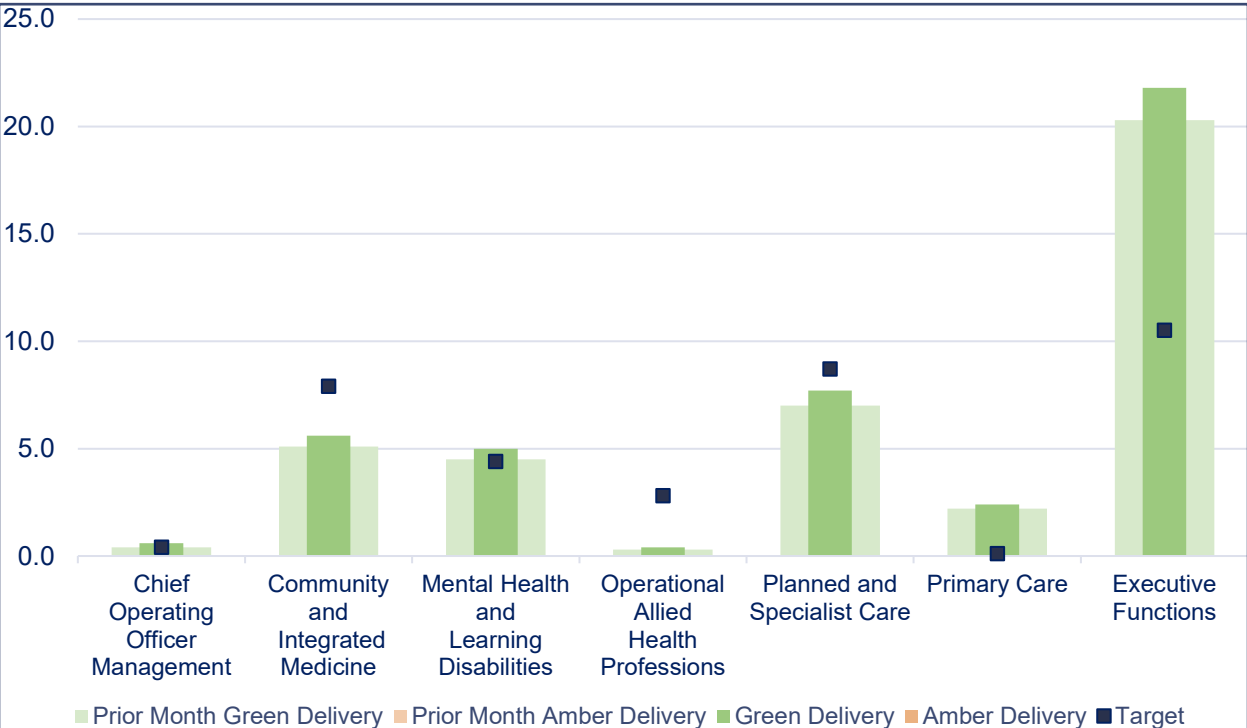
Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 31

Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.4	0.6	0.6	(0.2)
Community and Integrated Medicine	8.8	5.6	5.6	3.2
Mental Health and Learning Disabilities	4.9	5.0	5.0	(0.1)
Operational Allied Health and Health Sciences	3.1	0.4	0.4	2.7
Planned and Specialist Care	9.7	8.0	7.7	2.0
Primary Care	0.1	2.4	2.4	(2.3)
Executive Functions	11.6	21.8	21.8	(10.2)
Grand Total	38.6	43.8	43.5	(4.9)

Key Information

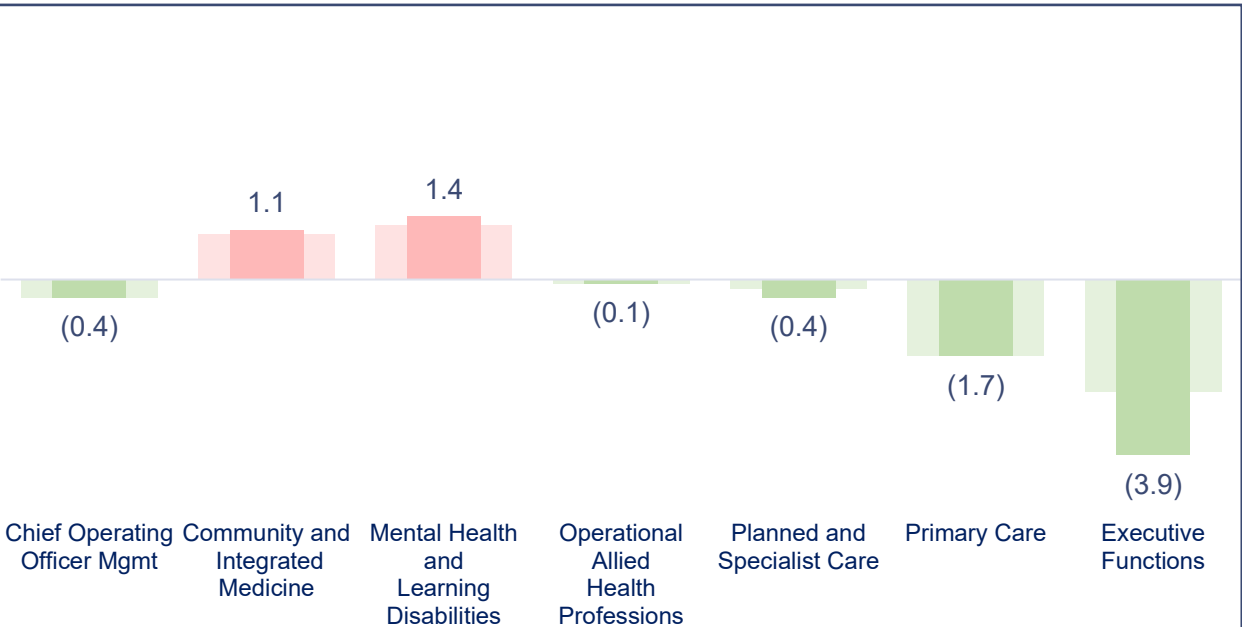
Overall savings delivery of £43.5m has been achieved, resulting in a £(5.2)m savings over-identification against £38.6m target, with variations across Clinical Care Groups, and £0.3m under delivery within Planned and Specialist Care.

This over delivery largely relates to Executive functions, due to pay vacancy underspends and a one-off Aseptic unit system drugs accountancy gain 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)	(0.3)	0.1	(0.4)
Community and Integrated Medicine	(0.5)	2.1	(0.5)	1.1
Mental Health and Learning Disabilities	(0.1)	1.5	0.0	1.4
Operational Allied Health and Health Sciences	1.0	(0.5)	(0.6)	(0.1)
Planned and Specialist Care	1.4	(1.0)	(0.8)	(0.4)
Primary Care	0.4	(3.2)	1.1	(1.7)
Executive Functions	(3.2)	2.4	(3.1)	(3.9)
Total	(1.2)	1.0	(3.8)	(4.0)

Key Information

Community and Integrated Medicine Purchase of disposable consumables due to increased infection prevention control and activity, purchase of insulin pumps, heart monitors, incontinence and Sleep Service products £1.0m. Prior year patient flow invoice £0.7m, and Continuing Healthcare packages £0.2m.

Mental Health High cost Continuing Healthcare packages and purchase of Psychiatric Intensive Care Unit beds from independent sector.

Primary Care Continued underspends relating to Dental due to contracts handed back to the Health Board, General Medical Services supplementary services and delays in Cluster projects.

Executive Functions Recognition of Band 2 to 3 pay uplift funding, income overachievement largely relating to Velindre drugs rebate for Mounjaro costs and reduction in Public Health uptake of vaccination programmes, offset by increase in Emergency activity relating to Long Term Agreements and Estates energy and maintenance contract uplifts.

Capital Performance



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NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 33

Capital

Total Capital Performance

£42.1m



Annual Plan £42.1m

All Wales Capital

£33.7m



Annual Plan £33.4m

Discretionary Capital

£6.5m



Annual Plan £6.8m

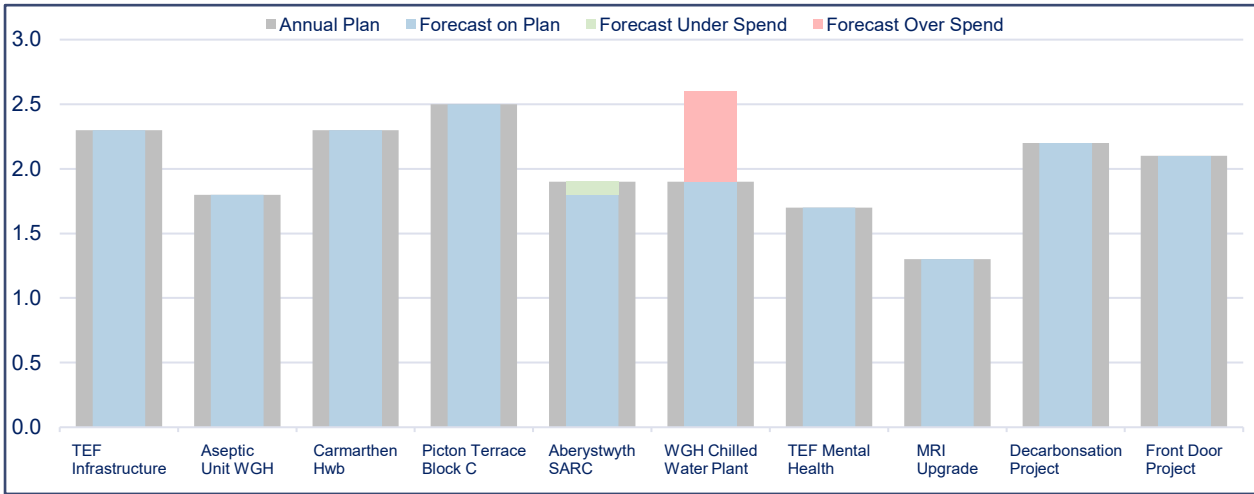
IFRS 16

£1.9m

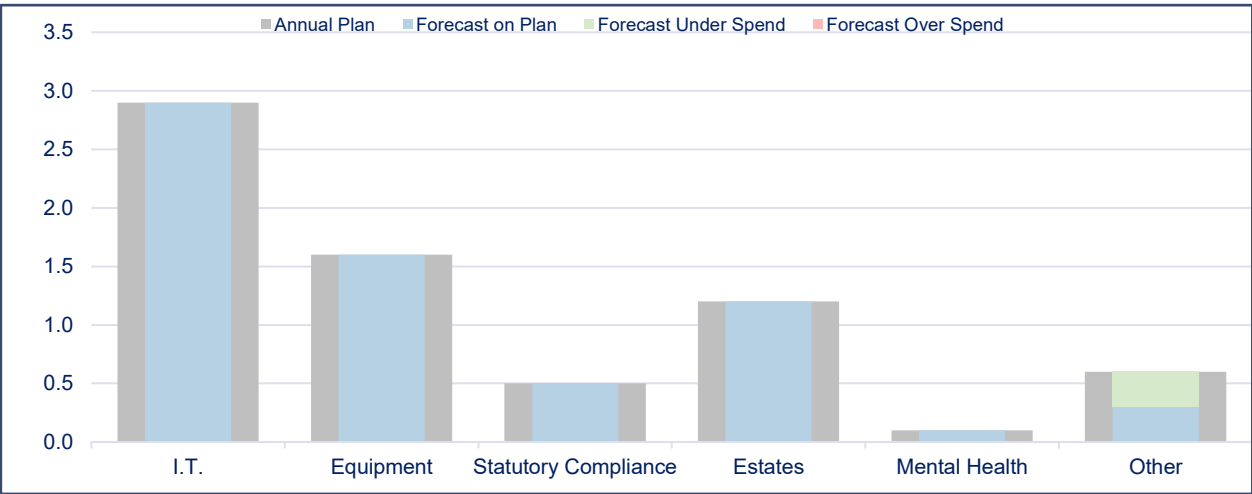


Capital Resource Limit £1.9m

All Wales Capital Programme Top 10 Schemes (£'m)



Discretionary Capital Programme Category Summary (£'m)



Key Information

60% (£24.0m of £40.2m) of capital funding remains 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.

Delivery against the capital programme remains at a medium risk. Due to the significant amount of expenditure forecast for the 2 remaining months of the year, there is a risk to overall delivery of the Capital Resource Limit, in addition to risk of underspends against All Wales funded schemes including, Carmarthen Hwb £0.2m, Aseptic Unit £0.15m and Gamma Camera Upgrade £0.2m. Close monitoring of these risks will be necessary and reallocation of funds where required.

Trend Analysis – Non-Pay and Income



Executive Summary

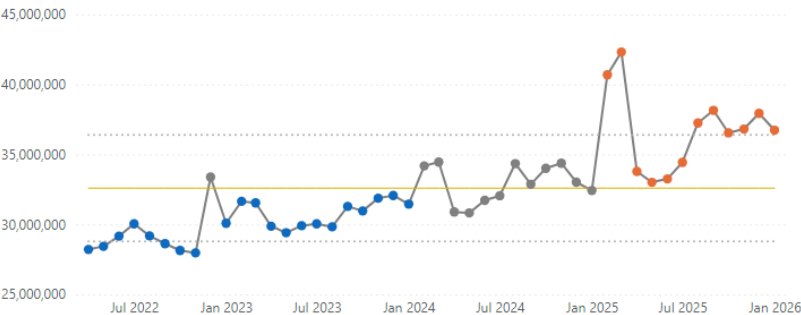
Income and Expenditure
Insights

Operational and
Financial Performance

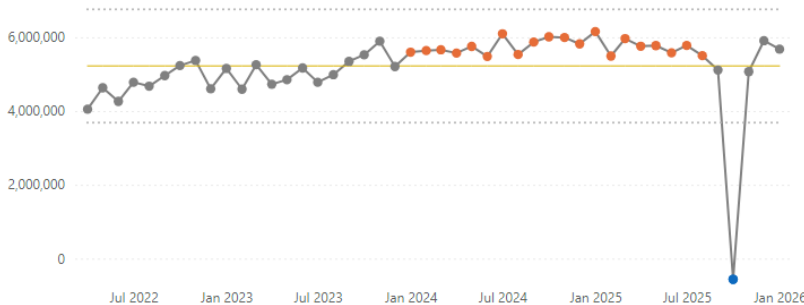
Appendices

Page 34

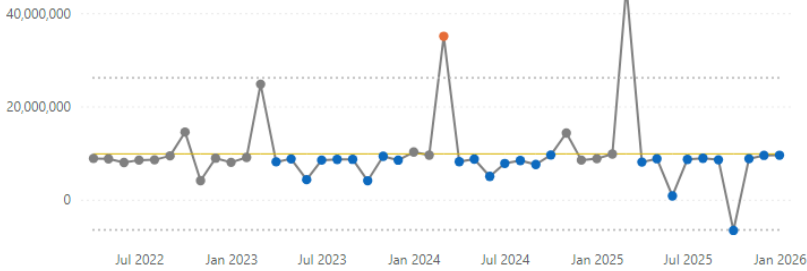
Commissioned Healthcare Services (£)



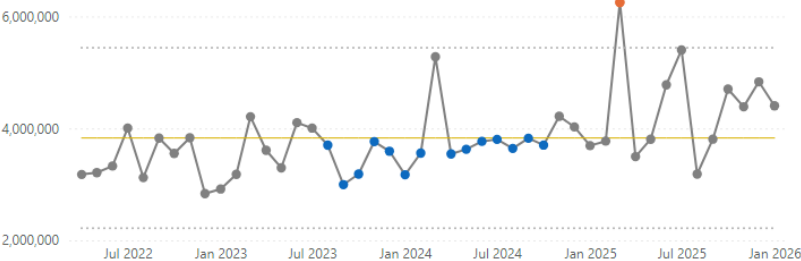
Secondary Care Drugs (£)



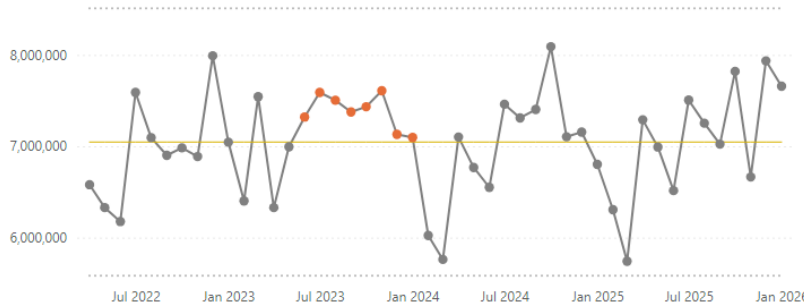
Other Non-Pay (£)



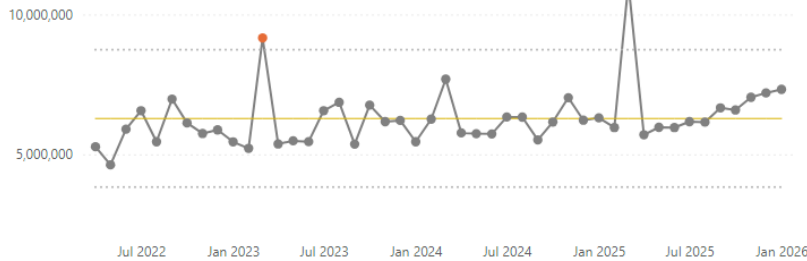
Clinical Services and Supplies (£)



Primary Care Prescribing (£)



Income (£)



Key Information

- Commissioned Healthcare Services** – Year to date Primary Care Dental, Pharmacy and General Medical Services increase in pay uplift expenditure in line with funding recognised in prior month returning to normal levels in-month.
- Secondary Care Drugs** – Aseptic Unit drugs accountancy gain saving in Month 7, with reduction in-month relating to Cancer Oncology Drugs due to price per patient decrease of 19%
- Clinical Services** – Purchases of disposables to support enhanced infection prevention control in prior month returning to normal levels in-month, with a reduction in Radiology Everlight outsourcing.
- Primary Care Prescribing** – Slight reduction from the September PARS price increase of 9 and reduction in drug volumes in-month.

Trend Analysis – Non-Pay and Income



Executive Summary

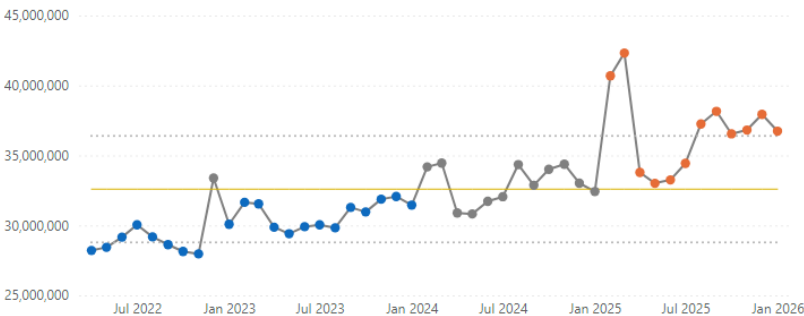
Income and Expenditure
Insights

Operational and
Financial Performance

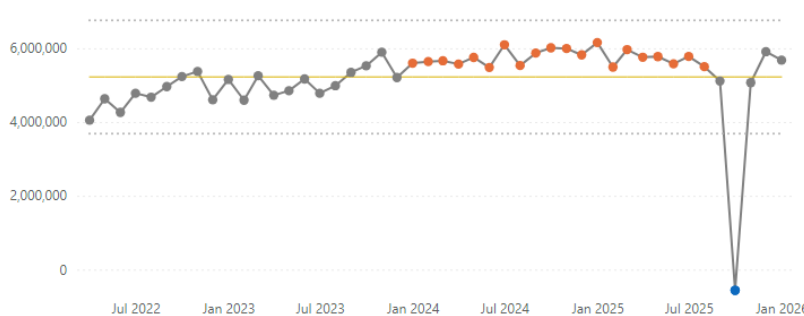
Appendices

Page 35

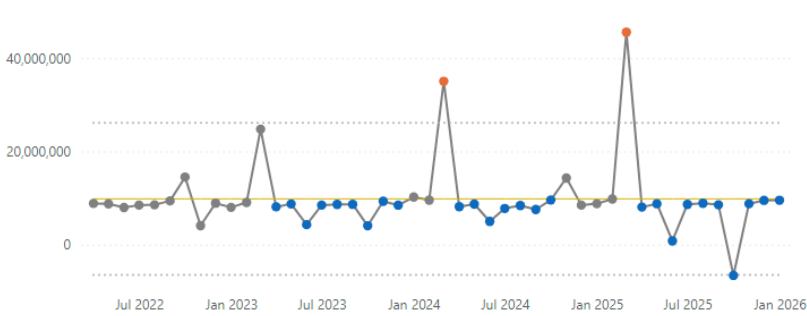
Commissioned Healthcare Services (£)



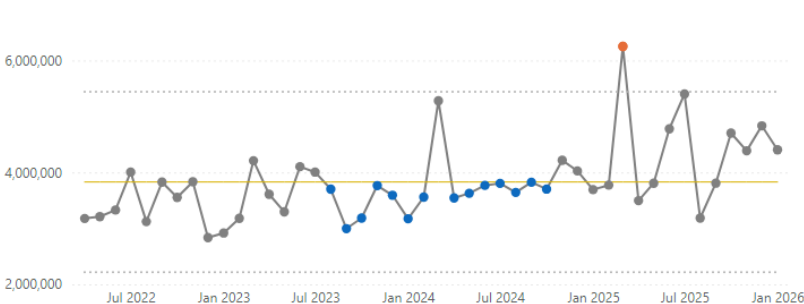
Secondary Care Drugs (£)



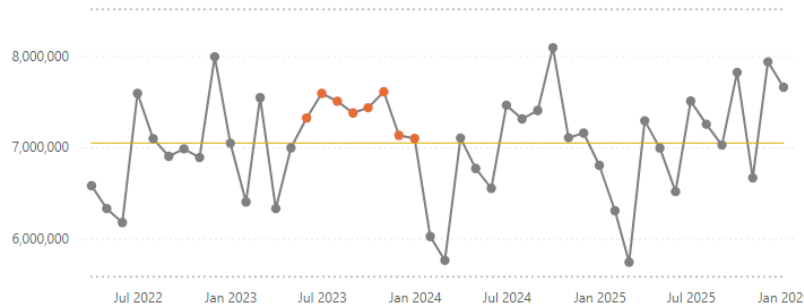
Other Non-Pay (£)



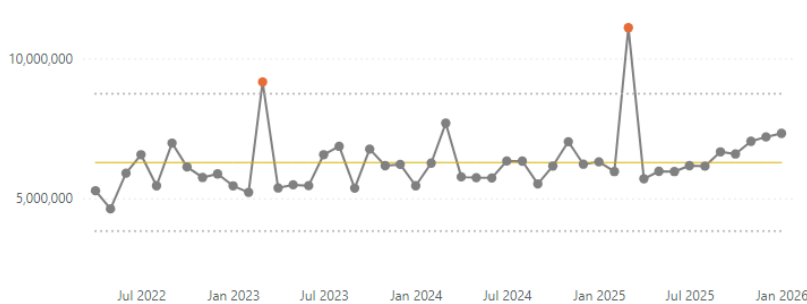
Clinical Services and Supplies (£)



Primary Care Prescribing (£)



Income (£)



Key Information

- Commissioned Healthcare Services** – Year to date Primary Care Dental, Pharmacy and General Medical Services increase in pay uplift expenditure in line with funding recognised in prior month returning to normal levels in-month.
- Secondary Care Drugs** – Aseptic Unit drugs accountancy gain saving in Month 7, with reduction in-month relating to Cancer Oncology Drugs due to price per patient decrease of 19%
- Clinical Services** – Purchases of disposables to support enhanced infection prevention control in prior month returning to normal levels in-month, with a reduction in Radiology Everlight outsourcing.
- Primary Care Prescribing** – Slight reduction from the September PARS price increase of 9 and reduction in drug volumes in-month.

Trend Analysis – Pay Agenda for Change



Executive Summary

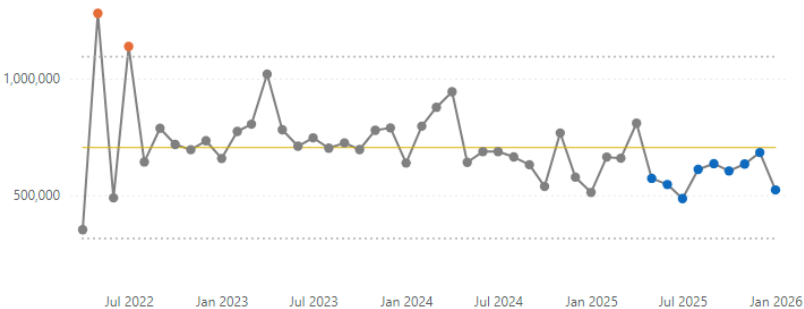
Income and Expenditure
Insights

Operational and
Financial Performance

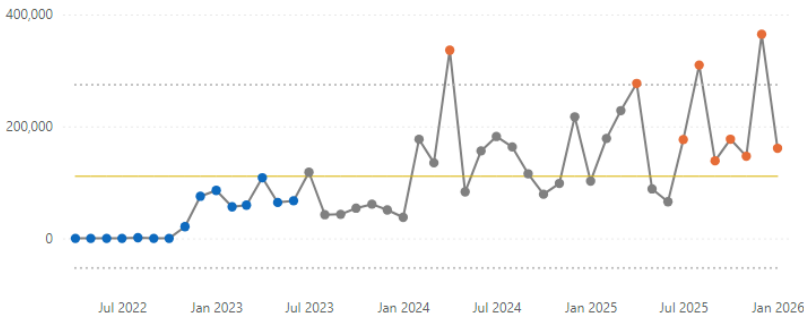
Appendices

Page 36

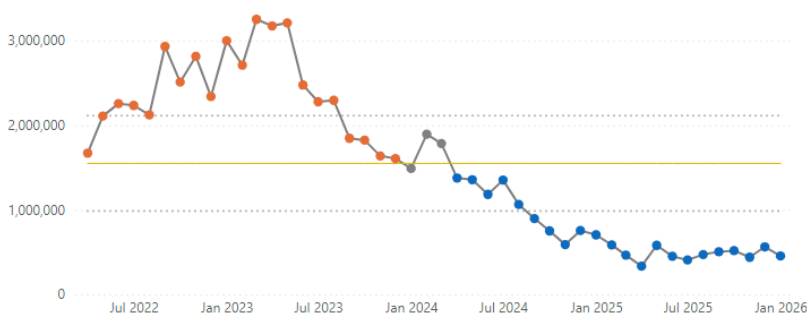
Overtime (£)



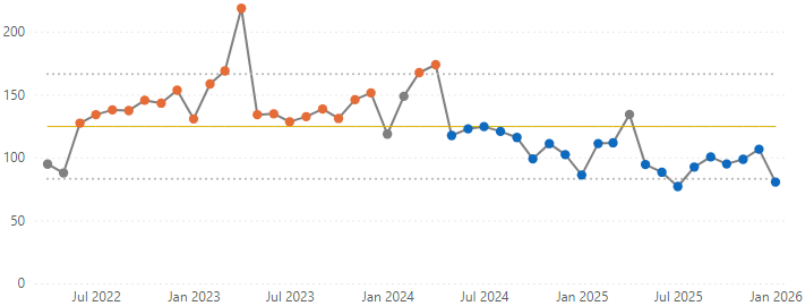
WLI (£)



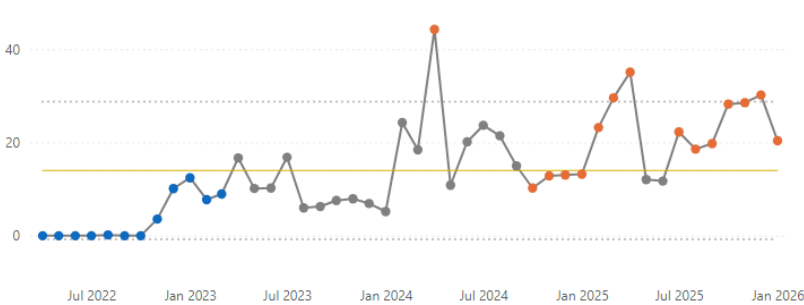
Agency (£)



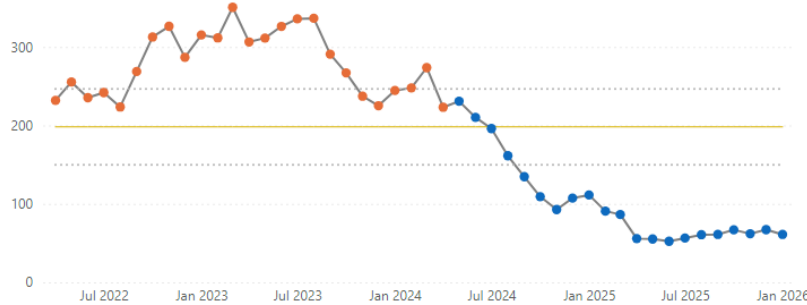
Overtime (WTE)



WLI (WTE)



Agency (WTE)



Key Information

Overtime – Cost reduction of £0.2m within acute sites, Estates and Facilities, Mental Health and Planned and Specialist Care.

Waiting List Initiative – Waiting List Initiative expenditure has reduced from Month 9 by £0.1m in Planned and Specialist Care due to retrospective shifts being paid in prior month.

Agency – Reduction in costs due to inability to fill agency requests within Community and Integrated Medicine, and a reduction in agency shifts within Operational Allied Health.

Trend Analysis – Pay Medical and Dental



Executive Summary

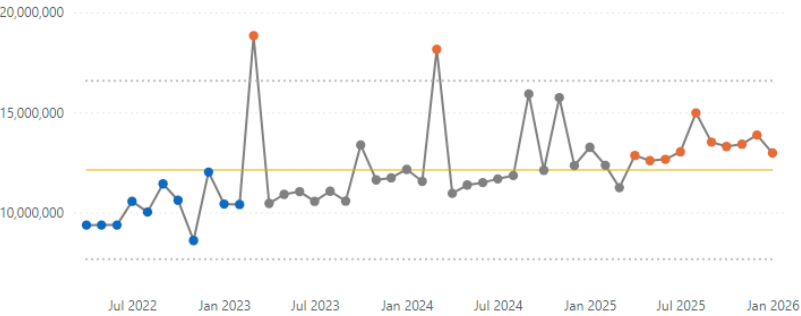
Income and Expenditure
Insights

Operational and
Financial Performance

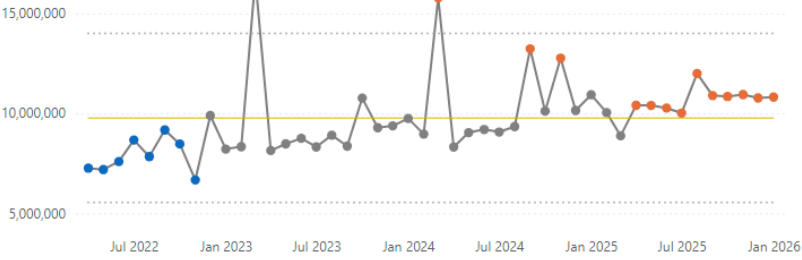
Appendices

Page 37

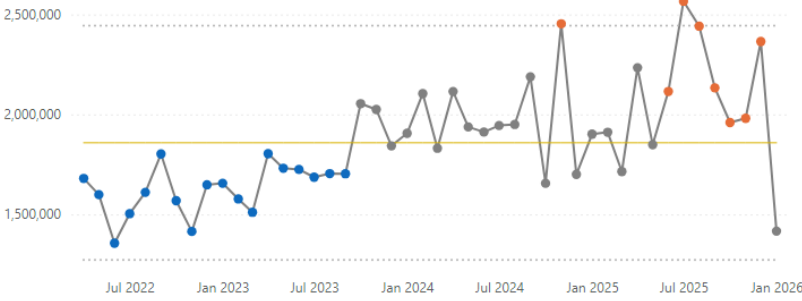
Total (£)



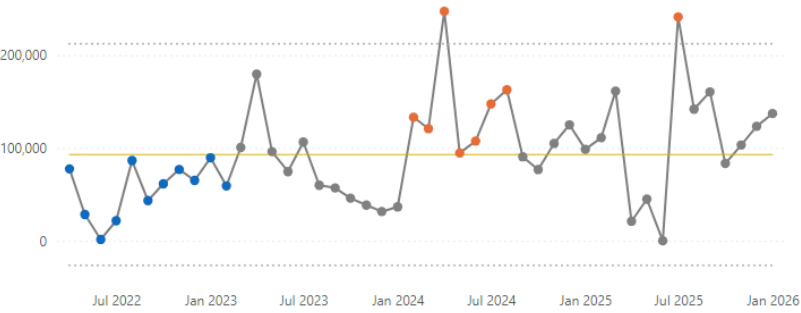
Substantive (£)



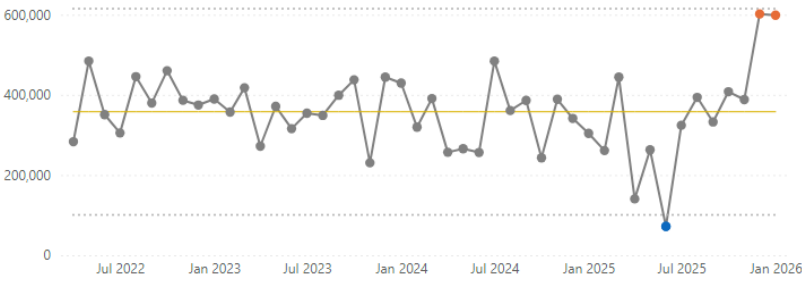
Additional Hours (£)



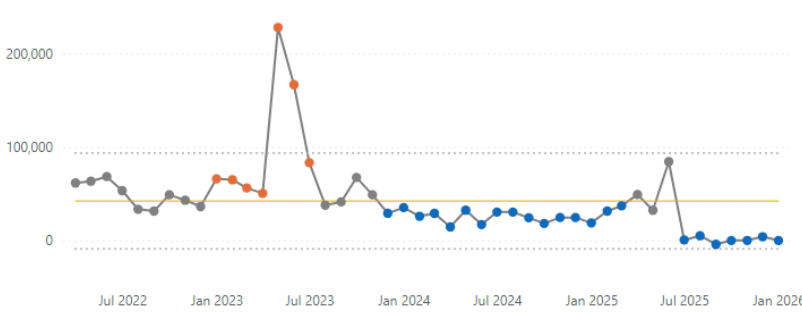
WLI (£)



On Contract Agency Premium (£)



Off Contract Agency Premium (£)



Key Information

- Additional Hours** – Significant decrease in additional hours in-month within Planned and Specialist Care as unable to fill sessions due to sickness, in addition to further reductions across various areas.
- Waiting List Initiative** – Medical Waiting List Initiative expenditure has increased from prior month in Planned and Specialist Care mainly within Anaesthetics due to continued use of Waiting List Initiative Sessions to meet Waiting Time Targets.
- On Contract Agency Premium** – Continuation of premium pay cost increases owing to recovery performance backlog within Scheduled Care, alongside an increased requirement for sickness cover.

Staffing Establishment Reports



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Page 38

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%	2,606	2,296	(292)	253	52	15
Community and Integrated Medicine	103.2%	1,862	1,629	(210)	183	46	20
Carmarthenshire Integrated System	103.5%	1,125	990	(115)	114	20	19
Ceredigion Integrated System	107.5%	321	265	(34)	38	16	20
Pembrokeshire Integrated System	99.4%	416	374	(61)	31	10	(19)
Mental Health and Learning Disabilities	104.7%	287	236	(38)	50	1	13
Planned and Specialist Care	96.6%	457	431	(44)	20	5	(18)
Cancer and Scheduled Care	94.6%	157	143	(28)	8	5	(14)
Children, Women and Family Health	97.6%	300	288	(16)	12	-	(4)
Grand Total	102.2%	2,606	2,296	(292)	253	52	15

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%	88	87	(8)	-	-	(7)
Chief Operating Officer	93.7%	5,202	5,081	(486)	111	8	(363)
Chief Operating Officer Management	81.6%	111	108	(21)	3	-	(17)
Community and Integrated Medicine	97.0%	1,401	1,367	(118)	32	2	(84)
Mental Health and Learning Disabilities	90.3%	912	903	(114)	8	-	(105)
Operational Allied Health and Health Sciences	97.2%	1,114	1,090	(57)	24	-	(32)
Planned and Specialist Care	95.0%	1,445	1,400	(123)	38	6	(78)
Primary Care	87.2%	219	213	(53)	6	-	(47)
Executive Director of Allied Health Professions and Health Sciences	95.2%	880	824	(84)	55	-	(29)
Executive Director of Finance	89.9%	418	413	(60)	4	-	(56)
Executive Director of Nursing, Quality and Patient Experience	90.9%	176	176	(17)	-	-	(16)
Executive Director of Public Health	87.6%	142	141	(20)	-	-	(19)
Executive Director of Strategy and Planning	93.9%	48	48	(3)	-	-	(3)
Executive Director of Workforce and Organisational Development	74.6%	226	225	(75)	1	-	(74)
Executive Medical Director	87.0%	324	324	(31)	-	-	(30)
Grand Total	90.6%	7,504	7,319	(784)	171	8	(597)

In-Month – Revenue vs Plan Variance (£'k)



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 39

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	(1)					13		(35)	(0)	(24)
Chief Operating Officer	(99)	71	519	(167)	546	(39)	(900)	382	(188)	124
Chief Operating Officer Management	37	34	(2)	(1)	(1)	(3)		(63)	(17)	(15)
Community and Integrated Medicine	(125)	(1)	283	(194)	205	(232)	(81)	373	(92)	136
Mental Health and Learning Disabilities	11	(36)	71	(57)	2	233	(1)	(4)	(9)	211
Operational Allied Health and Health Sciences	36	30	(1)	45	80	(24)	(111)	(1)	(62)	(8)
Planned and Specialist Care	(0)	16	134	73	189	171	(724)	23	(93)	(211)
Primary Care	(58)	28	34	(34)	71	(185)	17	53	85	12
Executive Director of Allied Health Professions and Health Sciences	(55)	(14)		(2)	(1)	0	0	(97)	(150)	(319)
Estates and Facilities	(67)			(2)	(1)		0	(97)	(150)	(317)
Executive Allied Health Professions and Health Sciences	12	(14)				0				(2)
Executive Director of Finance	12	6	(18)	(1)		(44)		235	(65)	126
Digital	13	6	(18)	(1)		(36)		239	(64)	138
Finance	(0)					(8)		(3)	(1)	(12)
Executive Director of Nursing, Quality and Patient Experience	(20)	29		(72)	0	(23)		31	35	(21)
Executive Director of Public Health	(31)	13	(3)	(42)	(4)	84	(139)	(197)	(19)	(338)
Executive Director of Strategy and Planning	4	0	0			84	0	(6)	18	100
LTAs with other NHS Providers	4					85	0	(0)		89
Strategy and Planning	(0)	0	0			(1)		(6)	18	12
Executive Director of Workforce and Organisational Development	42	19	(12)	(48)	1	(131)	(3)	(193)	13	(312)
Executive Medical Director	4	(29)	26	20	(12)	11	63	(19)	(402)	(337)
Medical	3	5	26	(13)	1		(0)	(51)	2	(26)
Pharmacy and Medicines Management	1	(34)		33	(13)	11	63	32	(404)	(311)
Health Board Wide	4		(387)	(167)	144	(275)	427	70	(198)	(382)
Planned Deficit								2,500		2,500
Savings Identification								171		171
Grand Total	(140)	95	124	(479)	673	(319)	(552)	2,841	(957)	1,286

Year to Date – Revenue vs Plan Variance (£'k)



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 40

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	(14)				0	1		(71)	(2)	(86)
Chief Operating Officer	(1,589)	421	5,214	(1,724)	2,543	157	(5,916)	1,844	(780)	171
Chief Operating Officer Management	(206)	24	(33)	35	42	(29)		(294)	68	(393)
Community and Integrated Medicine	(1,098)	(71)	1,541	(890)	1,199	276	(574)	1,231	(519)	1,092
Mental Health and Learning Disabilities	(78)	(427)	817	(434)	39	1,759	(277)	(28)	39	1,411
Operational Allied Health and Health Sciences	41	507	179	313	(2)	(317)	(360)	128	(636)	(147)
Planned and Specialist Care	(6)	(21)	2,046	(294)	1,590	1,593	(4,626)	488	(846)	(76)
Primary Care	(241)	409	665	(455)	(325)	(3,126)	(78)	319	1,114	(1,717)
Executive Director of Allied Health Professions and Health Sciences	(610)	(143)	9	(27)	50	0	4	695	(40)	(62)
Estates and Facilities	(730)		9	(27)	50		4	694	(40)	(40)
Executive Allied Health Professions and Health Sciences	120	(143)				0		1		(22)
Executive Director of Finance	(122)	66	(14)	15	0	(421)	0	29	(253)	(700)
Digital	(67)	15	(14)	15	0	(417)		108	(251)	(611)
Finance	(55)	51				(4)	0	(79)	(2)	(89)
Executive Director of Nursing, Quality and Patient Experience	(281)	(42)	0	71	(1)	29		394	103	271
Executive Director of Public Health	(209)	139	(84)	(250)	(42)	36	(630)	(17)	(192)	(1,249)
Executive Director of Strategy and Planning	(15)	41	0			1,296	2	44	(100)	1,268
LTAs with other NHS Providers	35					1,301	2	(2)		1,336
Strategy and Planning	(50)	41	0			(5)		46	(100)	(68)
Executive Director of Workforce and Organisational Development	(55)	2	(14)	67	2	(26)	(26)	(296)	(161)	(507)
Executive Medical Director	(16)	(357)	116	73	29	(49)	571	(316)	(1,290)	(1,239)
Medical	(8)	(7)	116	(78)	19		(0)	(434)	47	(345)
Pharmacy and Medicines Management	(8)	(350)		151	10	(49)	571	118	(1,337)	(894)
Health Board Wide	607		(506)	(1,696)	268	(233)	647	443	(1,125)	(1,594)
Planned Deficit								25,000		25,000
Savings Identification								(5,161)		(5,161)
Grand Total	(2,305)	127	4,720	(3,471)	2,850	789	(5,348)	22,589	(3,839)	16,112

End of Year – Revenue vs Plan Variance (£'k)



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 41

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	(30)				0	2		(58)	(3)	(88)
Chief Operating Officer	(2,037)	409	6,497	(1,985)	3,483	(1,136)	(6,652)	2,459	(985)	54
Chief Operating Officer Management	(298)	(9)	(56)	33	59	(34)		(316)	35	(586)
Community and Integrated Medicine	(1,362)	(44)	2,121	(1,123)	1,401	336	(632)	1,549	(637)	1,608
Mental Health and Learning Disabilities	(100)	(550)	938	(619)	39	1,992	(369)	(20)	56	1,367
Operational Allied Health and Health Sciences	65	591	190	416	198	(360)	(406)	155	(818)	33
Planned and Specialist Care	(13)	10	2,482	(173)	2,151	2,004	(5,187)	608	(949)	934
Primary Care	(329)	411	821	(518)	(365)	(5,073)	(58)	483	1,327	(3,301)
Executive Director of Allied Health Professions and Health Sciences	(630)	(172)	10	(31)	60	0	5	1,014	(251)	6
Estates and Facilities	(773)		10	(31)	60		5	1,013	(251)	33
Executive Allied Health Professions and Health Sciences	144	(172)				0		1		(26)
Executive Director of Finance	(336)	78	(50)	13	0	(495)	0	782	(315)	(323)
Digital	(273)	27	(50)	13	0	(490)		784	(294)	(283)
Finance	(63)	51				(5)	0	(2)	(20)	(39)
Executive Director of Nursing, Quality and Patient Experience	(337)	(53)	0	46	(2)	44		452	121	271
Executive Director of Public Health	(271)	166	(89)	(331)	(50)	43	(621)	(6)	(225)	(1,384)
Executive Director of Strategy and Planning	(58)	41	0			1,881	2	8	(122)	1,751
LTAs with other NHS Providers	43					1,887	2	(3)		1,929
Strategy and Planning	(101)	41	0			(6)		11	(122)	(178)
Executive Director of Workforce and Organisational Development	(142)	(10)	(39)	(155)	3	(19)	(31)	(300)	(182)	(876)
Executive Medical Director	(5)	(480)	173	113	33	(44)	2,717	(359)	(3,224)	(1,075)
Medical	2	3	173	(104)	21		(0)	(513)	47	(371)
Pharmacy and Medicines Management	(6)	(483)		217	12	(44)	2,717	154	(3,271)	(704)
Health Board Wide	618		(507)	(2,029)	217	(197)	488	567	(1,498)	(2,341)
Planned Deficit								30,000		30,000
Savings Identification								(3,895)		(3,895)
Grand Total	(3,228)	(21)	5,996	(4,358)	3,745	78	(4,092)	30,664	(6,684)	22,100

End of Year – Savings Detail (£'k)



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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Executive Summary

Income and Expenditure
Insights

Operational and
Financial Performance

Appendices

Page 42

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	474	84	390	474	(436)	14.0%	222	(184)	6.6%
Chief Operating Officer	32,438	25,179	8,596	16,309	24,905	7,533	3.8%	12,309	20,129	1.9%
Chief Operating Officer Management	500	576	0	576	576	(75)	4.5%	0	500	0.0%
Community and Integrated Medicine	10,565	6,631	2,842	3,788	6,631	3,935	2.7%	2,922	7,643	1.2%
Mental Health and Learning Disabilities	5,851	5,635	1,375	4,259	5,635	216	5.4%	1,375	4,476	1.3%
Operational Allied Health and Health Sciences	3,785	480	480	0	480	3,305	0.6%	494	3,291	0.6%
Planned and Specialist Care	11,638	9,366	3,799	5,294	9,092	2,546	4.3%	7,418	4,220	3.5%
Primary Care	99	2,492	100	2,392	2,492	(2,393)	22.2%	100	(1)	0.9%
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	638	2,315	493	1,822	2,315	(1,677)	10.0%	527	112	2.3%
Digital	532	1,705	384	1,321	1,705	(1,173)	9.9%	417	115	2.4%
Finance	106	610	109	501	610	(504)	10.2%	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	1,720	518	1,202	1,720	182	2.8%	518	1,384	0.9%
LTAs With Other NHS Providers	1,841	940	457	483	940	901	1.7%	457	1,384	0.8%
Strategy and Planning	61	780	61	719	780	(719)	20.9%	61	(0)	1.6%
Executive Director Of Workforce and Organisational Development	247	3,335	247	3,088	3,335	(3,088)	22.0%	247	(1)	1.6%
Executive Medical Director	6,421	2,819	2,440	379	2,819	3,601	2.8%	2,456	3,965	2.4%
Medical	74	74	74	0	74	(0)	1.7%	74	(0)	1.7%
Pharmacy and Medicines Management	6,347	2,745	2,366	379	2,745	3,602	2.9%	2,382	3,965	2.5%
Health Board Wide	2,303	12,486	1,371	11,115	12,486	(10,183)	34.4%	1,485	819	4.1%
Grand Total	46,400	50,295	14,373	35,648	50,021	(3,621)	5.2%	18,429	27,971	1.9%



Professor Phil Kloer
Chief Executive – Hywel Dda UHB

Our Ref: JS
Your Ref:

29 January 2026

Dear Phil,

2025-26 Strategic Cash Support to Hywel Dda UHB

Thank you for your letters dated 5th December 2025 and 7th January 2026, advising Welsh Government of the year-end cash pressures arising as a consequence of your forecast deficit position of £22.1m, I am responding on Jacqueline's behalf.

I am able to confirm the strategic cash support Welsh Government will provide your organisation in 2025-26 will be £22.1m.

It is my expectation that your organisation will continue work to deliver your forecast position.

On the 8 July 2020, the Minister for Health and Social services announced that the accumulated strategic cash only support previously provided by Welsh Government was no longer repayable. The 2025-26 strategic cash assistance must be disclosed in your financial accounts.

Funds will be available to draw from 17 March 2026 following the Senedd supplementary budget process. This is to ensure that the actual support provided reflects the cash support required, not simply the forecast position. You will be able to draw strategic cash up to your organisations Target Control Total immediately.

Please ensure all future monthly monitoring returns provide updates on the actual strategic cash assistance required.

Your request for working capital allocations for capital, revenue and IFRS 16 lease payments have been noted.

If working capital cash needs to be drawn prior to March 2026, please ensure that the type of assistance is detailed on your FIS forms and clearly identified as cash only support. Jacqueline Salmon, Financial Accountant should be informed in writing of your requirement and the circumstances necessitating early call down.

Yours sincerely



Hywel Jones

Cyfarwyddwr Cyllid | Director of Finance

cc

Jacqueline Totterdell DG Health/NHS Chief Executive
Huw Thomas Director of Finance Hywel Dda UHB

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.

4.2 - INVESTMENT, BENEFITS REALISATION AND DISINVESTMENT REPORT

*Sian Jenkins (Hywel
Dda UHB - Deputy
Director of Finance)*

| For assurance

Attachments

[Investment, Benefits Realisation and Disinvestment Report FPC 24 February 2026.pdf](#)

[Appendix 1 Investment Update.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
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:	Siân 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

The Health Board 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 the Health Board's 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 the Executive Team. The intention had been to conclude the review process by early June, however, to ensure robust cases are presented to the 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 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 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 these are being actioned in February payroll. An assessment of actual costs is being worked through with Payroll.

This includes the recognition payment, corrective payment and update of current payment terms going forward. The data shared by Workforce and Organisational Development to realise final payments has reflected a lower whole-time equivalent (WTE) compared to earlier estimates, the financial implications are being worked through.

- Two cases originally included as part of the 2025/26 process are due to be considered through the planning process for 2026/27, namely Health Coaches and Children and Young People Weight Management.

- **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 learning event with Swansea University Value-Based Health and Care Academy 'Building Better Cases for Change in Hywel Dda University Health Board (HDdUHB). A set of standard templates and associated process has been drafted 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. This has been considered within the approach that has been drafted. Once the process has been finalised and formally agreed it can commence.

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 has been reviewed and a refined approach drafted, aiming to standardise the information provided and support service leads in navigating the process of developing cases for change, presenting the associated business implications and subsequent benefits realisation as part of the planning process.

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 Termiau: 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



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University Health Board



Investment and Benefits Realisation Report Appendix

Finance and Performance Committee

24 February 2026

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, required greater clarity ahead of making recommendation, plus affordability challenge given budget available. 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. Plan to be considered as part of 26/27 planning priorities.	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 February update: recognition and corrective payments to be transacted in new year final staff numbers reduced from earlier estimates, final costs being assessed with Payroll.	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. Plan to be considered as part of 26/27 planning priorities, VBHC funding not an option, plan being reviewed in relation to affording the costs through Public Health underspends.	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 committed.	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 - THREE YEAR FINANCIAL PLAN 2026-29

Andrew Spratt
(Hywel Dda UHB -
Deputy Director of
Finance)

| For approval

Attachments

[Three Year Financial Plan 2026-29 FPC 24 February 2026.pdf](#)

[Appendix 1 Financial Plan Assessment 2026-29.pdf](#)

[Appendix 2 Financial Budget Accountability Letter 2026-27.pdf](#)

[Appendix 3 HDdUHB Accountable Officer Letter 13 February 2026.pdf](#)



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Three Year Financial Plan 2026/29 Update
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 Penderfyniad/For Decision

**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, but planning a deteriorating financial deficit compared to the breakeven position for 2027/28 and beyond, which would have been aligned to Welsh Government (WG) Targeted Intervention (TI) criteria and associated £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, risks and financial assessment of the key components of the 2026/29 three-year financial plan, prior to being presented to Public Board in March 2026 and onward submission to WG by 31 March 2026.

Asesiad / Assessment

Welsh Government Funding and Delivery Expectations For 2026/27

The following has been shared as part of the NHS Wales Planning Framework and Financial Allocations, to **align expectations for savings delivery, and manage expectations for investments** and were communicated to the Health Board in December 2025.

Key headlines affecting 2026-27 funding allocations and planning principles and assumptions include:

- Funding for **inescapable demand and unavoidable inflation is 1.11%** for core services and Mental Health services; this equates to £12.8m. It is not to support any discretionary investment
- General Medical Services (GMS) funding for inflationary increases confirmed at 5.8%
- **£43.0m of Conditionally Recurrent funding received in 2023-24 made recurrent**, and a number of fundings streams received in 2025-26 on a non-recurrent basis made recurrent in 2026-27, total £88.3m
- **Re-classification from Ringfence to Non-Ringfence of £24.4m**, including planned care sustainability and recovery funding
- **Capital funding has increased by 12%**, total Discretionally Capital Funding (DCF) is £11.3m
- There is an **explicit expectation that plans are investment free** plans with an expectation of delivering improved productivity, efficiency, outcomes within the same or less resource.
- Disinvestment and choices - As part of savings development, organisations should **rigorously examine the benefits of prior year investments and projects**; and consider dis-investing from projects that have under-delivered on benefits
- Non-recurring savings and the underlying deficit – underlying deficits have been growing, in part driven by recurring cost pressures addressed in-year by non-recurring savings or mitigations. Organisations should **ensure that savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis** and should seek to convert non-recurring savings into recurring benefits
- Plans are to provide clarity and visibility to how substantial savings will be realised in non-core areas and overheads to prioritise front-line services.

Financial Plan Assessment 2026/29

- The forward outlook continues to be challenging, needing to balance financial savings and efficiency improvements to offset above allocation macro-economic price and demographic growth trajectories, all whilst improving health prevention, patient experience, quality, and performance metrics.
- Work on the financial plan has been underway since October 2025. **Appendix 1** details the final draft iteration of the financial plan to enable a submission to the appropriate Committee forums before being presented to Board on 26 March 2026.
- The financial plan contains three financial years; the first time the organisation is preparing to submit a three-year financial plan for several years.
- Whilst the 2026/27 financial deficit is significantly higher than the expected 2025/26 outturn of £22.1m, there are two contributing factors to this; £13.1m 2026/27 Welsh Risk

Pool increase and £7.0m of accountancy gain savings delivered in 2025/26 that will not be available for 2026/27. With these items factored in, the proposed 2026/27 financial deficit is an improvement on the 2025/26 outturn, which could support the TI criteria to demonstrate year on year financial improvement.

- As part of the planning cycle, a series of updates have been presented to the Executive Team. Decisions have been required on how best to prioritise the demographic prevalence modelling implications, and growth has been capped at this rate, being £12.4m. There are a series of service or policy requests that have been deferred, or de-prioritised entirely from the plan, recognising the fine balance required between triangulating quality, performance, workforce and finance.

Update on Long Term Agreements 2026/27

Work on agreeing Long Term Agreements (LTAs) for 2026/27 is underway with a deadline of 27 February 2026 for final agreement. To date all agreements have been agreed with either Hywel Dda University Health Board (HDdUHB) as a commissioner or a provider of services apart from:

- Swansea Bay University Health Board (SBUHB) commissioning agreement – this is not agreed, due to our expectation of the removal of Neurology block elements (£397k). Other issues remain to be worked through on a regional working basis.
- Velindre University NHS Trust Commissioning agreement – agreement was reached in 2025/26 for it to be set at forecast outturn for 2026/27, this is now disputed by Velindre University NHS Trust and escalated to Directors of Finance for agreement.
- Powys Teaching Health Board Provider agreement – this is escalated to Directors of Finance for agreement as Powys Teaching Health Board have requested removal of LTA lines which had nil actual activity in 2025/26 (value of circa £400k).

Savings Proposals to be Confirmed

- It is recognised that the organisation must change the savings approach for 2026/27, due to the ongoing issues experienced where-by savings were not proactively declared resulting in a forecast for each month being lower than the actual savings delivered.
- In 2025/26, the savings target of £46.4m was over-identified, but as at the Month 10 reporting period, £28.8m was non recurrent in nature, primarily through underspend conversions.
- To ensure a clearer and more transparent financial approach for 2026/27, the Executive Team has agreed to the removal of non-recurrent savings from budgets and the conversion of these into recurrent schemes where appropriate.
- Consistent with the principles agreed at Executive Team, each Executive Director and delegated budget holder is asked to rebut any of the 2025/26 non-recurrent savings for assuming into 2026/27. The default will be that continued non-recurrent savings will be removed from budgets and will reduce the total savings requirement upon final submission. This will improve the underlying deficit position, which will be reflected to

WG in the Month 11 2025/25 Monthly Monitoring Return submission, as well as accompanying the final plan submission in the Minimum Data Set.

- The deadline for confirmation from Executive Directors is 17 February 2026, as such, a verbal update will be given to the Committee.

Outstanding Information

There are final submissions pending for certain aspects of the financial plan that were not received prior to this paper being submitted. Whilst these are not expected to be material, it should be noted that any changes will be included in the final financial plan shared with Public Board in March 2026. Notable items still pending include confirmations related to values for LTA's, Service Level Agreements (SLA's), NHS Wales Joint Commissioning Committee (NWJCC) and Digital Health and Care Wales (DHCW).

The final prioritisation of business cases included within the £12.4m prevalence modelling will also be updated once profiling of expenditure is confirmed. The make-up of the total savings requirement requires finalisation once budget reductions have been committed to for non-recurrent savings. A total of £47.5m of savings or budget reductions will not change however, but the final savings figure will be less than £47.5m.

Within the £12.4m prevalence modelling, business case scrutiny will be required via a similar process to the one reported to this committee throughout 2025/26. Whilst broad plans support each element, the normal full business case robust scrutiny process has not been conducted for all as yet and will need to follow. Should these elements not advance through the scrutiny process, in-year decisions will be required to confirm an appropriate action course.

Risks Contained Within the Financial Plan

There are five key risks contained resulting from the financial plan, these are explained as follows and are all contained within **Appendix 1**:

1. Welsh Government no longer allocating the £26.0m conditionally recurrent funding due to the plan breaching the criteria set as part of the conditions, namely, to breakeven financially in 2027/28. This has been assumed as recurrent in the financial plan, with the risk being that it could worsen the underlying deficit if this was changed to non-recurrent, or worse, this not being allocated at all and the full £26.0m deteriorates the financial deficit. It is expected that this would only impact 2027/28 onwards, however.
2. An estimate of a significantly increased Welsh Risk Pool risk share agreement has been included, which signals a material deterioration in the financial deficit compared to 2025/26, which could result in the Health Board not achieving its targeted intervention criteria.
3. The scale of the rebuttable non-recurrent savings might not fully alleviate the budget reductions required to continue to deliver a similar level of savings as experienced by the non-recurrent savings in 2025/26. This then gives rise to a further risk that the scale of new savings could further increase above the £19.0m currently assumed, which is not supported by an evidenced track record.

4. There is a significant quantum of mitigating actions that are requiring management action prior to the start of the new financial year.
5. Quality, safety and performance risks are presented within the broader planning document, recognising a prioritisation process has been required to curtail the financial implements and bring realism to the resources the Health Board is capable of onboarding, particularly over the first year of the three-year plan. Operational plans were to split performance implications and trajectories based on core capacity (what we could deliver within the agreed budgets) and additional capacity that would need to await further funding from Welsh Government prior to committing, which is assumed to be outside of the proposed financial plan.

Draft Accountability Letter

Appendix 2 sets out the proposed Accountability Letter for review, which will be cascaded from the Accountable Officer (Chief Executive Officer) with delegated officers on 2 March 2026, for signing by 31 March 2026. The letter will be issued to Executive Directors and their immediate deputies covering one lead for each Clinical Care Group or Executive Function.

Accountable Office Letter

Appendix 3 sets out the Accountable Officer letter sent to the Director General, NHS Chief Executive, Health, Social Care, and Early Years Group of Welsh Government, to confirm that the Health Board will not be able to submit a financial balanced IMTP.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **ACKNOWLEDGE** that the Health Board is proposing to submit a Three-Year Financial Plan, which breaches its statutory duties to financially breakeven over a three-year period;
- **ACKNOWLEDGE** and **SCRUTINISE** that the Health Board is proposing to submit a deteriorating financial deficit, and one that does not achieve breakeven by 2027/28, which will fail to meet the de-escalation criteria set out as part of Targeted Intervention, which also places a risk on £26.0m of assumed conditionally recurrent funding;
- **DISCUSS** and **SCRUTINISE** the income and expenditure modelling and decisions as part of the financial assessment for the 2026/29 Financial Plan;
- **DECIDE** whether the aspirations as set out are sufficient to gain Board approval in March 2026 when the final version of the financial plan is submitted for approval;
- **ENDORSE** the approach being taken to recognise underspends on a recurrent basis and the method of allocating savings targets to functions;
- **SCRUTINISE** the progress of savings actions to bridge the recurrent savings target and minimise any conversion loss from idea phase to robust deliverable plan;
- **APPROVE** the Financial Plan Accountability Letter 2026-27, for the Accountable Officer (Chief Executive Officer) to share with delegated officers on 2 March 2026, for signing by 31 March 2026;
- **APPROVE** the onward delegation and allocation of 2026/27 budgets based on Year 1 of the financial plan, **NOTING** the ongoing approach required for non-recurrent savings conversion to recurrent, potential savings aspiration changes, and business case

scrutiny being required for all items included within the £12.4m demand prevalence increases;

- **NOTE** the outstanding confirmations related to values for Long Term Agreements, Service Level Agreements, NHS Wales Joint Commissioning Committee and Digital Health and Care Wales; and
- **NOTE** the Accountable Officer letter that has been sent to Welsh Government on 13 February 2026.

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
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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
Partion / 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



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Three-Year Financial Plan 2026/29 Finance and Performance Committee

24 February 2026

- 1 Background and context
- 2 Principle components and approach
- 3 Key principles and assumptions
- 4 Draft financial plan assessment
- 5 Financial components
- 6 De-prioritisations and risks



- 1** **Background and context**
- 2** Principle components and approach
- 3** Key principles and assumptions
- 4** Draft financial plan assessment
- 5** Financial components
- 6** De-prioritisations and risks

Background and context



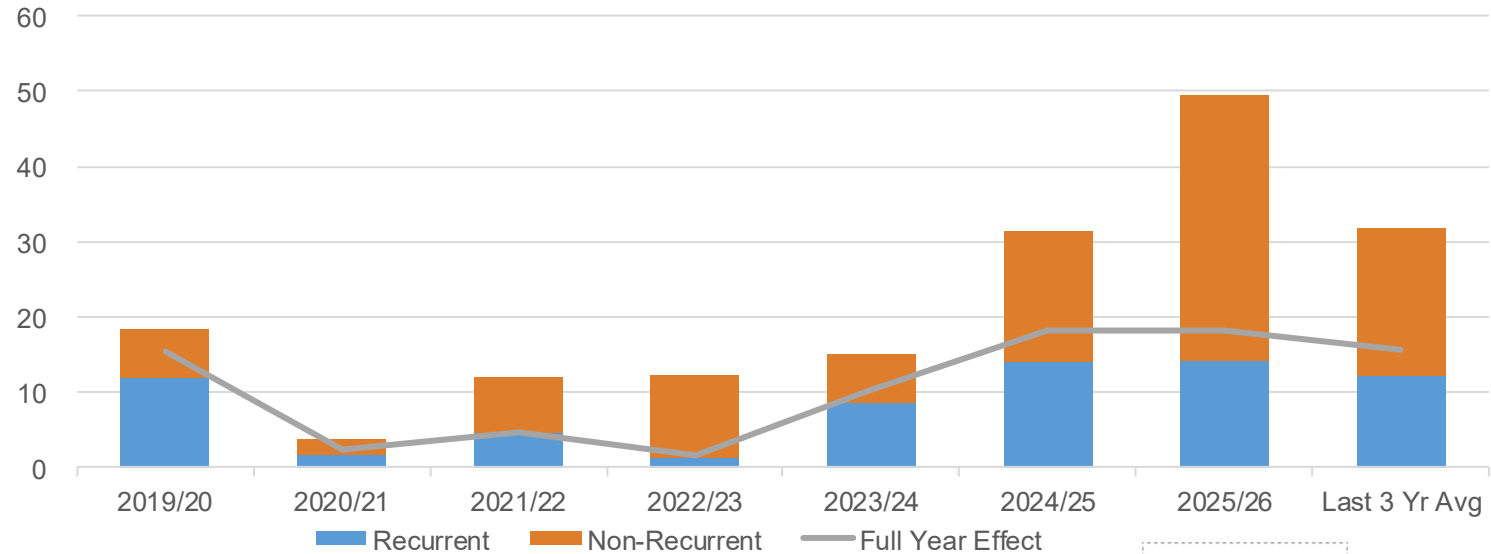
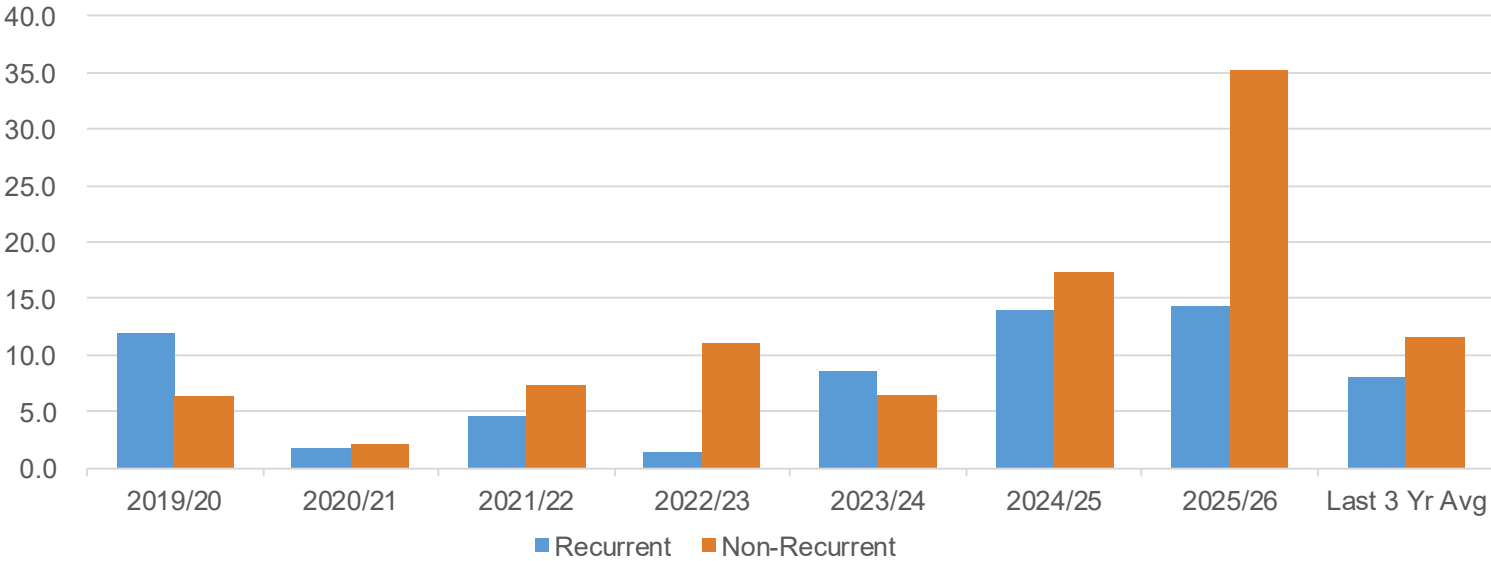
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- The Health Board has a **revised annual plan deficit of £30.0m for 2025/26**, which is an improvement on the original annual plan deficit of £31.5m. Whilst this achieved the target control total set in 2024/25 of £31.5m, **Welsh Governments expectations 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 for Finance, with a criteria to deliver breakeven by 2027/28. Significant change is required to meet this expectation, clearly set out by Welsh Government, and links to £26.0m conditionally recurrent funding;
- With challenges to deliver annual plans in the post pandemic era, 2024/25 and 2025/26 have reversed this trend with a reframed approach to internal escalation and accountability management;
- The Health Board is proposing to submit a Three-Year Financial Plan for 2026-29, but not an IMTP.

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 M10, and after the original plan was improved from £31.5m

Savings Deliverability Assessment (£'m)



- 2025/26 Savings are as at Month 10 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
- The **last two years have improved** with full year effect of recurrent schemes to c.£20m

Key milestone deadlines



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Item	Deadline	Delivery Owner
Executive Team sign-off of financial approach and assumptions	15/10/2025	Formal Executive Team
F&PC 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
Welsh Government (WG) core funding uplift confirmed	19/12/2025	Welsh Government
First Draft – F&PC review of Financial Plan	16/12/2025	Huw Thomas and Executive Leads
DOF review of macro economic cost review / Opportunities / Savings framework	16/01/2025	Huw Thomas and Senior Finance team
EITS/Escalation meetings, focusing on Plans and Savings	Jan/Feb 2026	Lead Exec, Service Lead, Finance, Exec Reps.
Touch Point meeting with Welsh Governance Finance team	★ 03/02/2026	Hywel Jones, Claire Green, Huw Thomas
Second Draft – Executive Team review of Financial Plan before F&PC	04/02/2026	Huw Thomas and Executive Leads
Accountable Officer Letter to be submitted to WG	13/02/2026	Chief Executive – Accountable Officer
Second Draft – Finance Plan presented to F&PC for assurance review, including savings progress from service areas. If F&PC have endorsed, budgets will be entered onto the ledger by the Finance team	24/02/2026	Huw Thomas and Executive Leads
Internal accountability letters issued to delegated officers	02/03/2026	Phil Kloer and Finance Team. 31/03/26 deadline
Profiling or mix changes of budgets confirmed by delegated officers	13/02/2026	Delegated officers
Annual Plan presented to Board for approval	26/03/2026	Executive Team
Annual Plan and supporting templates submitted to WG	31/03/2026	Lee Davies

- 1 Background and context
- 2 Principle components and approach**
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Planning Cycle Methodology and Owners



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Key elements to deliver planning aspirations

Ownership

Business Case Development to Delivery

Financial payback or resource shift detail evidenced

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

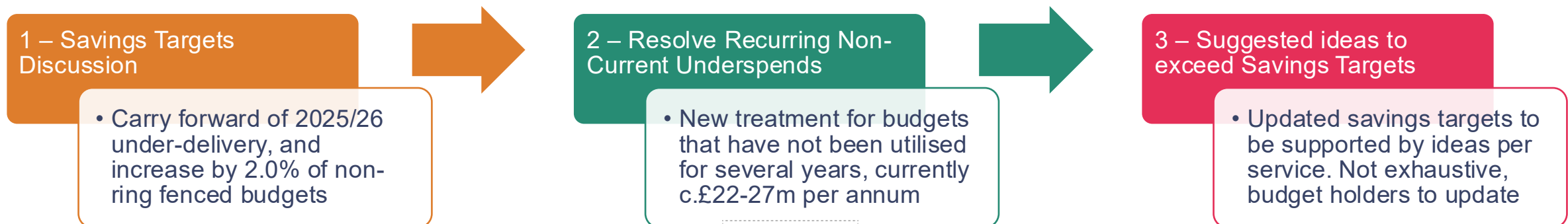
Financial Plan 2026/27 Savings Approach



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- The initial WG allocation letter has confirmed macro economic funding of 1.11% with confirmation Pay Awards will be funded in full;
- A savings target will be required to cover, as a minimum, over and above the 1.11% funding, for 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.



Principle Components and Approach



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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.



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

Budget delegation approach



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- Further refinement of the approach that was reviewed with Swansea Bay as part of the finance regional working to better align the requirements described within the budget delegation approach from 2025/26
- Proposed to conclude in advance of the new financial year and a window for engagement and profile/mix changes
- Finance & Performance Committee (February) and Board (March) will seek to endorse and then approve delegation of budgets



- 1 Background and context
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- **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);
- 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



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- The Health Board will be submitting a **Three-Year Financial Plan**, aspiring to a breakeven position by 2027/28;
- The Welsh Government allocation has confirmed funding for macro and inflationary cost pressures of 1.11%;
- Assessments included in 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. 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 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.

Key focus areas for budget setting



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- **Pay cleansing** – to update cost centre and band discrepancies within existing budgets (actual vs budget misalignments), 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 agency 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 savings** – 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 and non-recurrent conversions opportunities;
- **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.

- 1 Background and context
- 2 Principle components and approach
- 3 Key principles and assumptions
- 4 **Draft financial plan assessment**
- 5 Financial components
- 6 De-prioritisations and risks

Underlying deficit assessment



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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 10)	£'m
2025-26 Planned Deficit	30.0
Savings gap / (improvement)	(3.9)
Under / (Over) delivery of savings schemes	0.3
Core operational variation	(4.3)
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 gains	7.0
Add net non-recurring unplanned pressures / (gains)	1.6
2025/26 Planned Underlying deficit	58.5
2025/26 carried forward recurrent savings gap	0.6
Underlying deficit at 31 March 2026 (MMR M9)	59.1
Add recurrent cost pressures	2.0
Less recurrent funding	(2.7)
Underlying deficit c/f into 31 March 2026	58.4

Three-year financial plan summary

The draft 2026/29 financial plan is below, including the additional impact for Welsh Risk Pool. WRP excluded on last row:

Ref	2026/27 Financial Plan Assessment (£'m)		Year 1 2026/27			Year 2 2027/28			Year 3 2028/29		
			Rec	Non-Rec	Total	Rec	Non-Rec	Total	Rec	Non-Rec	Total
	Underlying deficit carried forward		58.4	-	58.4	69.4	-	69.4	59.6	-	59.6
1	Macro-economic inflation price modelling		10.7	-	10.7	9.0	-	9.0	9.1	-	9.1
2	Contractual or unavoidable (incl. WRP)		19.7	-	19.7	6.5	-	6.5	7.0	-	7.0
3	Prevalence, Quality and Outcomes	Volume & mix growth modelling	3.0	-	3.0	2.4	-	2.4	2.4	-	2.4
4		National pre-commitments	0.3	0.2	0.5	0.0	1.1	1.1	0.0	1.1	1.1
5		Planning cycle priorities	5.8	-	5.8	8.6	-	8.6	3.3	-	3.3
6		Local pre-commitments	1.1	-	1.1	1.8	-	1.8	-	-	0.0
7		Assessment cap of £12.4m	2.2	(0.2)	2.0	(0.4)	(1.1)	(1.5)	6.7	(1.1)	5.6
8	WG allocation funding / anticipated funding		(12.8)	-	(12.8)	(18.7)	-	(18.7)	(18.0)	-	(18.0)
9	Remove non-recurrent underspends		-	(28.5)	(28.5)	-	(28.5)	(28.5)	-	(28.5)	(28.5)
	Additional 2% savings requirement		(19.0)	-	(19.0)	(19.0)	-	(19.0)	(19.0)	-	(19.0)
Financial Deficit including the WRP impact			69.4	(28.5)	40.9	59.6	(28.5)	31.1	51.1	(28.5)	22.6
Financial Deficit excluding the WRP impact			56.4		27.8	44.6	(28.5)	16.1	34.1	(28.5)	5.6



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1. Macro-Economic Inflationary Price Modelling



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Investment Description (£'m)	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Secondary Care Drugs	1.1	1.1	1.1	Community and Integrated Medicine increase in price per issue of £1.97, 5.45% increase
Primary Care Prescribing	1.4	1.4	1.4	CAT M 2.2% (0.04p) increase on August Price, Baseline (0.34p) 1.6% increase on August Price
Continuing Health Care (CHC)	3.5	2.8	2.9	Based 5.5% and 2.6% FNC increase in price, 27/28 4.2% (with 2% national) and 2% FNC, 28/29 4.2% (with 2% national) and 2% FNC.
General Non-Pay Inflation (CPI)	2.5	2.0	2.0	Based on a 2.6% average CPI Inflation for 2026/27
Energy and Fuel	0.5	0.3	0.3	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	0.5	0.2	0.2	Mainly Digital and Waste Contract increases above CPI inflation
Medical and Agenda for Change Pay Award vacancy uplift	1.2	1.2	1.2	WG only fund staff in post, not vacancies. Vacancy element of 2025/26 pay award is an impact to the financial plan.
Total	10.7	9.0	9.1	

2. Contractual or Unavoidable



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Investment Description (£'m)	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
JCC Price	1.6	1.6	1.6	1.1% inflation increase as per WG inflation funding expectation, awaiting formal notification from JCC
JCC Investments	1.6	-	-	JCC investments under discussion, latest expectation is an increase of 1.1% for year 1, no year 2 and 3 investments update given
LTA / SLA uplift - Healthcare Services provided by Wales NHS	0.4	0.6	0.6	1.1% inflation increase as per WG inflation funding expectation
LTA / SLA NHS Wales Investments	0.2	-	-	Increase in Radio pharmacy Swansea Bay SLA
Uplift – Healthcare services provided by non Welsh NHS	0.0	0.0	0.0	Increase in English NHS and private providers
Uplift - DHCW	0.4	0.7	1.1	Based on schedule received from DHCW
Uplift - NWSSP	0.8	0.1	0.1	ESR, Oracle and Allocate e-rostering uplift in contract price
NICE High-Cost Horizon Drugs	1.6	1.6	1.6	Haematology, cancer and acute adoption of drugs
Welsh Risk Pool	13.1	1.9	2.0	NWSSP estimate of £16.3m offset by £3.2m recurrent budget available for WRP, awaiting final schedule from NWSSP
Total	19.7	6.5	7.0	

3. Volume and Mix Growth Modelling



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Investment Description (£'m)	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Secondary Care Drugs	1.4	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 2025/26 growth levels
Continuing Health Care (CHC)	-	-	-	No growth expected
Energy and Fuel	-	-	-	No growth in volume consumption anticipated
Medical and Agenda for Change spine point changes	1.6	1.0	1.0	WG do not fund spine point changes / incremental drift as part of pay award – modelled based on Payroll demographic as at November 2026
Total	3.0	2.4	2.4	

4. National Pre-Commitments



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Investment Description (£'m)	Recur / Non-Recur	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Pathology Laboratory Information Management System (LIMS)	Non-Recur	0.2	0.2	-	-	Based on latest LIMS development plan schedule from DHCW dated May 2025
Pathology Laboratory Information Management System (LIMS)	Recur	0.2	0.2	-	-	Based on latest LIMS development plan schedule from DHCW dated May 2025
Radiology Informatics System Procurement (RISP)	Recur	0.1	0.1	-	-	Based on latest schedule from DHCW
Future Workforce Solution update	Non-Recur	1.1	0.0	1.1	1.1	ESR Replacement system Implementation – system implementation costs
Total		1.6	0.5	1.1	1.1	

5a. Planning Cycle Priorities – Prioritised



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Investment Description (£'m)	Recur / Non-Recur	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Emergency & Urgent Care (EUCC)	Recur	0.6	0.6	-	-	EUCC provision at BGH. Agreed at Formal Executive Team 12.11.25
UEC Streaming Hub	Recur	1.5	1.1	0.4	-	Presented at Public Board 29.01.26, part year impact
UEC WGH SDEC	Recur	2.4	1.2	1.2	-	Presented at Public Board 29.01.26, due to start October 2026
UEC BGH SDEC	Recur	1.1	-	1.1	-	Presented at Public Board 29.01.26
UEC GGH SDEC	Recur	2.8	-	-	2.8	Presented at Public Board 29.01.26
Radiology Ultrasound & Everlight	Recur	4.4	1.7	2.7		Risk (797) to the ability to deliver ultrasound services across sites, recommendations from SBAR Apr 25
Sub-Total		12.8	4.6	5.4	2.8	

5b. Planning Cycle Priorities – Partially Deferred



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Investment Description (£'m)	Recur / Non-Recur	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Theatres (GGH & WGH) Nurse Staffing Levels (NSL)	Recur	2.4	1.2	1.2	-	Impact of NSL review on Theatres GGH & BGH, deferred by 6 months to start in October 2026
Dermatology Services	Recur	0.8	-	0.8	-	No substantive consultant or clinical lead; 22% skin cancer increase from prior year; reliant on insourcing and outsourcing, service needs to stabilise. Deferred by 1 year
Hearing care: Audiology services	Recur	1.0	-	0.3	0.3	Business Case with CCG; WG audit recommendation. Deferred by 1 year
Dietetics Paediatric Service	Recur	0.5	-	0.2	0.2	Risk (1603) of delayed response and breach of waiting time targets due to increased referrals for children eating disorders over and above funded baseline. Deferred by 1 year
Dietetics Adult Service	Recur	0.5	-	0.5	-	Risk (2169) of reduced quality, effectiveness of services for those with complex obesity with associated delay in subsequent treatment pathways. Deferred by 1 year
Podiatry Consumables	Recur	0.2	-	0.2	-	Risk (2041) of harm to service users of Podiatry & Surgical Appliances due to inability to see new patients in a timely way. Deferred by 1 year
Sub-Total		5.4	1.2	3.2	0.5	
Total		18.2	5.8	8.6	3.3	

6. Local Pre-Commitments



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Investment Description (£'m)	Recur / Non-Recur	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Linear Accelerating Machines (Swansea Bay)	Recur	1.0	0.3	0.7	-	Assumes 50/50 of 5th Linac business case with SBU, business case approved in principle, 6 th /7th plans in progress.
Reduction in revenue costs – Glien House, St Annes, St Davids Park	Recur	(0.4)	(0.4)	(0.0)	-	Reduction in revenue costs due to closures of existing premises as services move to Cams HWB & Picton Terrace, £49k in 27/28.
Carmarthen HWB gross running costs	Recur	0.8	0.4	0.4	-	£417k additional in FY27-28 to support new site
Picton Terrace gross running costs	Recur	0.1	0.1	-	-	Additional full-year effect funding over and above £253k previously funded in FY25-26
Pentre Awel gross running costs	Recur	0.3	-	0.3	-	£279k additional in FY28 to support new site, £0.3m funded in FY26
Cams HWB / Picton Terrace parking	Recur	0.2	0.2	-	-	Additional parking costs with the relocation of Corporate offices
Hydrotherapy pool at Pentre Awel	Recur	0.0	0.0	-	-	Running costs of Hydrotherapy pool at Pentre Awel £40k
BGH & GGH Fire Wardens	Recur	0.4	0.3	0.1	-	Investment approval panel June 2025
RAAC WGH & BGH	Recur	0.1	0.1	-	-	Additional Estates and Facilities resource costs directly linked to managing the RAAC risk via ongoing inspections, c£70k pa
Security Officers	Recur	0.1	0.1	-	-	4x Band 4 posts to align to regulations, Exec Team approved. £39k year 2.
Respiratory Panel	Recur	0.3	-	0.3	-	WG withdrawal of support for the Respiratory Panel
Total		2.9	1.1	1.8	-	

7. Prevalence



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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	

7. Prevalence – Further Considerations



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- 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.

8. Welsh Government Allocation Headlines (1 of 2)



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Welsh Government Allocation letter for 2026-27 was received in December with key headlines aligned to savings delivery and to manage expectations for investments:

1. All health bodies will **need to make significant savings** and cost mitigations in order to deliver and implement financially sustainable plans
2. New additional funding is to support **inescapable demand and unavoidable inflation**. It is to be utilised for this purpose only and **not to support any discretionary investment**
3. Disinvestment and choices - As part of savings development, organisations should rigorously examine the benefits of prior year investments and projects; and consider **dis-investing from projects that have under-delivered on benefits**
4. Non-recurring savings and the Underlying Deficit – Underlying deficits have been growing, in part driven by recurring cost pressures addressed in-year by non-recurring savings or mitigations. Organisations should ensure that **savings and mitigations delivered in 2025/26 are maintained in full on a recurrent basis** and should seek to convert non-recurring savings into recurring benefits
5. Plans provide clarity and visibility to how substantial savings will be **realised in non-core areas and overheads** to prioritise front-line services

8. Welsh Government Allocation Headlines (2 of 2)



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Key Funding Changes affecting 2026-27 budgets:

1. Welsh Government funding of **cost and inflationary growth is 1.11%**
2. GMS funding for inflationary increases confirmed at 5.8%
3. New funding total of £23.0m
4. **£43.0m of Conditionally Recurrent funding received in 2023-24 made recurrent**, and a number of funding streams received in 2025-26 on a non recurrent basis made recurrent in 2026-27, total £88.3m
5. **Re-classification from Ringfence to Non Ringfence of £24.4m**, including Planned care sustainability and recovery funding,

8a. FY26-27 Allocation Funding rollover

Breakdown below of the movement in Allocation Funding from FY25-26 to FY26-27

Funding (£'m)	Recurrent	Non- Recurrent	Total	Additional Comments
25/26 Allocation Funding brought forward	1,186.4	134.6	1,321.0	
Add: New funding confirmed in FY26-27	21.5	-	21.5	Confirmed via allocation letter
Less: Funding not anticipated to continue	0.0	(16.8)	(16.8)	
Recurrent re-classification of funding	85.4	(85.4)	0.0	
26/27 Allocation Funding	1,293.3	32.4	1,325.7	

8b. Funding uplift assumptions



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Core and Ringfenced allocation – New allocations (£'m)	Recur / Non-Recur	FYE Impact	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Core Cost and Demand Uplift 2026/27	Recur	11.7	11.7	16.1	15.5	1.11% inflation funding 2026-27
Mental Health Services Core Cost and Demand	Recur	1.1	1.1	2.6	2.5	1.11% inflation funding 2026-27
Additional allocation Sub-Total		12.8	12.8	18.7	18.0	
GMS 2026/27 agreement	Recur		4.0	-	-	5.8% inflation funding 2026-27
In-year pay mapping (JCC)	Recur		3.0	-	-	Pass through costs JCC LTA
Employers NIC Funding 2025/26 (JCC)	Recur		1.3	-	-	Pass through costs JCC LTA
Genomics for Precision Medicine Strategy	Recur		0.4	-	-	Pass through costs JCC LTA
VBHC Recurrent Schemes (HB & JCC)	Recur		0.1	-	-	Pass through costs JCC LTA
Top slice for central procurement of flu vaccines	Recur		(0.1)	-	-	Pass through costs NWSSP LTA
Pass through allocation Sub-total		0.0	8.7	0.0	0.0	
Grand Total		12.8	21.5	18.7	18.0	

Key Information

- WG will fund macro-economic inflationary and growth rises at 1.11%, and GMS funding has been agreed as an increase of 5.8% in 2026/27
- Assumed that WG will fund pay awards in full (excluding vacancies), and therefore no cost pressure for years 2026-29, not included above
- £43.0m conditionally recurrent has been confirmed as recurrent funding and included within the base allocation
- Years 2 and 3 calculated on inflation rate of 1.6% and 1.5% respectively. This is based on 0.5% reduction in inflation in real terms from 2.6% average CPI rate (Bank of England Monetary Policy Committee) to 1% average in 27/28 and 2.0% average for 28/29..

8c. Recurrent re-classification of funding



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Allocations received from Welsh Government in-year non-recurrently, recognised recurrently in 2026/27.

Funding (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Conditionally Recurrent funding 2023/24	43.0	(43.0)	0.0	
2025/26 Pay Award Mapping	22.3	(22.3)	0.0	
2025/26 National Insurance Mapping	10.2	(10.2)	0.0	
Urgent & Emergency Care	2.7	(2.7)	0.0	
Real Living Wage Social Care	2.3	(2.3)	0.0	
Dementia Action Plan	1.7	(1.7)	0.0	
Medical Training Posts	1.4	(1.4)	0.0	
Shingles Vaccinations	0.9	(0.9)	0.0	
111 Press 2	0.3	(0.3)	0.0	
Tier 4 CAMHS	0.2	(0.2)	0.0	
DOLS	0.2	(0.2)	0.0	
RSV Vaccinations	0.1	(0.1)	0.0	
Save a Life Cymru	0.1	(0.1)	0.0	
Total	85.4	(85.4)	0.0	

8c. Ringfence re-classification of funding

Allocations received from Welsh Government previously as Ringfence re-classified as Discretionary in 2026/27.

Funding (£'m)	Discretionary	Ringfence	Total	Additional Comments
Planned and Unscheduled Care Sustainability	15.3	(15.3)	0.0	
Planned Care Recovery	4.9	(4.9)	0.0	
Critical care funding (incl. JCC funding & PACU)	2.1	(2.1)	0.0	
Critical care funding (JCC funding for EASC)	0.3	(0.3)	0.0	
Value based Recovery	1.8	(1.8)	0.0	
Total	24.4	(24.4)	0.0	

8d. Assumed Pending Allocations



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Allocations received annually from Welsh Government on a non-recurrent basis, assumed to continue into FY26/27:

Assumed Pending Allocations (£'m)	Recurrent	Non-Recurrent	Total	Additional Comments
Substance Misuse	-	2.5	2.5	
GP IM&T Refresh Programme	-	1.5	1.5	
Neurodivergence	-	1.0	1.0	
Prevention and Early Years	-	0.7	0.7	
Bro Myrddin	-	0.6	0.6	
RIF Short Break for Carers	-	0.2	0.2	
Clinical Impact Awards	-	0.1	0.1	
Invest to Save Facilities schemes	-	(0.1)	(0.1)	
Total	0.0	6.5	6.5	

9a. Financial Plan 2026/27 Savings Scenario



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- 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 10 (January) 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	2.7
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		1.1	0.4	1.5
Total		28.5	19.0	47.5

9b. Non-recurrent conversion for budget setting



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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

9c. Non-recurrent conversion for budget setting



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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

9d. Savings Progress



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The following table sets out the progress made to date for the savings identification and commitment across all functions. The non-recurrent conversions of underspend savings are excluded from these numbers:

Whilst there is c.50% of the identified savings requirement (£19.0m recurrent), assuming all non-recurrent savings are converted as part of budget setting, 95% of those identified are not yet supported with robust assured plans, given they are in Blue and Red status.

The full year effect increases to £12.1m from £9.4m, which demonstrates good progress if they can be progressed to Green and Amber plans and fully delivered as currently identified.

Delegated Officer (£'000)	Recurrent 2026/27 Saving Plans Identified					
	Blue	Red	Amber	Green	Total In Year	Total Full Year Effect
Chief Operating Officer	2,130	4,188	0	0	6,318	8,783
Chief Operating Officer Management	0	0	0	0	0	0
Community and Integrated Medicine	368	0	0	0	368	491
Mental Health and Learning Disabilities	0	101	0	0	101	100
Operational Allied Health and Health Sciences	160	568	0	0	728	1,334
Planned and Specialist Care	1,602	3,520	0	0	5,121	6,857
Primary Care	0	0	0	0	0	0
Executive Director of Allied Health Professions & Health Sciences	0	0	0	0	0	0
Estates and Facilities	0	0	0	0	0	0
Executive Allied Health Professions and Health Sciences	0	0	0	0	0	0
Executive Director of Finance	0	426	0	0	426	694
Digital	0	307	0	0	307	575
Finance	0	119	0	0	119	119
Executive Director of Nursing, Quality and Patient Experience	0	0	0	0	0	0
Executive Director of Public Health	0	132	0	0	132	132
Executive Director of Strategy and Planning	0	0	0	0	0	0
LTAs with other NHS Providers	0	0	0	0	0	0
Strategy and Planning	0	0	0	0	0	0
Executive Director of Workforce and Organisational Development	0	0	0	0	0	0
Executive Medical Director	2,380	0	90	0	2,470	2,470
Medical	0	0	90	0	90	90
Pharmacy and Medicines Management	2,380	0	0	0	2,380	2,380
Health Board Wide	0	0	0	0	0	0
Grand Total	4,562	4,771	90	0	9,423	12,104

- 1 Background and context
- 2 Principle components and approach
- 3 Key principles and assumptions
- 4 Draft financial plan assessment
- 5 Financial components
- 6 **De-prioritisations and risks**

De-prioritisation decisions taken to remove



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Further to Executive Team prioritisation of choices, the following are de-prioritised and are not included in the financial assessment:

Investment Description (£'m)	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Clinical Service Plan	-	-	TBC	TBC	This is not de-prioritised but Phase 1 is cost neutral. Further understanding required for phase 2 onwards.
CAD System Manager – National Bereavement framework	0.6	0.6	-	-	New CAD Manager commences in December to implement new National Bereavement framework model
Listening to People implementation	TBC	TBC	-	-	Implementation of new regulations – Listening to People which replaces Putting Things Right
Community Health Workers	TBC	TBC			Director of Public Health strategy to develop the service
Community Health Pathways	0.2	0.2			Digitally enabled solution supporting GPs, WG funding reducing
Implementation of Ortho-Geriatrics at GGH	TBC	TBC			No paper presented to Executive Team but acknowledged as a planning priority (9 Feb Contingent Finance Touchpoint)
Climate Adaption plan	TBC	TBC			No clear indication of costs as yet
WGH Medical Staffing	TBC	TBC			WGH SBAR Medicine Medical Staffing agreed September 25 (included in cost drivers 26/27)
28 Day cancer diagnosis	5.1	2.5	2.6	-	Lower GI CT colons 54 days; Urology, Lower GI, Gynae highest volumes
Radiology Ultrasound & Everlight	0.6	0.6			Non –Recurrent element of the Radiology investment request
Additional Breast Consultant	0.2	0.2	-	-	Retiree budget to be used to cover the additional cost
Sub-Total	6.7	4.1		-	

Choices pending Executive decision



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The table below summarises local commitments pending further prioritisation with Executive Team – these have not been included in the ‘Three-year financial plan summary’ but could support the remaining prevalence modelling.

Investment Description (£'m)	Recur / Non-Recur	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Swansea Bay CT Scanner Simulator - LTA	Recur	0.1	0.1	-	-	Investment for CT Scanner Simulator for 3D imaging £32k.
VBHC – Fracture Liaison service	Recur	0.3	0.2	0.1	-	Part year funding requirement year 1
Children & Young People Weight Management	Recur	0.1	0.0	0.1	-	£126k additional in FY27-28, £0.3m in reserves
Public Health – Health Coaches	Recur	0.6	0.6	-	-	Full business case review and decision required
Medical Rate Card	Recur	0.4	0.4	-	-	V&S paper November, minimum £0.4m included, range could be up to £2.3m, pending outcome of LMC/BMA discussions
Sub-Total		1.5	1.3	0.2	-	
Total		8.3	5.4	2.8	-	

Existing financial risks requiring mitigation



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The table summarises the priority financial risks affecting the in-year financial position. Proactive mitigation is required to ensure these pressures are managed within the broader financial plan, as they have been through 2025/26.

Function	Financial Risk	£'m
Community and Integrated Medicine	Medical staffing costs have risen sharply. There are currently 25 agency doctors across USC sites covering sickness and vacancies — a 257% increase compared with earlier in the year.	1.9
Mental Health and Learning Disabilities	Increasing demand for inpatient services is exceeding available bed capacity, creating an urgent need for alternative outsourced arrangements to maintain continuity of care.	1.0
Planned and Specialist Care	Additional activity delivered in 2025/26 is funded from in-year underspends. These underspends will not be available in 2026/27. Therefore, this activity will need to cease unless further external recovery funding is secured.	2.0
Primary Care	This year's underspends in both Dental and GMS contracts have delivered a non-recurrent benefit, Welsh Government has confirmed that these budgets are expected to be fully utilised in 2026/27	3.8
Purchased of outsourced beds	Purchase of outsourced beds and nursing costs from Independent sector - for PICU, Bryngofal, Morlais and St Caradogs – driven by rising patient acuity and capacity constraints	1.0
Estates Maintenance	Estates Maintenance Pay and Non pay underlying pressure -SBAR to be followed through IQFPD	1.6
Health Board Wide Vacancy Effect Reduction – impact on savings conversion	Since Q1, the Health Board substantive workforce has grown month-on-month, with a 2% (221 wte) rise since July and total WTE is now above the level at the start of the year and apart from HCSW, all staffing groups have increased. This will impact on the pay underspend expected in 2026/27.	10.1
Total		21.4

Finance risks to the financial plan



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The table summarises the priority financial risks affecting the financial position anticipated for 2026/27. Proactive mitigation is required to ensure these risks are managed within the broader financial plan, predominately via seeking additional support from Welsh Government due to their national implication.

Investment Description (£'m)	FYE	Year 1 2026/27	Year 2 2027/28	Year 3 2028/29	Additional Comments
Future Workforce Solution update – internal project team	-	0.6	0.6	-	ESR Replacement system Implementation internal Workforce (Non recurrent) project team requirements. Assumed to be funded by Welsh Government should the Health Board continue as early adopters
National Resident Doctors pay reform	TBC	TBC	TBC	TBC	New pay structure to be implemented – assumed to be funded by WG but may be local pay scale cost implications
Welsh Government Conditionally Recurrent funding	26.0	26.0	26.0	26.0	£26.0m funding received in 24/25 was on the condition that the health Board would be financially breakeven in 2027/28. Currently the plan does not breakeven, and therefore a risk is being highlighted that Welsh Government could remove this allocation from the Health Board in any or all of the three years
Total	26.6	26.6	26.6	26.0	



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Gofynnwch am/Please ask for: Kelly Sursona
Rhif Ffôn /Telephone: 01267 239581
Ffacs/Facsimile: 01267 239579
Dyddiad/Date: 2 March 2026

Swyddfeydd Corfforaethol, Ail Lawr, Bloc C.
Adeiladau'r Llywodraeth, Heol Picton,
Caerfyrddin, Sir Gaerfyrddin, SA31 3BT

Corporate Offices, Second Floor, Block C,
Government Buildings, Picton Terrace,
Carmarthen, Carmarthenshire, SA31 3BT

Re: Delegation of budget manager responsibilities for the 2026/27 financial year

Dear colleague,

Following the approval of our financial plan by the Finance and Performance Committee, I am formally writing to you as the Health Board's Chief Executive and Accountable Officer to delegate budget manager responsibilities to you.

This process recognises the critical role you play in ensuring the effective delivery of our services. The delegation carries with it an important responsibility: to uphold the highest standards of governance, stewardship, quality and safety in all that we do. I want to thank you for your commitment to this shared responsibility.

It is both a privilege and a duty for us to serve those who are reliant on us, and I have full confidence in your ability to carry out this role with integrity, professionalism and care.

1. Accountable Officer

As Accountable Officer, I have responsibilities set out by Welsh Government in the following areas:

1. Regularity and probity: ensuring public money is spent in accordance with the law, the rules set out by Welsh Government, and ethical standards.
2. Value for money: ensuring that resources are used efficiently, effectively, and economically to deliver our objectives.
3. Governance: ensuring that we maintain robust financial controls, have appropriate risk management arrangements in place, and broader governance arrangements are in place to manage our business.
4. Reporting: ensuring we can meet the reporting requirements of our Board, Government and the Senedd.
5. Compliance with the principles set out in "Managing Welsh Public Money" on financial management in government.
6. Delegated Authority: ensuring internal arrangements are in place to delegate responsibilities within our organisation.

This letter is a key part of me discharging my responsibilities and should be read in conjunction with our Standing Orders, our Standing Financial Instructions and our Scheme of Delegation.

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

Cadeirydd / Chair
Mr Neil Wooding
Prif Weithredwr / Chief Executive
Professor Phil Kloeer

2. Our internal process

There are seven domains by which we will measure the organisation this year, these are:

1. Quality and safety
2. Governance
3. Workforce
4. Finance
5. Strategy, planning and fragile services
6. Population health
7. Performance and outcomes

Within these domains, there are four escalation levels. These are:

1. Level 1, where you have provided reasonable assurance that your function can meet prescribed targets in a given domain within the year.
2. Level 2, where there is limited assurance that your function can meet prescribed targets in a given domain within the year.
3. Level 3, where there is no assurance that your function can meet prescribed targets in a given domain within the year, or there is insufficient engagement with Targeted Intervention objectives.
4. Level 4, where there is no assurance that your function can meet prescribed targets in a given domain within the year, and there are insufficient actions or engagement in place to secure recovery.

This delegation letter is issued on the expectation that you will put in place reasonable measures to remain at Level 1 escalation across the seven domains, and that any movement from this position will be actively managed and escalated.

3. Annexes and further details

The annexes to this letter provide further detail which are specific to your responsibilities:

- Annex A – Summary of the Opening Budget
- Annex B – Responsibilities as a Delegated Officer
- Annex C – Onward Delegation of Budget
- Annex D – Approval Pro Forma

4. Specific responsibilities

Across all domains below, assurance will be sought on the scale, significance, timeliness and quality of response, and on appropriate escalation where issues cannot be resolved locally.

4.1 Quality and safety

Our responsibilities are set out by Government, and include legislative requirements set out in UK-wide Health and Safety legislation; the NHS Wales Act (2006); Health and Social Care Wales Act (2020); NHS Wales Safe Staffing Levels Wales Act (2016). Alongside these, we have responsibilities set out in regulations such as the Duty of Quality; the Duty of Candour; Putting things Right; and Professional Regulations set out by our professional regulators.

Health Inspectorate Wales provide independent scrutiny over design and effectiveness of our quality and safety arrangements.

It is important that you ensure the services you provide are safe, effective, patient-centred, timely, efficient and equitable. Our escalation arrangements will seek assurance that you are managing the following appropriately, in terms of the scale, significance, timeliness and quality of response:

- Incidents
- Complaints
- Duty of Candour
- HIW/CIW
- Deteriorating patients
- Patient experience

Any concerns you have which cannot be resolved through local mitigating actions should be promptly escalated.

4.2 Governance

Our responsibilities are laid out in the NHS Wales Act (2006), supplemented by Managing Welsh Public Money. Our Standing Orders, Standing Financial Instructions and Scheme of Delegation provide further internal guidance.

Audit Wales provide independent scrutiny over the design and effectiveness of our governance arrangements.

Our escalation arrangements will seek assurance that you are managing the following appropriately, in terms of the scale, significance, timeliness and quality of response:

- Risks
- Audits/inspections
- WHCs/Ministerial Directions
- Governance arrangements

4.3 Workforce

Our workforce is central to delivering high quality, safe and sustainable services. Our responsibilities include those laid out in legislation, such as the Equality Act (2010) and NHS Staffing Levels Wales Act (2016). “A Healthier Wales” requires us to ensure that we are planning for the longer term.

Colleagues will have professional regulatory requirements as set out by their professional bodies (e.g. GMC, NMC, HCPC).

Our escalation arrangements will seek assurance that you are managing the following appropriately, in terms of the scale, significance, timeliness and quality of response:

- Employee relations cases
- Sickness
- PADRs
- Turnover
- Mandatory training
- Overdue pay progressions
- Rosters and job plans (includes the use of agency)

4.4 Finance

4.4.1 Background

We have a statutory duty under the NHS Wales Act (2006) to achieve breakeven over a three-year period. During 2025/26, we made good progress in improving our financial position, to a position which is aligned to our Target Control Total as advised by Government (£22.1m deficit).

As part of achieving the Target Control Total, Government provided £26.0m of conditionally recurrent funding. This was conditional on a number of requirements, one of which was to achieve financial balance by 2027/28, year two of the coming three-year planning cycle. The funding settlement for year one of this cycle (2026/27) represents a 1.11% uplift to the Health Board, excluding Pay Awards which will be provided by way of an additional allocation.

While this funding uplift is welcome, especially given the difficult choices taken at Government level to direct additional funding into the NHS, the funding uplift does not keep pace with cost growth. Historic budget issues have been addressed, and the settlement for 2026/27 is full and final. There will be no further allocations in-year unless additional funding is provided by Government.

Consequently, our plan next year is predicated on delivering the cumulative impact of any residual brought forward undelivered historic recurrent savings targets plus an additional 2.0% for 2026/27. Until assurance can be provided to the Board that this is achievable equitably across services, difficult choices may remain in place to maintain underspend and non-recurrent savings delivered in 2025/26, but now on a recurrent basis, alongside maintaining the discipline of the financial controls oversight.

4.4.2 Financial governance

As a minimum, it is expected that you hold monthly business performance meetings which embed financial management principles into your governance, and ensure that you focus on:

- **Financial management:** Delivery of financial balance within your current resources, including the delivery of required savings.
 - Underpinned by clear and transparent reporting, linking financial and non-financial measures.
 - Ensuring that you are focused on mitigating actions where adverse variances and unbudgeted pressures are noted.
 - Ensuring that you are tracking costs over the longer term, including actions to make savings, to provide assurance that there is a focus on run rate reductions.
 - Ensuring that you regularly scrutinise forecast expenditure to provide assurance over delivery for the year.
 - Budget profiles will only be changed annually, and you should ensure your involvement in the process to allocate appropriate budget profiles. Any expected deviation in-year need to be adequately understood and explained.
- **Non-recurrent:** measures are not an acceptable substitute for failure to deliver recurrent plans, except where explicitly agreed as part of a mitigating recovery trajectory.
- **Savings reporting:**
 - Only robust assured plans with certainty around actions, trajectories and financial implications should be included as Green or Amber, depending on clarity pertaining to implementation dates for all actions. Once reported to Welsh Government, there can be no changes to planned benefits or timelines, and there is a maximum period of three months to convert an Amber saving plan to Green status.
 - Schemes are to be reported gross of any non-linked cost pressures to ensure that appropriate management action is undertaken to mitigate cost pressures and not under-declare genuine savings. Transparency surrounding cost pressures is critical for their effective understanding, management and decision-making.
- **Opportunities:** Identification of opportunities for improvement and savings and tracking of savings over time to ensure that they are progressing with pace.

- **Pay:** You should have arrangements in place to provide assurance over the pay cycle. This includes:
 - A recruitment panel in place to provide assurance over your recruitment into new or replacement roles, ensuring they are afforded within delegated budgets.
 - Adherence to approved authorisation procedures for the control of vacancies.
 - Adherence to payroll procedures, especially with Trac and ESR processes.
 - Adherence to systems and processes in place to reduce the reliance on variable pay and agency.
 - Adherence to procedures for the management of leave and other staff absences.
- **Non-pay:** You should have arrangements in place to provide assurance over the non-pay cycle. This includes:
 - Adherence to the Health Board's "No Purchase Order, No Pay" procedure.
 - Appropriate and prompt receipting of goods and services.
 - Prompt authorisation of invoices.
 - Proactive management of contracts, ensuring that suppliers are providing services in line with procurement documents, and including the timely tendering for contracts which are approaching expiry.
 - A hierarchical Oracle approval structure has been implemented to allow greater transparency for Purchase Requisition approvals across each level, meaning that all approvers in the chain before the financial limit will need to check and approve items.
- **Business cases:** Testing any business case proposals locally before any proactive investment choices are provided through internal governance arrangements up to and including the Executive Team. Any business case needs to demonstrate clear returns on investment and be tracked to ensure those returns are delivered.
- **Financial control checklist:** Self-assessing against our financial control checklist, where you are expected to ensure that your internal control environment facilitates good financial governance.
- **Risk management:** Appropriate risk management arrangements to allow local innovations to drive improvements, while assuring that potential adverse impacts are managed. You must ensure that risk registers reflect the risk environment you are managing, alongside appropriate controls, mitigations and assurances. You must ensure that risks are escalated where these cannot be managed within tolerable levels within your delegated level.
- **Delivery of "Enabling Actions – Annex 2" requirements:** As part of the NHS Planning Framework, the Cabinet Secretary has written to Chairs to highlight expectations for the new financial year. Within the letter several enabling actions are mandated on the basis of "adopt or justify". Plans should be in place to adopt the actions, including milestone timelines, performance trajectories and financial impacts.

4.4.3 Mid-year budget changes

To ensure our efforts are directed at value-added activity, we will implement further budgetary controls to limit budget changes made during the financial year. While budgets will be updated for any new allocations or agreed changes to management structures, the re-profiling of budgets and 'cleansing' exercises mid-year will no longer be routine and will only occur by exception as part of agreed corporate processes.

Consequently, it is important that you maintain a focus on forecasting accuracy of income and expenditure to ensure that appropriate actions are directed at delivering opportunities and mitigating pressures.

You will have a period to review your budgets following this communication and provide any final amendments to your finance representative by no later than **noon on 13 March 2026**.

4.4.4 Opportunities framework

A revised framework was implemented from November 2023. As part of this, a continuously updated list of variation, is available through the Finance Value and Business Intelligence and Strategic Business Partnering functions. Enquire, Discover, Design and Deliver are the four stages of an opportunity's journey to savings delivery.

This process requires active engagement with all parts of the organisation, and you are required to support the development of this framework. While it is expected that opportunities are delivered with pace, I recognise that they will not all be deliverable within one year as they may require transformational service change. You will be expected to lead the development of opportunities into deliverable plans within your area or support those opportunities which require strategic decisions at Board level through the Clinical Services Plan.

Your proportion of the in-year savings expectation will be transacted from budgets as they are identified as robust plans (defined as Amber or Green). You will also be expected to ensure arrangements are in place to move savings ideas and broad plans (defined as Blue and Red) into robust and deliverable local plans. Your savings requirement will be issued alongside your budget.

4.4.5 Delegation

The delegated budget must be committed in accordance with the Health Board's Plan, and in line with our Standing Orders, Standing Financial Instructions and Financial Procedures. This includes the Budgetary and Allocation Control Policy.

A summary of the budgets allocated to you is appended alongside this letter. From time to time during the year these figures are likely to change to take account of additional allocations, transfers and savings plans, but this letter will remain in force as the covering delegations for any revisions.

Any funding not agreed within your appended budget cannot be assumed, and you therefore cannot commit expenditure against assumed funding except when specifically agreed with the Executive Director of Finance.

Any new funding bids to Government or other organisations require a business case through your governance arrangements and to the Formal Executive Team.

Should the Board make in-year commitments then you will be notified accordingly of such commitments and an appropriate budget adjustment will be made. You should not incur or sanction expenditure against a budget you are not responsible for.

You may further delegate to your teams some or all of the budgets which I have delegated to you, although you will still retain ultimately accountability in full for these budgets, just as I am ultimately responsible for the Health Board budget as a whole. You are responsible for deciding on the exact arrangements, but your delegations should be clear, unambiguous and conferred and accepted in writing.

The individuals to which you sub-delegate your budget should have the appropriate training and understanding to fulfil their responsibilities as a budget manager to carry your confidence that they can discharge their duties to the same standard that you will be held.

You will need to complete **Annex C** to sub-delegate part or all of your budget. The Finance Function will formally delegate budgets from my instruction to Executive Directors and the immediate Clinical Care Group or Executive Function leads. It will be the responsibility of those Clinical Care Group or Executive Function leads to further delegate to other levels of budget manager responsibility in your team. I acknowledge not all leads will be wholly responsible for the

budget in their function due to the differing structures across Executive Director functions, but I expect the onward delegation from yourselves to be clear in setting this out.

Nothing in this delegation alters collective executive accountability or the Board's ultimate responsibility for the organisation.

4.4.6 Escalation arrangements

Our escalation arrangements will seek assurance that you are:

1. Operating within budget or delivering a recovery plan which will return to no more than budget in-year; and
2. Identifying and delivering recurrent savings to the level required.

4.5 Strategy, planning and fragile services

You are responsible for ensuring that there are adequate arrangements in place to stabilise, sustain or transform services as may be required dependent on the issues, challenges, and opportunities of which you become aware. This may be within your direct service, or in conjunction with colleagues across our broader organisation.

Our escalation arrangements will seek assurance that you are managing the risk of service failure occurring within a rolling six-month period through developing robust mitigating plans. We will also seek assurance that you have a triangulated plan across all domains to operate services effectively for the year.

4.6 Population health

Our Standing Orders are clear around our duty to plan and deliver healthcare services to meet the needs of our population, and to improve the health of our population. You are responsible for ensuring that your services support better population health through prevention and early intervention, addressing health inequalities, collaborative working with partners within and outside the Health Board, supporting an environment conducive to making healthier choices, and using data to drive evidence-based decision making.

The Wellbeing of Future Generations Act (2015) places a legal duty on public bodies to improve population health by focusing on sustainable, long-term wellbeing. Alongside this, "A Healthier Wales" creates the strategic framework for Health Boards.

Our measures in this area remain in development, but you have a responsibility to ensure that you create an environment which encourages our colleagues and patients to make healthier choices.

4.7 Performance and outcomes

You will have submitted trajectories for improvements in our performance measures as part of our Annual Plan. You are responsible for ensuring that you have arrangements in place to work within the trajectories which the Board has approved.

5. Confirmation

Your core budget and savings expectation are confirmed within **Annex A**.

Please acknowledge your understanding and acceptance of these delegations by signing and completing **Annex C** and **Annex D**, and returning all sections of this letter to me, the Executive

Director of Finance, and those who were copied into my original letter to you, by **no later than 31 March 2026**.

I am very grateful to you for your support to me as Accountable Officer and I am committed to do everything I can to support you in your own roles.

Yours sincerely

Professor Phil Kloer
Chief Executive

C.c. Huw Thomas, Director of Finance

Summary of the Opening Budget for 2026/27

This letter authorises the budget manager stated in **Annex D** to exercise control of the named function budget in accordance with the Health Board's approved scheme of delegation.

The table below provides a summary of the opening budget by function within the delegated accountability:

Function(s) (£)	Recurrent Budget	Non-Recurrent Budget	Total Budget	Recurrent Savings Target
Grand Total				

Please note the following items, in respect of the 2026/27 financial year, are confirmed as included within the base budget unless explicitly stated otherwise:

- Roll forward recurrent and non-recurrent budgets from 2025/26;
- Full year impact of recurrently identified 2025/26 Green and Amber savings plans;
- Specific investment decisions approved in the Health Board's Plan, including macro-economic inflationary and growth modelling increases/decreases for the 2025/26 and 2026/27 financial year;
- Premium agency pay budgets have been issued recurrently on the same basis as the prior financial year, increased for any additional costs identified in the Financial Plan and ratified by Board;
- Non-recurrent savings repeatably delivered have been deducted from the budget, as agreed by Executive Directors as a new principle to ensure time is afforded for those services that have under-delivered to implement savings plans, and to ensure an inflated financial plan is not put forward to Board or Welsh Government.

Budgets for the following funding elements are being held in central reserves and will be issued during the year based on evidenced assessments made:

- Agenda for Change and Medical and Dental pay budgets do not yet reflect the pay award for 2026/27, which is pending confirmation by Welsh Government, funding for which will be made available once known;
- Investments included within the Financial Plan, which are not yet approved by a scrutiny forum – for each month where the investment has not been approved, that month's element of the investment will be released to the financial position centrally;
- Regional Integration Fund (RIF) and other targeted project budgets where plans are yet to be finalised;

- Welsh Government allocations will be issued out as an adjustment to budgets no later than one month after the month in which they are received;
- Savings targets will only be transacted out of budgets once robust plans (Green or Amber status) are signed-off through your finance representative.

You are again reminded of the requirement to deliver both a breakeven position and the required savings target, in full. Please contact your finance representative who will be happy to answer any questions you may have and provide you with a detailed breakdown of the amounts included within your budget.

Responsibilities as a Delegated Officer

1. I confirm that I have read, understood, and will make my best endeavours to comply with the requirements laid out in the Standing Financial Instructions. I understand that my performance as a budget manager may be scrutinised at any time by the Board, Internal Audit or Audit Wales.
2. I confirm that I accept the budget which has been allocated to me.
3. I confirm that I understand what it is expected of me and that I will make my best endeavours to deliver the Health Board's safety, quality and performance requirements within the budget allocated to me.
4. I confirm that I will:
 - Remain accountable for my budget, even where I have delegated responsibility to others;
 - Review my budget on a regular, at least monthly, basis with the assistance and advice of finance colleagues;
 - Seek advice promptly from my finance lead as the need arises;
 - Ensure a proactive and robust approach is undertaken to identify and deliver my savings requirement, at least on a recurrent full year effect basis by the end of this financial year, making up any in-year recurrent shortfall with non-recurrent savings as required.
5. I confirm that in relation to expenditure against my budget, I will:
 - Not knowingly incur expenditure where I do not hold sufficient budget;
 - Not knowingly attempt to charge expenditure to a budget which I am not directly responsible for;
 - Not knowingly commit recurrent expenditure against a non-recurrent budget;
 - Not knowingly recruit over my funded establishment;
 - Not knowingly incur temporary staffing costs over my total available budget without agreeing this in advance via an escalation process and / or Executive Director. Where temporary staffing costs need to be incurred urgently or out of hours, these will be confirmed retrospectively with the same;
 - Ensure that staffing data held on the ESR and rostering systems is accurate and up to date to the best of my knowledge and belief and that staff overpayments are minimised by informing Employment Services in a timely manner of any relevant changes;
 - Ensure as far as I am able that all non-pay expenditure complies with the requirements of the Standing Financial Instructions including the requirement for an official purchase order to be raised in advance of incurring the expenditure.
6. Where I identify a potential or actual overspend during the financial year, I confirm that I will:
 - Develop an action plan designed to bring the position back into line within the financial year;
 - Involve my finance lead and other expert sources of advice, e.g. Management Team, Workforce and Organisational Development lead, in developing the action plan;
 - Make my best endeavours to deliver the requirements of the action plan to ensure a full-year balanced position.
7. I confirm that I have identified and managed (and escalated if appropriate) any risks to achieving the financial objectives I am responsible for.
8. I confirm that I will support the Health Board to ensure that the needs of the Health Board's catchment population, as a whole, are met.
9. I am able to provide reasonable assurance of compliance with legal and regulatory frameworks relevant to my areas of responsibility. These will be achieved through adhering to the Health Board's policies.
10. All staff within my area of responsibility have been appraised of their duty to raise concerns and to deal promptly and efficiently with any concerns raised with them in line with the relevant health board policy.

11. I am able to confirm that all staff within my area of responsibility will be expected to receive an annual appraisal over the financial year and will be expected to complete their mandatory training as required.
12. I confirm that I am aware of my duties and responsibilities under the NHS Code of Conduct.
13. I confirm that should I become aware of any suspected fraud, bribery, or corruption, I will advise the Local Counter Fraud Service promptly and support any investigation.
14. I confirm that I will keep my finance lead and line manager aware of any significant changes to risks over the year.

Onward Delegation of Budget

Executive Directors are not required to further delegate budgets as a separate accountability letter will have been issued to the appropriate Clinical Care Group or Executive Function lead.

Where this letter relates to a Clinical Care Group or Executive Function lead, you are formally required to delegate part or all of the budget that has been delegated to you to senior budget manager(s) in the function. Please complete the below table to confirm who you will be further delegating to:

[illegible]

Where this delegation goes below the Clinical Care Group or Executive Function structure, you acknowledge that you will formally write to these individuals and delegate the budget in a similar manner as I have to you, and you will request written acceptance of the same.

Approval Pro Forma

Name of Budget Manager:	Enter name of executive director, clinical care group lead or executive function lead
Function:	Enter executive director function, clinical care group or executive function

I, as named above, acknowledge receipt of your letter appointing me as the Delegated Officer for the function stated, and confirm I have read and completed the annexes enclosed with your letter and accept the responsibilities placed upon me as a Delegated Officer.

Delegated Officer to complete the following table:

Signed:	
Job Title:	
Date:	



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ein cyf/Our ref: CEO.19167

Gofynnwch am/Please ask for: Kelly Sursona

Rhif Ffôn /Telephone: 01267 235969

Dyddiad/Date: 13th February 2026

Swyddfeydd Corfforaethol, Ail Lawr, Bloc C.
Adeiladau'r Llywodraeth, Heol Picton,
Caerfyrddin, Sir Gaerfyrddin, SA31 3BT

Corporate Offices, Second Floor, Block C,
Government Buildings, Picton Terrace,
Carmarthen, Carmarthenshire, SA31 3BT

Ms Jacqueline Totterdell
Director General Health and Social Services
NHS Wales Chief Executive
Health and Social Services Group
Cathays Park
Cardiff
CF10 3NQ

By e-mail to: dsdghsceynhswce@gov.wales

Dear Jacqueline,

Hywel Dda University Health Board Accountable Officer Letter 2026/27

Following our recent discussions, and those held at the Public Board meeting on 29 January 2026 and the Finance and Performance Committee on 21 October 2025 and 16 December 2025, I am writing to formally notify you of our intention to submit a three-year financial plan covering the period 2026–29.

Despite the progress outlined below, the Board has concluded that we are not yet in a position to submit an Integrated Medium-Term Plan for 2026–29 that achieves full financial balance across the three-year period. This judgement reflects a realistic assessment of the scale of the financial challenge, the recurrent gap that remains, and the risks associated with assuming a pace of recovery that is not yet deliverable. This position is held despite the material improvements now in place in governance, organisational maturity, and financial grip.

The Board is fully sighted on our statutory responsibilities and the seriousness of this position. In line with the NHS Wales Oversight and Escalation Framework, we consider this decision to be consistent with operating transparently within Targeted Intervention. We are prioritising credible planning assumptions, patient safety, and service sustainability, while enabling continued close working with Welsh Government and NHS Wales Performance and Improvement to agree a deliverable trajectory to financial balance.

During 2025/26, we have made further positive progress in improving our financial position and our forecast remains to deliver the revised control total of £22.1m. This reflects, in part, additional in-year non-recurrent support provided by Welsh Government in respect of Band 2 and 3 re-banding and the Welsh Risk Pool risk-

Swyddfeydd Corfforaethol, Ail Lawr, Bloc C.
Adeiladau'r Llywodraeth, Heol Picton,
Caerfyrddin, Sir Gaerfyrddin, SA31 3BT

Corporate Offices, Second Floor, Block C,
Government Buildings, Picton Terrace, Carmarthen,
Carmarthenshire, SA31 3BT

Cadeirydd / Chair
Dr Neil Wooding CBE
Prif Weithredwr / Chief Executive
Professor Phil Kloer

share agreement, alongside demonstrable progress against our Targeted Intervention criteria.

While this progress is significant, we still need to plan a credible three-year trajectory to achieve financial balance, something that has not been achieved since our establishment in 2009. The 2025/26 financial year represents the second year of our approach to de-escalating against the Targeted Intervention criteria, and we look forward to continuing a constructive dialogue and demonstrating further progress in the year ahead.

Despite good progress, it would be remiss not to acknowledge the wider operating context. While financial improvement has been achieved over the past two years, current planning discussions remain challenging. Delivery against the performance expectations continues to be assessed and the opportunities for productivity and efficiencies will be a key component of the plan. Given the financial challenges, the Health Board is unable to allocate additional resources to meet increasing demand and capacity deficits in a number of key areas previously addressed through national funding. Furthermore the Health Board has a large number of risks, the majority of which are assessed as high or extreme, underlining the significant quality deficits we have alongside the financial deficit.

This increases the risk to our short term delivery over the coming financial year. The extent of the increase from Welsh Risk Pool for the risk share agreement is significant, and that will also be factored into our final planning submission following dialogue with the Director of Finance for Health, Social Care and Early Years Group.

The Board, and my Executive Team, remain focused on delivering the improvements we need to see in our Health Board.

Yours sincerely,



Prof Phil Kloer
Prif Weithredwr / Chief Executive

CC:
Neil Wooding (Chair)
H DUHB Executive Team

4.4 - BALANCE SHEET REPORT

*Huw Thomas (Hywel
Dda UHB - Director
of Finance)*

| For assurance

Attachments

[Balance Sheet Report FPC 24 February 2026.pdf](#)

[Appendix 2 Balance Sheet Dashboard 31 December 2025.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Balance Sheet Analysis – as of 31 December 2025
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)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the report is to outline the Health Board's Balance Sheet position as at the end of Quarter 3 2025/26 (Month 9), to provide an explanation for any key movements and to provide assurance to the Committee that robust, routine and effective monitoring is in place.

The report also outlines the monthly scrutiny of the Balance Sheet and any further developments.

Cefndir / Background

The Health Board's Financial Accounts team, on behalf of the Executive Director of Finance, and as part of a monthly review process and sign off, will ensure scrutiny and completeness of the Health Board's Balance Sheet.

Asesiad / Assessment

Quarter 3 2025-26 Balance Sheet Review

The Month 9 Balance Sheet, with explanation of key variances, is shown in **Appendix 1**. The movement of £40m from the opening position can be summarised as follows:

	2025-26 Opening balance £m	31 Dec 2025 £m	Movement £m
Non-Current assets			
Fixed Assets	379	399	20
Other non- current assets	60	68	8
	439	467	28
Current Assets			
Inventories	12	12	0
Trade and other Receivables	69	76	7
Cash	4	2	-2
Total Assets	524	557	33
Liabilities			
Trade and other Payables	-169	-154	15
Provisions	-95	-103	-8
Total Liabilities	-264	-257	7
Net Assets less Liabilities	260	300	40
Financed by:			
General Fund	199	227	28
Revaluation Reserve	61	73	12
Total Funding	260	300	40

Appendix 2 shows the Power BI platform for Balance Sheet analysis.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **NOTE** the Balance Sheet as at the end of Quarter 3 2025/26

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.2	Provide assurance on financial performance and delivery against Health Board financial plans and objectives and, on financial control, give early warning of potential performance issues, making recommendations for action to continuously improve the financial position of the organisation, focusing in detail on specific issues where financial performance is showing deterioration or there are areas of concern
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086.	Current Risk Score = 20.
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:	Not Applicable
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 2 Financial recovery and route map 6 Clinical services plan
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:	Monitoring returns to Welsh Government based on the Health Board's financial reporting system.
Rhestr Termiau: Glossary of Terms:	Explanation of terms is included in the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Finance 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:	Not Applicable
Gweithlu: Workforce:	Not Applicable

Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	The Health Board 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 the Health Board's financial plan will affect its reputation with Welsh Government, Audit Wales and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

BALANCE SHEET: APPENDIX 1

APPENDIX 1: Statement of Financial Position as at 31 December 2025	Opening Balance 1 April 2025 £'000	Closing Balance 31 December 2025 £'000	Movement £'000
Non-Current Assets			
Property, plant and equipment (PP&E)	377,071	397,922	20,851
Intangible assets	1,952	1,409	(543)
Trade and other receivables	59,122	67,566	8,444
Other financial assets	826	826	0
Non-Current Assets sub total	438,971	467,723	28,752
Current Assets			0
Inventories	12,475	12,429	(46)
Trade and other receivables	68,508	75,803	7,295
Cash and cash equivalents	3,943	1,635	(2,308)
Other financial assets	148	148	0
TOTAL CURRENT ASSETS	85,074	90,015	4,941
TOTAL ASSETS	524,045	557,738	33,693
Current Liabilities	(162,040)	(149,117)	12,923*
Provisions	(33,839)	(36,590)	(2,751)^
NET CURRENT ASSETS / (LIABILITIES)	(110,805)	(95,692)	15,113
Non-Current Liabilities			
Trade and other Payables	(6,837)	(5,371)	1,466*
Provisions	(61,742)	(66,760)	(5,018)^
TOTAL ASSETS EMPLOYED	259,587	299,900	40,313

There has been an increase in the total of Non-Current Assets of £28.7m since the end of 2024/25. Fixed assets (PP&E) have increased by £20.8m - this is the net of any indexation increase and depreciation as at the end of Quarter 3. Trade and other receivables have increased by £8.4m. This is mainly due to the increase in the Welsh Risk Pool debtor.

There has been a net increase of £4.9m in the total amount of Current Assets since the end of 2024/25, of which an increase of £7.3m relates to Trade and other receivables. This is mainly due to an increase in the Welsh Risk Pool debtor.

*There has been a net decrease in Total Liabilities (excluding Provisions) of £14.4m since the end of 2024/25. This decrease relates to Trade and Other Payables – further details are provided below**

^Total provisions have increased by £7.8m since the end of 2024/25. The movement was mainly due to an increase in the provision for clinical negligence cases from the end of 2024/25. This is due to a increase in the number of cases and the provision across multiple cases.

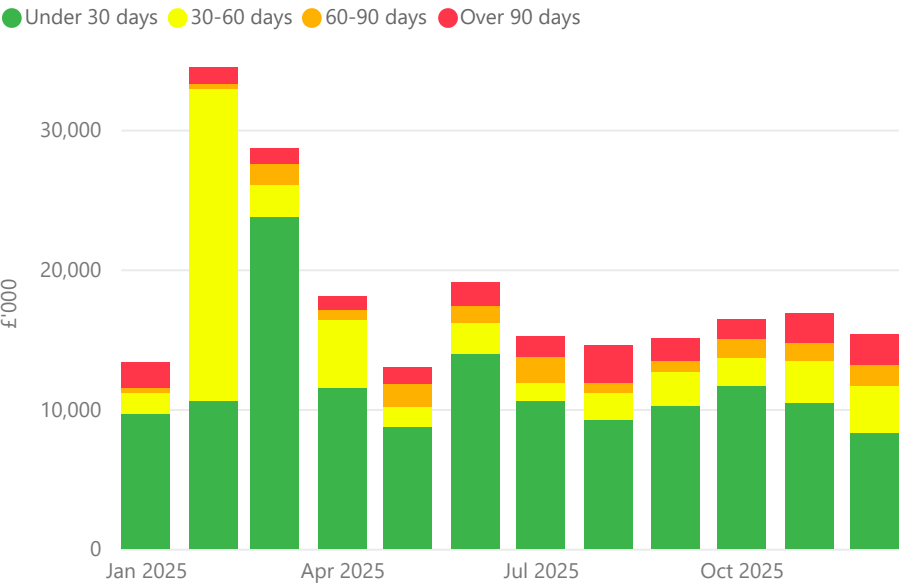
FINANCED BY:			
Taxpayers' Equity			
General Fund	198,951	226,926	27,975
Revaluation Reserve	60,636	72,974	12,338
TOTAL TAXPAYERS' EQUITY	259,587	299,900	40,313

**Additional information in respect of the decrease in Trade and Other Payables:

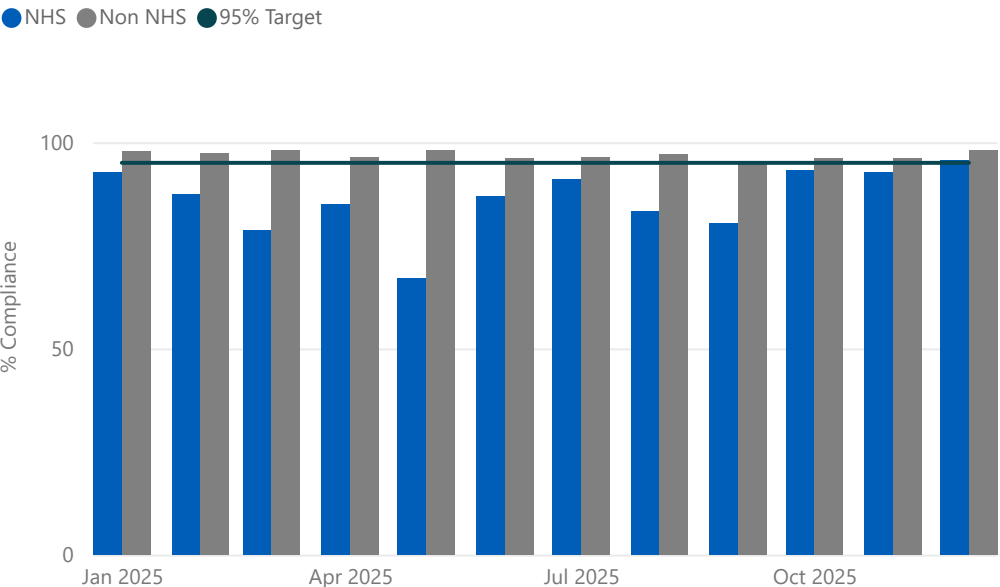
The main movements in Trade and Other payables are as follows :

Trade Payables (£18.4m) decrease	(£13.0m) Timing of year end reversals (£8.8m) Timing of Month 9 primary care contractor payments (6.9m) Timing of invoices processed through AP £11.8m Timing of CHC invoices
NHS Payables (£2.8m) decrease	(£2.5m) Health Commission Wales (£2.3m) Swansea Bay £3.3m Healthcare Contracting
Other Payables £5.4m increase	£5.9m Core Processing

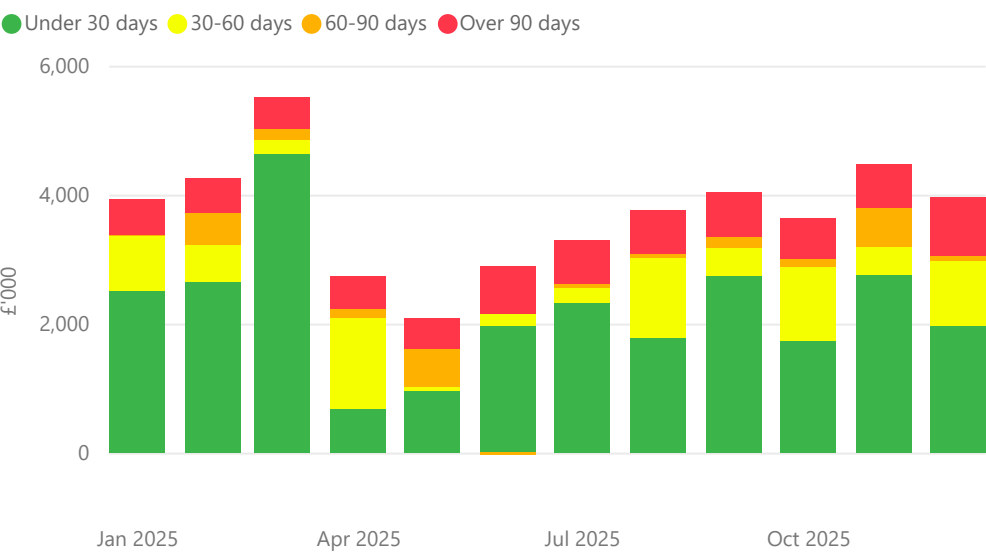
Aged Payables



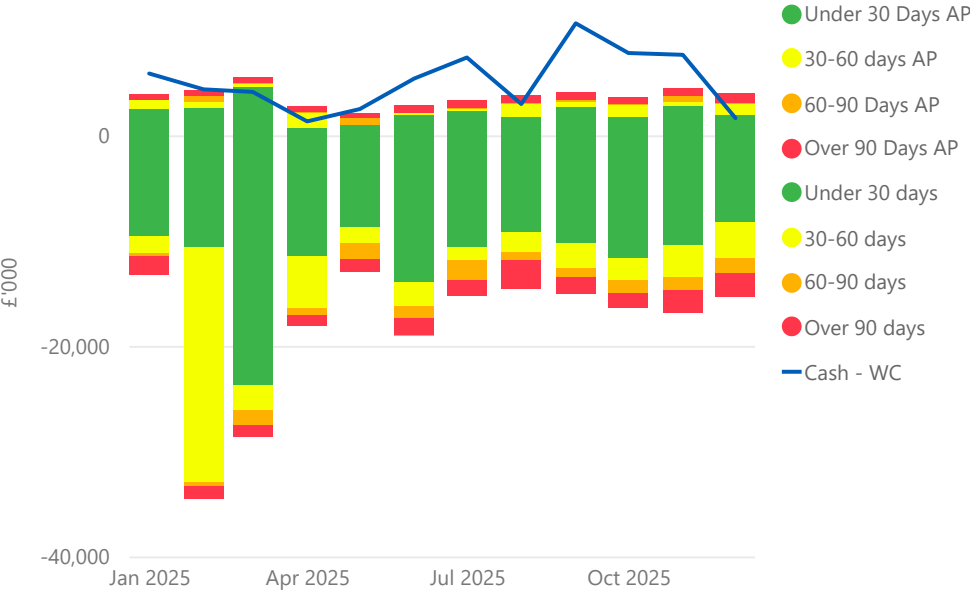
Public Sector Payment Policy (PSPP)



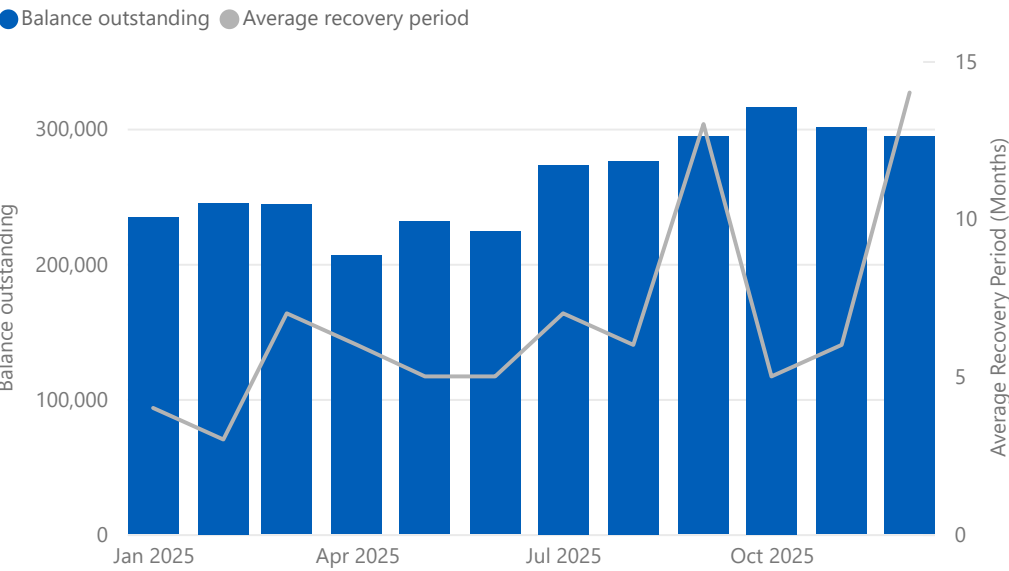
Aged Receivables



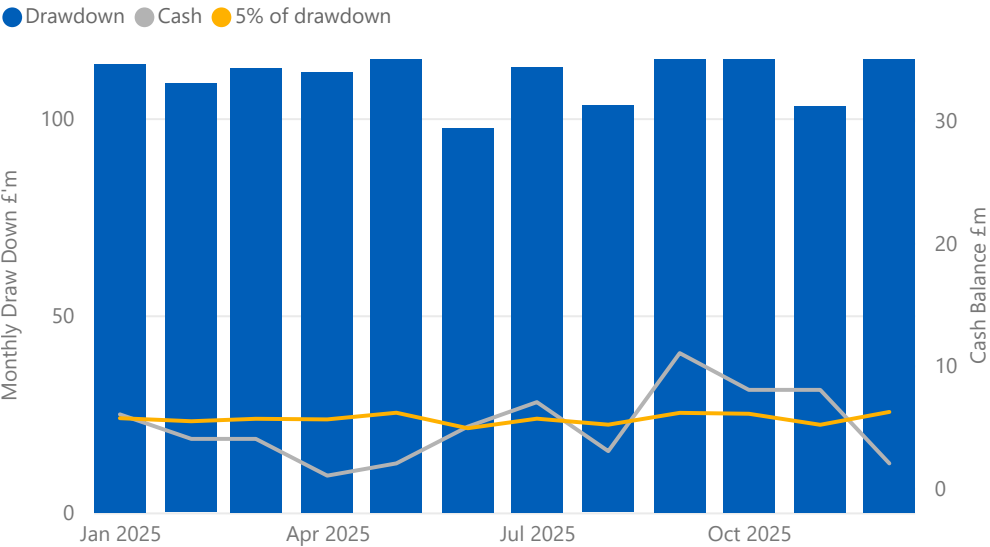
Working Capital



Overpayments of Salaries

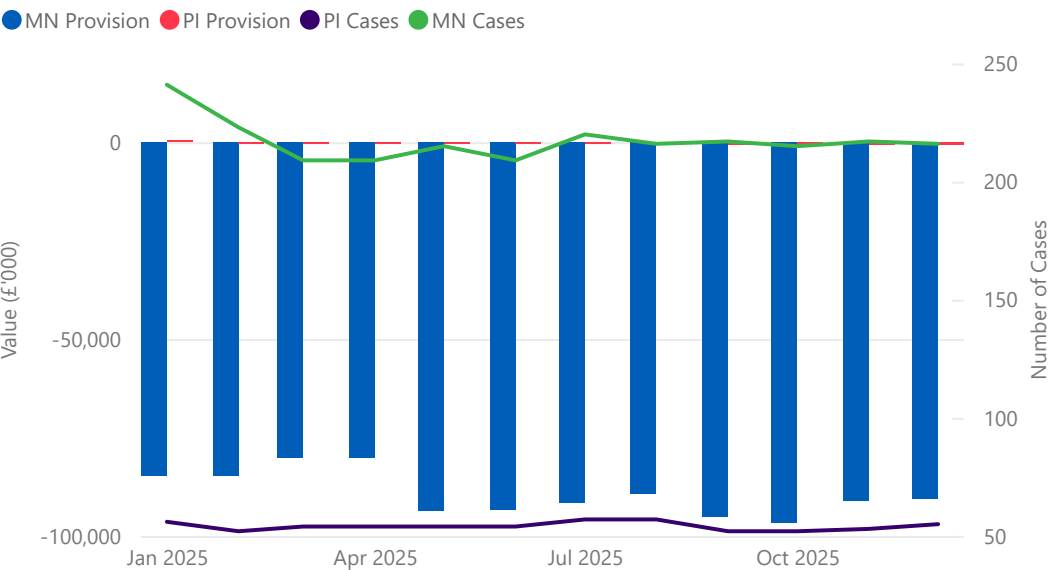


Cash WG Allocation



Summarised	Opening Balance £'000	Month 9 £'000	Movement M9 £'000
Fixed assets	377,071	397,922	20,851
Other non current assets	61,900	69,801	7,901
Total Non Current Assests	438,971	467,723	28,752
Cash	3,943	1,635	-2,308
Inventories	12,475	12,429	-46
Other financial assets	148	148	0
Trade and other receivables	68,508	75,803	7,295
Total Current Assets	85,074	90,015	4,941
Total Assets	524,045	557,738	33,693
Provisions	33,839	36,590	2,751
Trade and other payables	162,040	149,117	-12,923
Total Current Liabilities	195,879	185,707	-10,172
Total Net Assets less Liabilities	328,166	372,031	43,865
Provisions	61,742	66,760	5,018
Trade and other payables	6,837	5,371	-1,466
Total Non-current liabilities	68,579	72,131	3,552
Total Assets Employed	259,587	299,900	40,313
General Fund	198,951	226,926	27,975
Revaluation reserve	60,636	72,974	12,338
Total Taxpayers' equity	259,587	299,900	40,313

Medical Negligence & Personal Injury





Aged Payables



Aged Receivables



PSPP



Cash



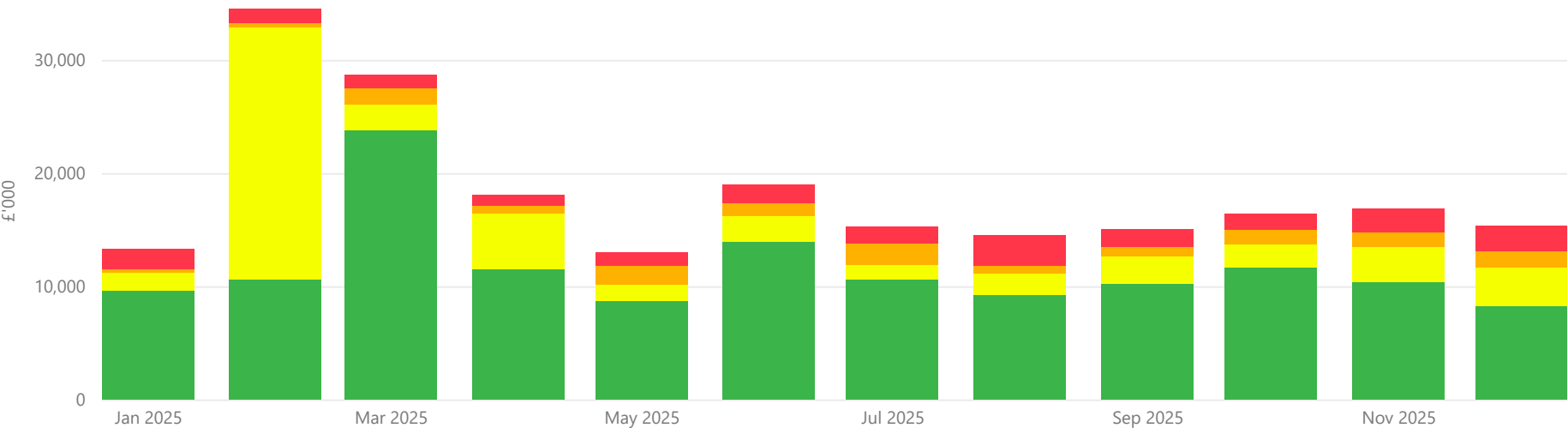
Working Capital



Medical Negligence

Aged Payables

Under 30 days 30-60 days 60-90 days Over 90 days



As at the end of December there were £15.4m of unpaid supplier invoices in the Oracle financial ledger (£15.0m at the end of September). Of these, £7.1m were over 30 days old, representing 46% of the overall outstanding number of invoices (32% at the end of September).



Aged Payables



Aged Receivables



PSPP



Cash



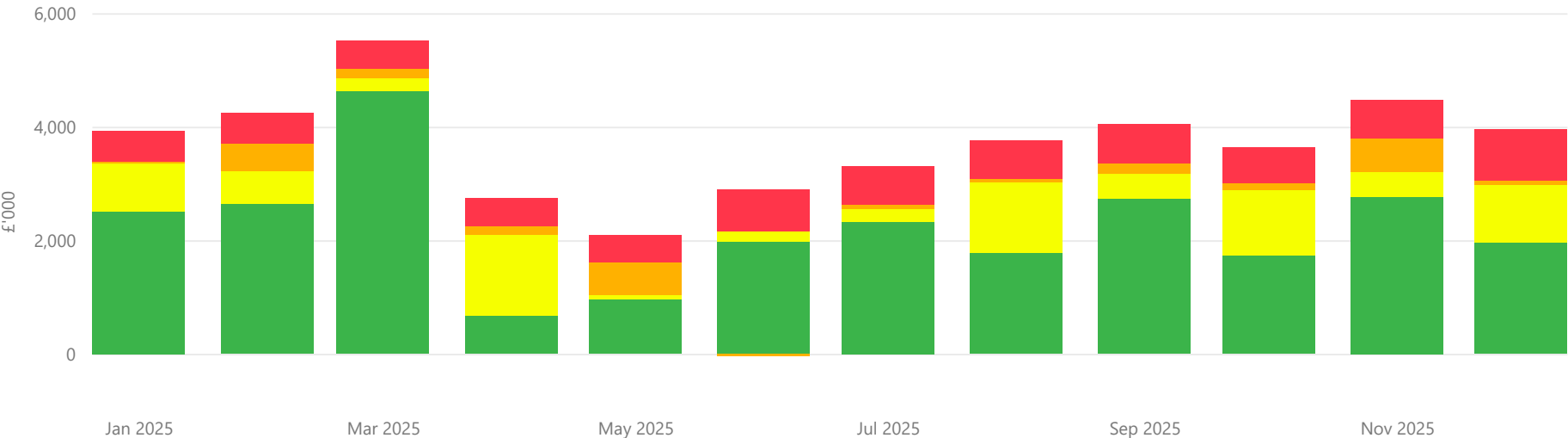
Working Capital



Medical Negligence

Aged Receivables

Under 30 days 30-60 days 60-90 days Over 90 days



A sum of £103k is being repaid directly to the Health Board by instalment or salary deduction.

A sum of £253k is currently being managed on our behalf by our debt recovery agency, CCI.

As at the end of December there was £4.0m (£4.0m at the end of September) of debt owed to the Health Board, of this £2.0m, (50%) (corresponding September figure was £2.7m, 68%) was under 30 days old.



Aged Payables



Aged Receivables



PSPP



Cash



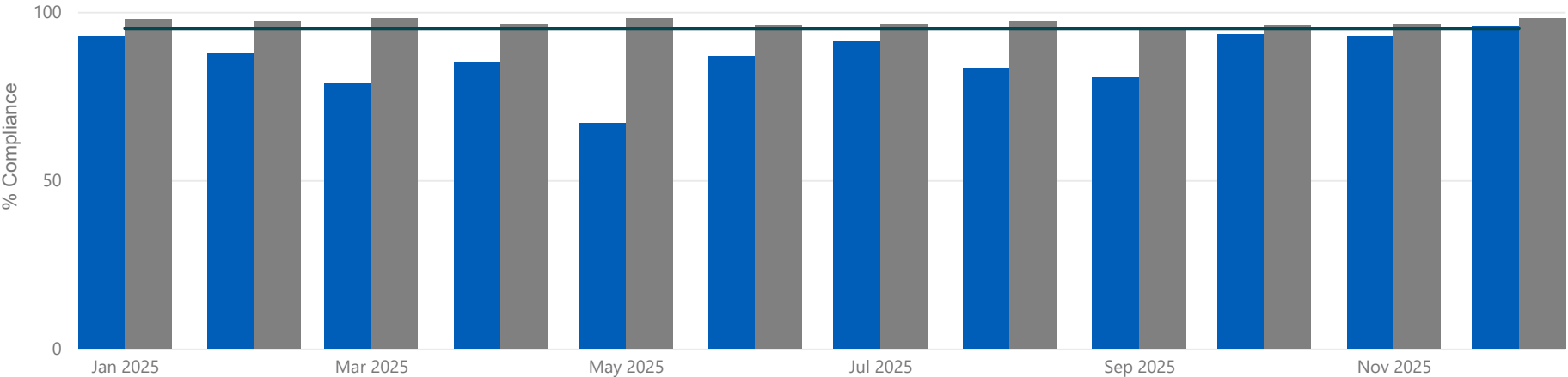
Working Capital



Medical Negligence

Public Sector Payment Policy (PSPP)

● NHS ● Non NHS ● 95% Target



The Health Board has achieved its PSPP target of paying 95% of its non-NHS invoices within 30 days in December with 98.0%, but has achieved a cumulative position of 96.6%. Compliance for Quarter 3 was 96.8% (95.9% for Q2). The Health Board achieved its PSPP target of paying 95% of its NHS invoices within 30 days in December with 95.7%, and a cumulative position of 88.3%. Compliance for Quarter 3 was 98.9% (84.9% for Q2).



Aged Payables



Aged Receivables



PSPP



Cash

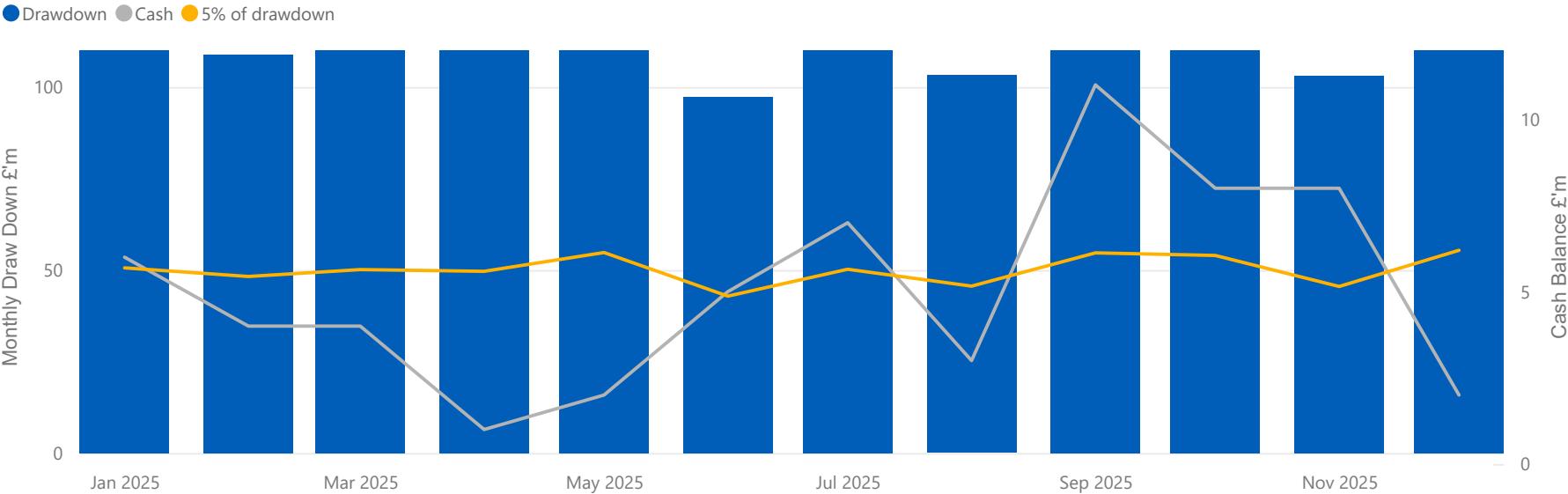


Working Capital



Medical Negligence

Cash WG Allocation



The Health Board has an approved cash limit of £1,341.4m split between revenue of £1,299.7m and capital £41.7m. Cumulative cash draw down to the end of December is £1,018.5m. The closing balance as at 31st December 2025 was £1.6m.



Aged Payables



Aged Receivables



PSPP



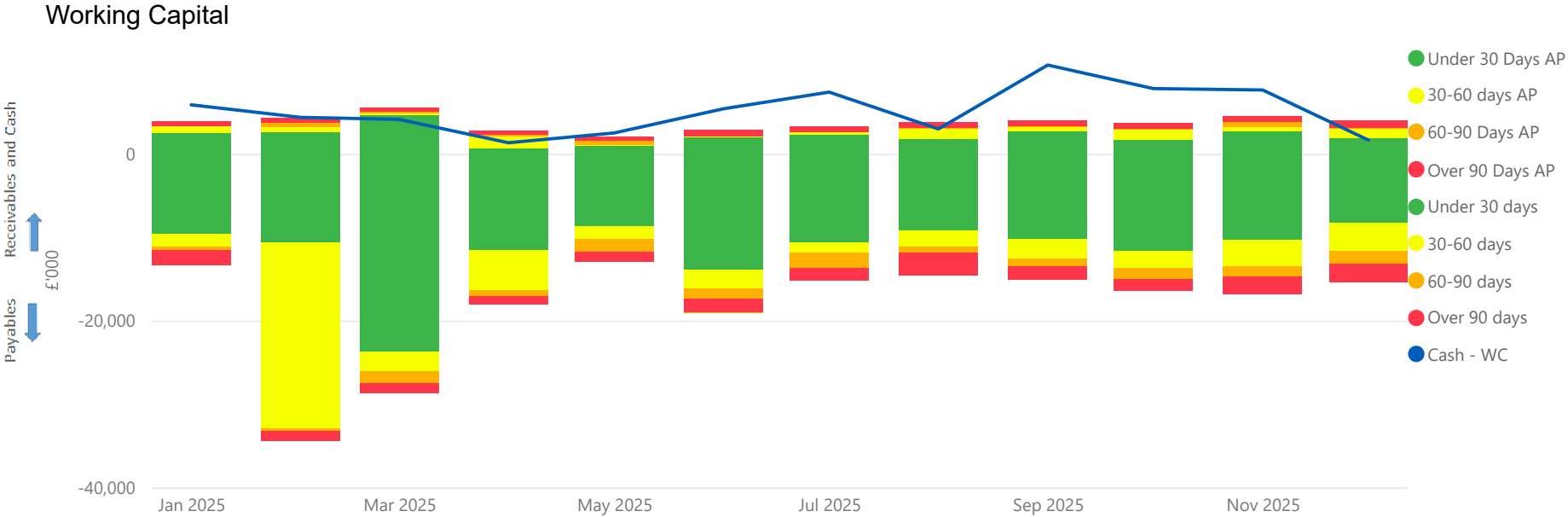
Cash



Working Capital



Medical Negligence



As at the end of December, the cash balance is £1.6m (£10.6m at the end of September). Balances owed to the Health Board at the end of December are £4.0m (£4.0m in September). It is imperative that this is collected promptly to reduce reliance on cash support from WG. Balances owed to suppliers at the end of December are £15.4m (£15.1m in September).



Aged Payables



Aged Receivables



PSPP



Cash

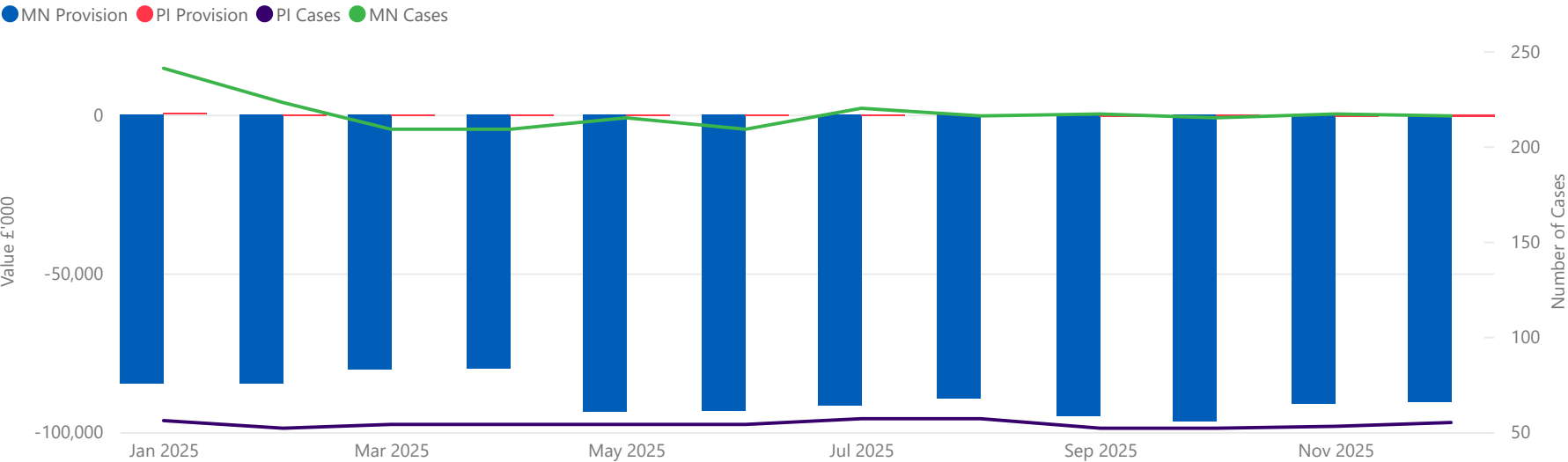


Working Capital



Medical Negligence

Medical Negligence & Personal Injury



The movement in the provision for medical negligence cases from the end of 2024/25 is £10.3m increase. This is due to an increase in the number of cases and increases in the provision across a number of cases.

4.5

12:15 PM, 10 Mins

4.5 - PROCUREMENT SCRUTINY

Gemma Deverill
(NWSSP -
Procurement)

| For assurance

Attachments

[Procurement Scrutiny FPC 24 February 2026.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
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 Members of the Finance and Performance Committee of:

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. **Principal Contractor for Construction Delivery – Glangwilli Hospital Phase 2 Fire Improvement Works**

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
May 2026 (subject to WG BJC approval) for a two-year term	TBC - This will be confirmed post SRC and will be included within the Board paper.	N/A	£2,571,639.27	£5,143,278.85 Exc VAT

2. Principal Contractor for Constructor Delivery – Glangwilli Hospital Phase 2 Fire Improvement External Civils Works

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 FPC 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. Outsourcing of IVT Procedures

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 FPC and will be included within the Board paper.	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.	TBC - This will be confirmed post FPC and will be included within the Board paper.

Asesiad / Assessment

1. Principal Contractor for Construction Delivery – Glangwilli Hospital Phase 2 Fire Improvement Works

The project will deliver essential fire safety upgrades at Glangwili Hospital (GGH) in accordance with Fire Safety Matters notices issued by Mid and West Wales Fire and Rescue Service (MWWFRS).

The works form part of an agreed phased programme to enhance fire precautions across clinical and non-clinical areas, ensuring statutory compliance and patient safety. The scope of works includes vertical and horizontal fire stopping; repair or replacement of fire doors and ironmongery; replacement of fire dampers and associated power, controls and panel

connections; temporary service diversions; and reinstatement of finishes affected by the works. Asbestos surveys and, where required, licensed removal are included.

Works are informed by validated surveys, design information, and pre-construction data prepared by the client's appointed design team. Contractor design responsibility is limited to detailed installation elements. Works will be undertaken within a live hospital environment, including agreed out-of-hours working where required. Performance will be monitored against defined KPIs covering cost, programme predictability, defects, health and safety, and value for money, aligned with Welsh Government construction policy and NHS Wales objectives.

A mini competition was undertaken via the South & West Wales Regional Construction Framework (SWWRCF) Lot 4a. Two bids were evaluated, and following stakeholder review, it is recommended that the contract be awarded to the highest scoring bidder.

The proposed contract term will run for two years from May 2026 (subject to WG approval).

2. Principal Contractor for Constructor Delivery – Glangwilli Hospital Phase 2 Fire Improvement External Civils Works

To complete outstanding fire safety and evacuation compliance works at Glangwili Hospital, as required by MWWFRS. The works were agreed with MWWFRS and delivered in two phases:

- **Phase 1** (Internal Works): completed between June 2021 and February 2025.
- **Phase 2** (External Works): addresses the remaining evacuation requirements. The Business Justification Case is being re-developed following appointment of the design team.

Key works include a new external evacuation lift, link bridge, access ramps, an external CAT ladder, and the upgrade of an existing lift to evacuation-compliant standards. The objectives are to achieve full compliance with fire safety and evacuation requirements, while improving delivery efficiency and value for money. Performance will be monitored against defined KPIs covering cost, programme predictability, defects, health and safety, and value for money, aligned with Welsh Government construction policy and NHS Wales objectives.

A mini-competition is in progress using the South & West Wales Regional Construction Framework (SWWRCF) Lot 3a – West, facilitated by Carmarthenshire County Council.

The contract term and value will be confirmed post Full Project Confirmation (FPC) and included in the Board paper.

3. Outsourcing of IVT Procedures

HDdUHB seek to commission outsourcing services to support with WG Eye Care Measures for ophthalmology. Speciality includes initial assessment, vision, Intraocular Pressure (IOP) and Optical Coherence Tomography (OCT) (further test such as widefield retinal photograph, OCT may be required dependent on the patient) intravitreal injection, review and follow up.

An estimated volume of up to 2700 Intravitreal injection procedures to be administered over 12 months (circa 300 Intravitreal injections every 4-6 weeks) will be called off by 31 March 2027.

A Mini Competition is in process utilising the All-Wales Framework Agreement for Provision of Clinical, Surgical and Diagnostics Procedures, Lot 1.

The contract term and value will be confirmed post-FPC and will be included within the Board paper. Please note this is a zero-commitment contract.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to scrutinise and recommend for Board to:

- **APPROVE** the award of Principal Contractor for Construction Delivery - Glangwilli Hospital Phase 2 Fire Improvement Works to (provider, value and contract term to be confirmed prior to Board). This contract will have onwards submission to HDUHB Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award of Principal Contractor for Constructor Delivery - Glangwilli Hospital Phase 2 Fire Improvement External Civils Works to (provider, value and contract term to be confirmed prior to Board). This contract will have onwards submission to HDUHB Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award of Outsourcing of IVT Procedures to (provider, value and contract term to be confirmed prior to Board). This contract will have onwards submission to HDdUHB Board and Velindre University NHS Trust (as hosts of NHS Wales Shared Services Partnership).

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 Termiau: 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

4.6

12:25 PM, 5 Mins

4.6 - PLANNING OBJECTIVE UPDATE REPORT Q3 2025/26

*Huw Thomas (Hywel
Dda UHB - Director
of Finance)*

| For assurance

Attachments

[Planning Objective Update Report Q3 2025-26 FPC 24 February 2026.pdf](#)

[Annex 1 Planning Objective Highlight Report Q3 2025-26.pdf](#)



**PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planning Objectives Update Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Angharad Lloyd-Probert, Senior Project Manager (Planning)

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

A set of 10 Planning Objectives (POs) have been developed and reviewed through Quarter1 of 2025/26 as an integral part of the Hywel Dda University Health Board's (HDdUHB) Annual Plan for 2025/26. The POs set out the aims of the organisation, *i.e.* the horizon that HDdUHB is driving towards over the long term, as well as a set of specific, measurable actions, which move the organisation towards that horizon over the next year.

For 2025/26, four Planning Objectives have been aligned to the Finance and Performance Committee (FPC), namely:

- **Planning Objective 2:** Financial Recovery and Roadmap
- **Planning Objective 3:** Urgent and Emergency Care
- **Planning Objective 4:** Planned Care including Cancer and Diagnostics
- **Planning Objective 5:** Mental Health and Learning Disabilities

As in previous years it is the expectation that FPC will receive an update on the progress made in the development (delivery) of the Planning Objectives for onward assurance to the Board through the Board Assurance Framework.

Cefndir / Background

The Planning Objectives are the bedrock of our Annual Plan for 2025/26, and this report is presented as an update on the key elements of Planning Objectives 2,3,4 and 5 and can be found in **Annex 1**. The PO updates have been brought to committee for assurance of progress.

Asesiad / Assessment

The Planning Objectives remain a key element of the Annual Plan for 2025/26, The updated position on 2025/26 Planning Objectives is detailed in the **Annex 1** Highlight Reports.

Planning Objective	Executive Lead	Updated position on 2025/26 Planning Objectives
2: Financial Recovery and Roadmap	Director of Finance	On Track
3: Urgent and Emergency Care	Director of Operations	On Track
4: Planned Care including Cancer and Diagnostics	Director of Operations	On Track
5: Mental Health and Learning Disabilities	Director of Operations	On Track

For **PO2, Financial Recovery and Roadmap**, this is **on track**: On track having undertaken several reviews across the Executive Team, Board Seminar and Finance and Performance Committee. Whilst the expectation of the roadmap was to align to the targeted intervention criteria, i.e. financial breakeven by 2027/28, with the recent budget allocation confirmations, there is a risk that the level of savings required to deliver breakeven might not be practically possible to deliver, even though a suite of opportunities in excess of the required are available. It should be noted that a Welsh Government (WG) one year budget was committed, with clarity around 2027/28 and beyond not yet provided

For **PO3, Urgent and Emergency Care**, this is currently **on track**: The Majority of deliverables against the portfolio of work are complete, A minority remain behind due to resource, but mitigations are in place to address.

For **PO4, Planned Care including Cancer and Diagnostics**, the overarching progress is **on track**, with the three individual components being:

- Referral To Treatment – on track
- Diagnostics – on track
- Cancer – on track

For **PO5, Mental Health and Learning Disabilities**, this is **on track** the overarching progress is on-track, with progress having been made in a number of key areas, although there is acknowledgement that there is more to do.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked **RECEIVE 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.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.17 Seek assurance on delivery against all Planning Objectives aligned to the Committee in
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	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
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:	3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map 3 Transforming Urgent and Emergency Care programme 4 Planned care, diagnostics and cancer Recovery 5 Mental health and CAHMS
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:	Annual Plan 2025/26
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board	Public Board - March 2025 (acceptance of 2025/26 Planning Objectives being developed through Quarter 1 25-26 as part of the Annual Plan)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Any financial impacts and considerations are identified in the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Any issues are identified in the report.

Gweithlu: Workforce:	Any issues are identified in the report.
Risg: Risk:	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed.
Cyfreithiol: Legal:	Any issues are identified in the report.
Enw Da: Reputational:	Any issues are identified in the report.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Planning Objective: Planning Objective 2 – Financial recovery and route map	Executive Lead: Huw Thomas
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Reporting Period: February 2026

Overall status: ~~Complete~~ / ~~Ahead~~ / On-track / ~~Behind~~

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

On track having undertaken a number of reviews across the Executive Team, Board Seminar and Finance and Performance Committee . Whilst the expectation of the Roadmap was to align to the targeted intervention criteria, i.e. financial breakeven by 2027/28, with the recent budget allocation confirmations, there is a risk that the level of savings required to deliver breakeven might not be practically possible to deliver, even though a suite of opportunities in excess of the required are available. It should be noted that a Welsh Government one year budget was committed, with clarity around 202728 and beyond not yet provided.

Activities completed in previous reporting period

Launched recovery route map within finance, collaborating to ensure owners are identified for all component parts.
 First draft shared with Executive Team and further versions then shared with Board Seminar and Finance and Performance Committee.
 Updated modelling undertaken for all three year horizon costs 2026-29.
 Insight provided for an approach to cap investments linked to academic evidenced prevalence demand within our region.
 Long list of opportunities over-achieve the required levels of savings.
 New approach agreed in principle to ensure sustainability by converting non-recurrent savings.

Activities planned for next milestone and reporting period

Executive Team scrutiny on 28 January 2026.
 Functional savings plans to be received by 31 January 2026 – **current high risk** to met expectation.
 Update following revised operational/clinical plans being submitted with planning priorities further refined.
 Full submission to Finance and Performance Committee in February 2026 for endorsing and ongoing inclusion in the March 2026 Public Board meeting to approve the proposed financial plan across the three-year time horizon.
 Refinement required at each stage to ensure latest modelling is reflected.

Any other Comments

Matters for information: The adopted Planning Coordinate Group approach to ensure leadership scrutiny and prioritisation has not achieved its set goal, resulting in uncertainty to some of the priority investments that will be required.

Risks to delivery: Similarly, operational pressures are noted as reasons for Savings Plans not being fully developed at this stage, signally an element of risk and assumption that is taken into the roadmap.

Any other comments: A Roadmap will be finalised and submitted to Board in March 2026, but it is currently unclear if this will meet the expectations set out by Welsh Government – namely to demonstrate financial improvement year on year until achieving breakeven in 2027/28.

Planning Objective PO3: UEC

Executive Lead: Andrew Carruthers

Reporting Period: Q3 2025

Overall status: On-track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery): Majority of deliverables against the portfolio of work are complete, A minority remain behind due to resource but mitigations are in place to address.

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances): Please see Slide 2

Example Activities completed in previous reporting period

- 7-Day CSH, Hosdpital@Home and SDEC Business Case completed and submitted for decision at Public Board on the 29th of January
- Clinical Mentorship, Care Home Training/Equipment and Clinical Streaming Hub Transport Projects all implemented and live
- Clinical Streaming Hub dashboard established and reporting aligned to National requests for data
- Business Cases developed for additional Clinical Streaming Hub monies from Welsh Govt., these are centred on the procurement of the Istumble App, the pop-up Aberystwyth SDUC and additional administrative staff to support Clinical Streaming.
- Health and Social Care discharge training programme undertaken, online discharge toolkit established and further Criteria Led Discharge Training progressed across Hywel Dda
- UEC Environmental audits undertaken and Environmental plans developed across all Hospital sites

Activities planned for next milestone and reporting period (Q4)

- Detailed implementation Plan for 7-Day Business Case and operationalisation of model
- Care Home support evaluation
- Development and sign off of the 26/27 Six Goals Programme Business Cas
- Winter Sprint 2 – Boarding and Surge Bed review and implementation of reaccommodation's

Any other Comments

Risks to delivery:

- The Unscheduled care Risk remains the most challenging Risk for the care group and the transformation required will be a resource challenge as we move forward at pace to achieve a different model prior to next winter
- Unexpected project work being driven through additional funding from Welsh Govt
- Project Management support – the rapid implementation requirements around the 7-day business case, in addition to the commitments from the Six Goals Programme, Winter Sprint and additional funded projects, may mean that the team are under capacity to support. To mitigate work plans will be reviewed once approvals have been made with regard to the scope of the 7-day business plan and Six Goals Programme plan, and shortfalls escalated appropriately

Programme Metrics, Quarter Three 2025

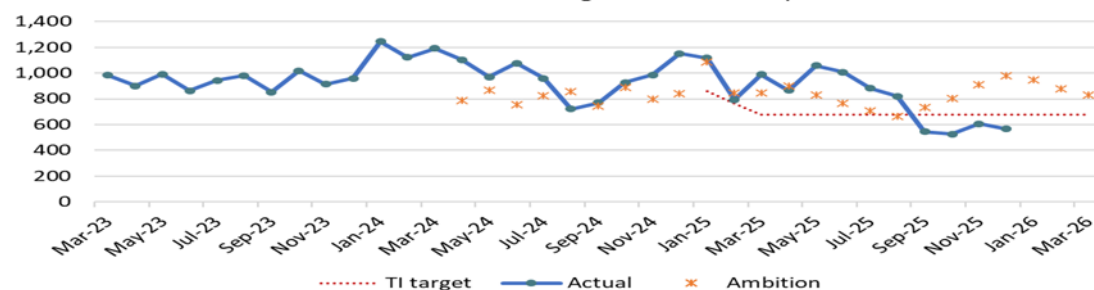


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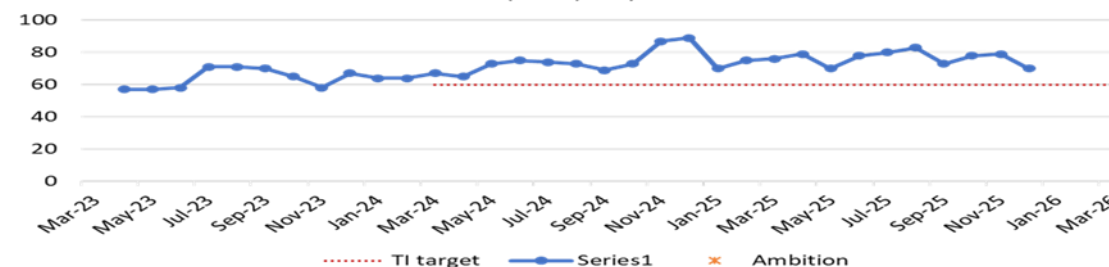


Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

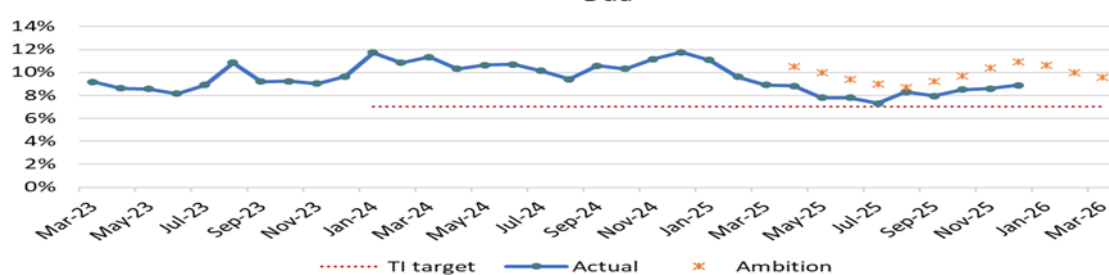
SAI Ambulance handovers taking over 1 hour - Hywel Dda



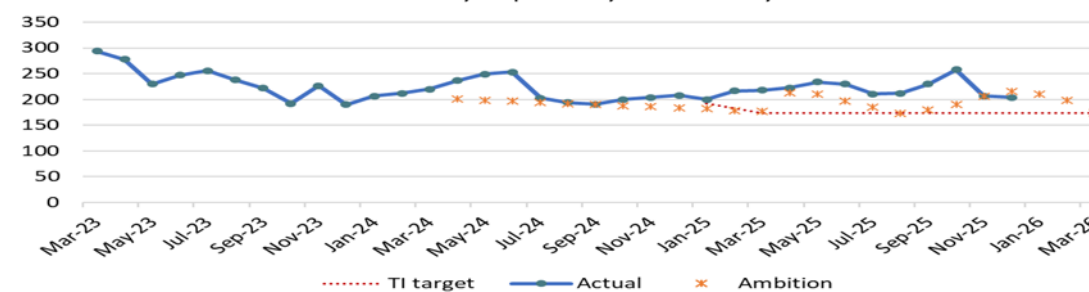
Median time from arrival at ED to assessment by a clinical decision maker (mins) - Hywel Dda



% patients waiting over 12 hours in an emergency department - Hywel Dda



Number of delayed pathways of care - Hywel Dda



Targeted Intervention targets met for Ambulance Hanover >1hr in last quarter, other targets remain over (last data point December 2025).

- Health Board >1hr ambulance delays have shown an improving trend over the last year, with the Health Board being below TI targets since September 2025.
- Median time from arrival to assessment in December was 70 mins, remaining above TI target of 60 mins for the Health Board.
- % of patients waiting >12 hours has shown an increasing trend for Quarter 3 and in December 2025 was at 8.9%, above TI target of 7%
- The number of POCDs has shown an improving trend in Quarter 3, in December 2025 at 204. However, this is still above TI target of 174 for the Health Board.

Planning Objective PO 4: Plannned Care

Executive Lead: Andrew Carruthers

Reporting Period: Q3 (25/26)

Overall status: On Track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

52 Week Outpatients: The care group achieved zero breaches over 52 weeks at the end of December 2025 for all specialties apart from Rheumatology (7). This was due to consultant sickness. Ongoing monthly delivery trajectories indicate that the Care group will achieve and maintain the zero breach position by utilising de mand and capacity forecasts to highlight risk areas and allocate any additional funding to appropriate specialties accordingly.

RTT 104 Weeks: Whilst work is underway to achieve zero breaches over 104 weeks by the end of March 2026, there is a high risk associated with around 26 patients under ENT pathways. The focus through 2025/26 is to achieve and maintain the zero breach position by utilising demand and capacity forecasts to highlight risk areas and allocate any additional funding to appropriate specialties accordingly.

Activities completed in previous reporting period

- Recovery is supported by outpatient modernisation plans including maximisation of self-management pathways such as See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).
- Demand and capacity trajectories anticipate this target being maintained in most specialties.
- Recurrent recovery monies are being prioritised for areas that anticipate breaches
- Active management and triage of referrals has resulted in no waiting list growth.
- Recent waiting list initiatives for end of year targets contribute to the increase in follow up waiting lists as more patients are processed through their pathways.

Activities planned for next milestone and reporting period

- Recovery plans being progressed in ENT & Ophthalmology (Ocular Plastics) . These plans include insourcing of theatre staff to secure core capacity and mitigate cancellations, outsourcing of tonsillectomy procedures and delivery of additional lists to recover backlogs
- Recovery plan in place to support recovery of quarter 2 orthopaedic breaches
- Key focus on maintaining waiting times targets into 2025/26 using capacity and demand forecasts to highlight risk areas in each specialty, with a view to allocate any additional funding to appropriate specialties.
- There is a refreshed Theatre Optimisation and Efficiency workstream led by the new Clinical Care Group to promote further improvements in theatre productivity across all specialties and achievement of GIRFT standards.

Any other Comments

Matters for information: Performance is reported monthly within the Integrated Performance Assurance Report (IPAR), Welsh Government Integrated Quality Performance and Delivery (IPQD). Additional scrutiny undertaken via weekly scrutiny meetings & external WG meetings.

Risks to delivery: Staffing due to national shortages. Demand exceeding capacity including additional cancer demand spikes.

Any other comments: The WG First outpatient plan has been approved by the Board and is planned to commence in September 2025 and run through until March 2026. Plan B is being progressed and will require support of insourced specialties and clinic OPD staff which is in the draft tender stage. These projects are managed by a well-established transformation team and underpinned by a Senior Governance review panel

Planning Objective 5 – Mental Health and Learning Disabilities

Executive Lead: Andrew Carruthers, Chief Operating Officer

Reporting Period: Q3 2025/26

Overall status: On-track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

Art Therapy - Continues to be a limited resource with 1.0wte covering 3 counties. All clients on the waiting list have been offered a supportive group interventions along with the therapist running Art Therapy groups to reduce the wait times as much as possible. We have strong links with the teaching institution, with regular student placements that support an increase in productivity for the duration of their placements.

Psychological therapy – The service has now commenced a prudent and tiered approach to high intensity intervention to support the increase in demand with a focus on groups as the initial intervention. Digital options continue to be explored, caps in therapy sessions in place, along with job plans to increase efficiencies across the service provision. The planned treatment groups have commenced across the 3 counties with further groups commencing over the next 2 months.

Child neurodevelopmental waits: The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position with the latter reported by Children’s Services. Children’s ASD performance in November 2025 of 21.5%, shows concerning variation but the target of 80% was not met. Performance is driven by ASD, where 517 of 3,499 (14.8%) patients had an ASD assessment < 26 weeks. Demand for assessment for continues to increase year on year, ranging from an average of 20 referrals per month (2016) to 110 per month (2025) with longest wait times approximately 3.6 years. Workforce constraints compounded by non-recurrent funding have a significant impact.

Adult neurodevelopmental waits: Adult ASD total waiting list is 2255 with a compliance of 16.2% waiting less than 26 weeks. This is contributed by demand outstripping capacity and no uplift in RIF budget since the service’s inception in 2019. For Adult ADHD, the total waiting list has increased to 5163, with a compliance of 19.2% waiting less than 26 weeks for diagnostic assessment. 865 adults are waiting to start treatment and trial medication. Lack of recurrent, ring-fenced money for adult ND services is creating unsustainable demand on services and extensive waiting times.

Activities completed in previous reporting period

1. Workforce stabilisation for in-patient areas continues. All wards are participating in the HCSW pay band review and recruitment for HCSWs is underway.
2. Outsourcing of Children’s neurodevelopment assessment for ASD to commence before end of Q4.
3. The development of a Single Point of Assessment service as part of 111 # 2 transformation, requires a location on the Prince Philip site. A meeting to identify a clinical area to provide this has been held but no progress to date.

Activities planned for next milestone and reporting period

- Review job plans and implementation of stepped care model in adult psychological therapies

Any other Comments

Matters for information:

- 72 hour follow up following discharge from adult inpatient consistently 100% achievement throughout reporting period.

Risks to delivery:

Delays in improvement work to Ty Bryn to enable LD service to be relocated from Penlan. Works now planned during Q1 26/27.

5 - PERFORMANCE

5.1

12:30 PM, 10 Mins

5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT

*Anthony Tracey
(Hywel Dda UHB -
Digital Director)*

| For assurance

Attachments

[IPAR M10 2025-26 FPC 24 February 2026.pdf](#)

[Appendix 1 IPAR Overview M10 2025-26.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Performance Update for Hywel Dda University Health Board – Month 10 2025/2026
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance In association with all Executive Leads
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Executive 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 10, 2025/26 Integrated Performance Assurance Report (IPAR) which summarises progress against a range of national and local performance measures. The IPAR consists of this covering report and the following supporting documents:

- **Appendix 1** 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 Integrated Performance Assurance Report Dashboard as of 31 January 2026. Ahead of the Committee meeting, the dashboard will also be made available via our [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:

- Audiology data has been included retrospectively for the period April 2025 to December 2025. This data is provisional pending completion of a data cleansing exercise within the service and development of formal internal and external reporting processes, including sign-off protocols.

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
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Jan 2026	1,368	Concerning	Missing target	n/a	Alert
% child neurodevelopment assess waits <26 weeks	80%	Dec 2025	20.5%	Usual	Missing target	n/a	Alert
Median time ambulance emergency category calls	8	Dec 2025	10	n/a	n/a	n/a	Alert
% R1 eyecare appts attended in target or 25% delay	95%	Dec 2025	55.5%	Concerning	Missing target	n/a	Alert
Pts waiting 8 wks+ for specified diagnostic	0	Jan 2026	3,669	Improving	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Jan 2026	72.0%	Improving	Missing target	n/a	Alert
Dental: % of Welsh resident adults accessing NHS primary dental care treatment within 24 months	n/a	Jun 2025	29.1%	Concerning	n/a	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Dec 2025	57.1%	Concerning	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Jan 2026	2,438	Concerning	Missing target	n/a	Alert
Financial in month deficit	n/a	Jan 2026	£1,286,000	Improving	n/a	◆ Trajectory met	Alert
S. aureus: Number of confirmed cases (in-month)	6	Jan 2026	14	Usual	Hit and miss	n/a	Alert
% Autumn 2025 COVID booster uptake for eligible residents	75%	Dec 2025	55.3%	n/a	n/a	n/a	Alert
E. coli: Number of confirmed cases (in-month)	21	Jan 2026	22	Usual	Hit and miss	n/a	Advise
% R1 eyecare patients waiting within 25% delay to target date	95%	Dec 2025	39.4%	Concerning	Missing target	◆ Within 5% of Trajectory	Advise
% sickness absence rate of staff	6.60%	Jan 2026	6.60%	Concerning	Hitting target	n/a	Advise
Dental: % of Welsh resident children accessing NHS primary dental care treatment within 12 months	n/a	Jun 2025	41.5%	Improving	n/a	n/a	Advise
Median time ambulance arrest category calls	8	Dec 2025	8	n/a	n/a	n/a	Advise
Number of Pathways of Care delayed discharges	n/a	Jan 2026	213	Usual	n/a	◆ Within 5% of Trajectory	Advise
Ambulance handover > 4 hours Hywel Dda	0	Jan 2026	195	Improving	Missing target	◆ Trajectory met	Advise
% pts on single cancer pathway within 62 days	75%	Dec 2025	66%	Improving	Missing target	◆ Trajectory met	Advise
Ambulance handover > 45 minutes Hywel Dda	0	Jan 2026	813	Improving	Missing target	n/a	Advise
Ambulance handovers > 1 hour Hywel Dda	0	Jan 2026	716	Usual	Missing target	◆ Trajectory met	Advise
% uptake of flu vacc - 65+ years	75%	Mar 2026	66.1%	n/a	n/a	n/a	Advise
C. difficile: Number of confirmed cases (in-month)	8	Jan 2026	10	Usual	Hit and miss	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	n/a	Jan 2026	43.2%	Improving	n/a	n/a	Advise
Follow-up appts - delayed >100%	0	Jan 2026	15,753	Improving	Missing target	n/a	Advise
Patients waiting 104 weeks+ RTT	0	Jan 2026	42	Improving	Missing target	n/a	Advise
Patients waiting over 52 weeks RTT	0	Jan 2026	10,555	Improving	Missing target	n/a	Advise
Waits over 52 weeks: new outpatient appointment	0	Jan 2026	16	Improving	Missing 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
% MH assess within 28 days (age 0-17)	80%	Dec 2025	98.6%	Improving	Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Dec 2025	92.1%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 0-17)	80%	Dec 2025	98.1%	Improving	Hit and miss	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Dec 2025	96.4%	Improving	Hitting target	n/a	Assure
Consultations delivered through PIPS	n/a	Nov 2025	2,976	Improving	n/a	◆ Trajectory met	Assure

Triangulating our data: 1st April 2022 to 31st January 2026.

- **Quality safety and risk** – the number of incidents causing moderate harm or above reported by month, continues to decrease since July 2025 (184), with January reporting 129. There has been an overall increase in the number of patient falls from 193 in August 2025 to 257 in January 2026. However, medication errors have decreased from 148 in June 2025 to 81 in January 2026. We continue to have significant numbers of high and extreme risks on the risk register with 549 in January 2026. There has been a significant decrease in the number of new complaints received since September 2025 (249) with 67 in January. The number of new infections decreased with January reporting 55 cases (S. aureus=14 cases, E. coli=21 cases, C. difficile=10 cases).
- **Workforce** – In month, staff sickness decreased slightly with 6.8% in January 2026. This is a change to the previous increasing trend. Short-term sickness increased slightly to 2.6% for January whilst long-term sickness decreased slightly to 4.3%. 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 (255). In January it was 64.4 whole time equivalent (WTE). Rolling 12-month staff turnover percentage is at its lowest ever recorded at 6.7%.

Quality, safety and risk	Best		Worst	Latest	Trend
Reported incidents causing moderate harm or above	124		305	129	
Patient falls	189		301	257	
Medication errors	61		148	81	
Pressure damage developing or worsening during care	54		215	73	
New complaints by month received (ward level not available)	62		249	67	
Number of high and extreme risks (health board & function only)	381		550	549	
Infections: new cases	53		81	55	
Infections: C. difficile cases	9		23	10	
Workforce					
Number of staff/contractor related incidents	98		186	159	
Sickness - short term	1.7%		2.8%	2.6%	
Sickness - long term	3.3%		4.9%	4.3%	
Number of vacancies	To follow				
Staff turnover (12 month rolling)	6.7%		9.8%	6.7%	
Nursing and midwifery vacancies	To follow				
Nursing and midwifery agency (WTE)	56.38		379.79	64.44	
Bank (WTE)	212.99		352.85	308.46	

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **DISCUSS** the IPAR – Month 10 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 31st January 2026

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](#)

Statistical process control (SPC) charts

[Why use SPC charts?](#)

[Anatomy of a SPC chart](#)

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](#)

Finance

[Financial Deficit](#)

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.

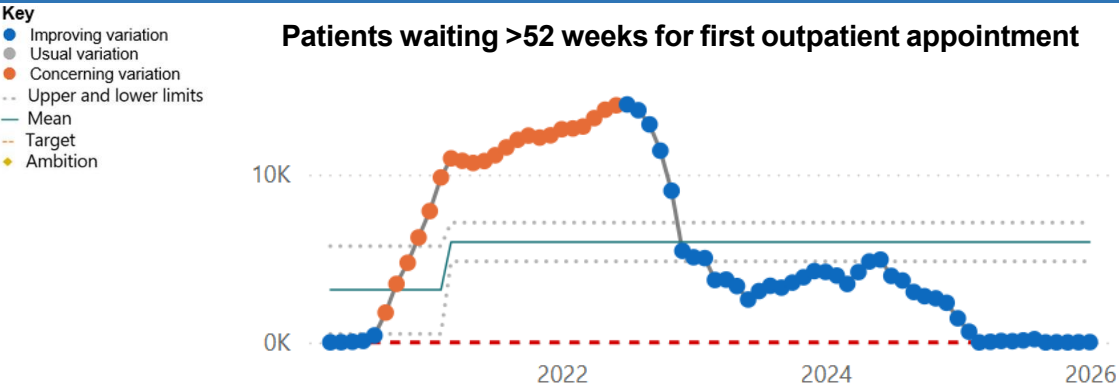
For data on all performance measures we are tracking, see our IPAR dashboard: [Integrated Performance Assurance Report \(IPAR\) dashboard as at 31st January 2026.](#)

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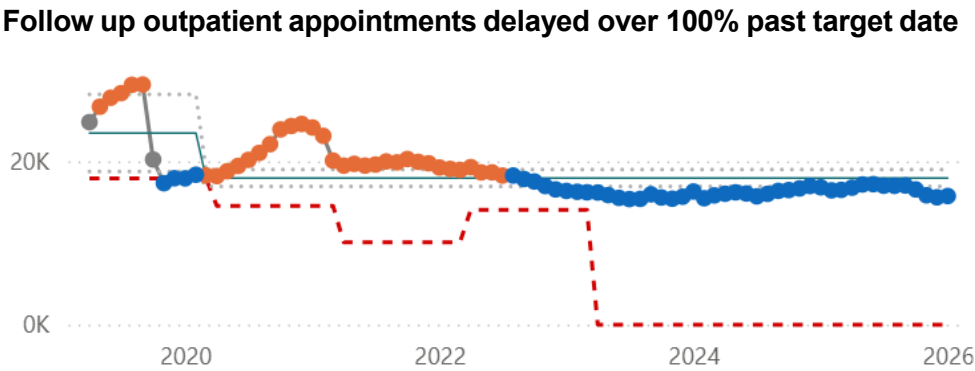
Alert
(may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

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.



Performance shows improving variation. There were 16 breaches in January 2026. Breaches have significantly reduced from the June 2024 peak (4,930).



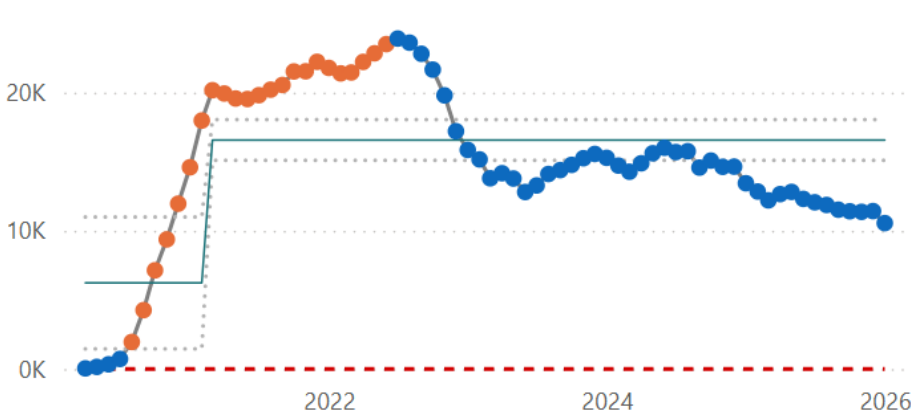
Performance shows improving variation. There were 15,753 follow ups delayed over 100% past their target date in January 2026.

Key challenges / issues	Key actions / initiatives	Due date
- The Health Board recorded zero 52-week waits for a first outpatient appointment across all specialties apart from General Medicine & Care of the Elderly (COTE) (16) at the end of January 2026, due to having insufficient orthogeriatric staff capacity to meet the demand. - Most specialties are expected to maintain targets, with recovery funding prioritised for Ear, Nose & Throat (ENT), Neurology, and Rheumatology. - 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. - Initiatives for reducing new outpatient waits have increased follow-up waits as more patients progress through pathways.	- 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). - Delayed follow-up wait reduction to below 12,000 supported by national clinical leadership and CIN (Clinical Implementation Network) guidelines. 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. - 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. - 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 Governor.	31/03/26 31/03/26 31/03/26 31/03/26 31/03/26

Key

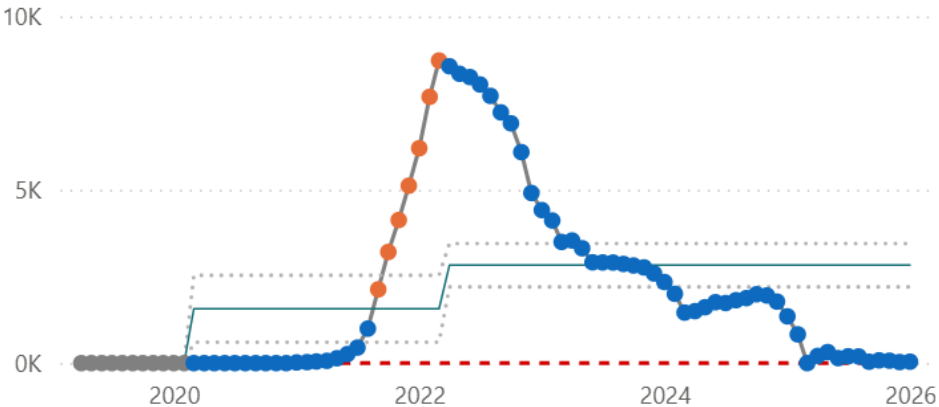
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting over 52 weeks from referral to treatment



Performance shows improving variation. The 10,555 breaches in January 2026 is the lowest in over five years.

Patients waiting over 104 weeks from referral to treatment



Performance shows improving variation. There were 42 breaches in January 2026. 99.9% of our patients are now waiting less than two years from referral to treatment.

Key challenges / issues

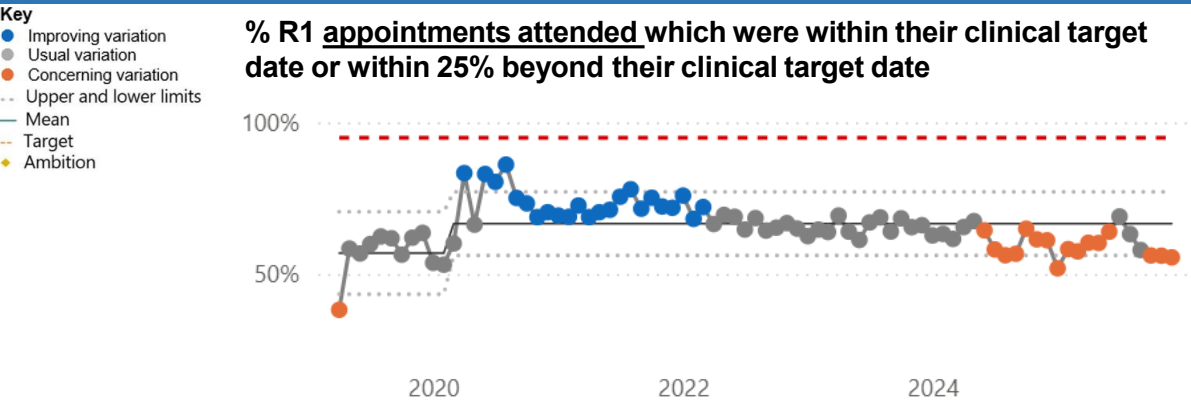
- Due to a reduced level of theatre staffing and cancellations, ENT (19) recorded breaches over 104 weeks for RTT. The 16 breaches in Orthopaedics relate to complex patients requiring additional multi-disciplinary team review and non-arthroplasty specialist treatment (i.e., upper limb). The 5 breaches in Gynaecology relate to equipment failure in Theatre and the 2 breaches in General Medicine relate to specific orthogeriatric diagnostic requirements.
- 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, and urgent cases consuming rescheduled theatre slots.
- Inpatient/day case activity exceeds pre-pandemic levels, but challenges remain with late starts, early finishes, and fallow (non-utilised) theatre lists due to workforce constraints.

Key actions / initiatives

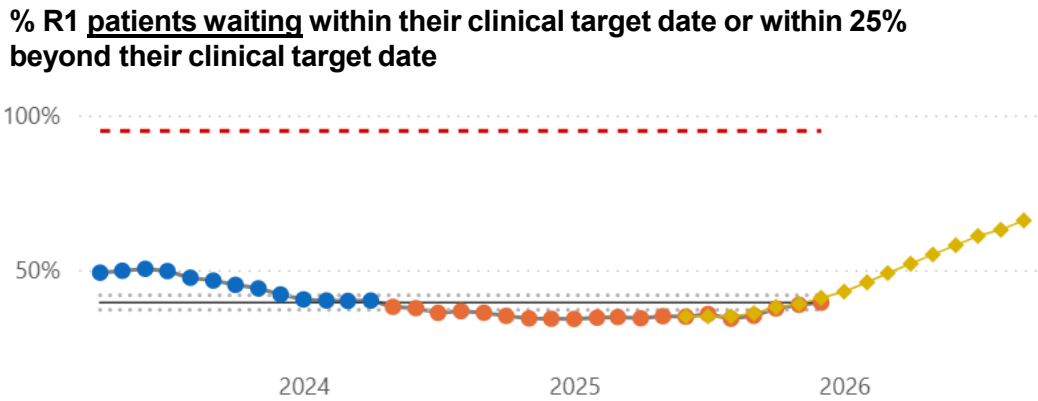
- Specialties are working to maintain and improve their 104-week positions into quarter 4 2025/26, the ambition being to clear all breaches.
- The directorate continues to focus on maintaining waiting time targets in 2025/26 using demand and capacity forecasts to highlight risks and guide funding allocation.
- 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 developed alongside the annual planning requirement.

Due date

- 31/03/26
- 31/03/26
- 31/03/26
- 31/03/26



Performance shows concerning variation, with December 2025 (55.5%) marking the fifth consecutive month of decline.



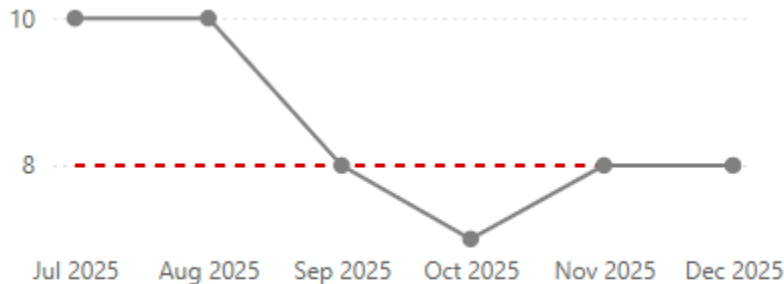
Performance shows concerning variation; however, December 2025 (39.4%) marks the fourth consecutive month of improvement.

Key challenges / issues	Key actions / initiatives	Due date
- Improvements in R1 patients waiting performance has led to a deterioration in R1 appointments attended performance. The advice from the Welsh Government is to focus on the patients waiting target as these are higher risk. Booking these patients, who have already breached, will improve this trajectory but will directly affect the appointments attended trajectory as patients have already breached. Once corrected, R1 appointments attended performance will naturally improve as capacity grows and the backlog reduces. - Increasing outpatient delivery has been stalled by interdependencies, including outpatient staffing and medical records constraints in Carmarthenshire and staff sickness in Pembrokeshire. This stall to increasing outpatient delivery equates to seven clinics per week. - Reduced workforce continues to impact on delivery, with vacancies for two whole time equivalent (WTE) consultant posts and two WTE specialty, associate specialist and specialist (SAS) doctor posts. - SAS doctor took a work break from September 2025 to May 2026 resulting in the loss of 10 sessions per week for a period of 5 months, impacting on delivery.	- Monies awarded to improve the patients waiting target have been utilised to onboard and train the necessary staff to improve this trajectory. More activity is being incrementally introduced. The next key action is to recruit the replacement SAS doctor in North Road Eye Clinic (NREC) to increase delivery. The second key action is to move the Intravitreal (IVT) service into Amman Valley Hospital (AVH) outpatients 5 days a week, meeting went ahead on the 12th January 2026. - Outpatient staff requirements outlined in annual planning cycle to build into Ophthalmology staffing model, with the intention of Ophthalmology staffing the blue suite in Glangwili Hospital (GGH) entirely. This will allow for the incremental increase in clinic delivery by 11 sessions per week. This requires staff to be recruited and trained in Ophthalmology. - Two regional consultant posts have been out to advert and interview date confirmed for 13th March 2026. Two SAS doctor posts are out to advert, closing date 22nd February 2026. One part time SAS agency doctor in post for month period to cover work break.	01/06/26 28/02/27 01/07/26

Key

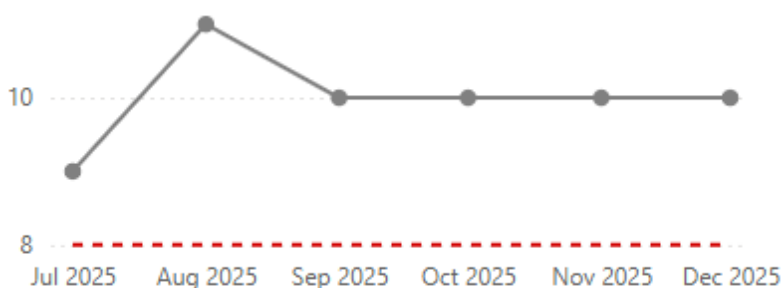
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Median emergency ambulance response time to purple: arrest category calls



In December, the median response time was 07:56 minutes for ARREST (Purple) Calls.

Median emergency ambulance response time to red: emergency category calls



In December, the median response time was 10:20 minutes for RED (Emergency) calls.

Key challenges / issues

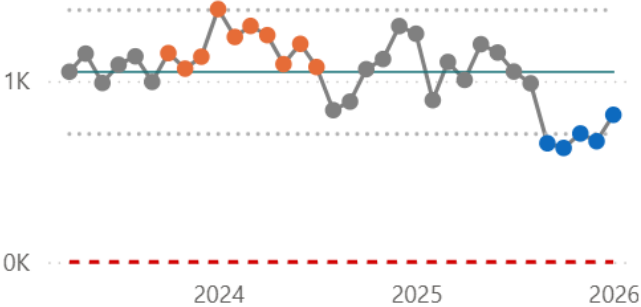
- As of the 2nd December 2025 further response category changes are being introduced and AMBER and GREEN calls will now be categorised as ORANGE now, YELLOW soon, GREEN planned, with further integration with remote clinicians aimed at admission avoidance and directing patients correctly at first point of contact, either through 111 or 999.
- Overall attended demand in Hywel Dda Health Board area for January 2026 on average has been above forecast.
- Hospital delays in ambulance hand over for WAST ambulance crews, 2,436 hours lost at the 4 acute Hywel Dda hospital sites during January 2026, slightly worsening from December 2025 by around 400 hours.
- There were 9 Immediate Vehicle Release (IVR) requests in January 2026, with one declined, resulting in an overall rate of 88.9%.

Embedded improvement actions

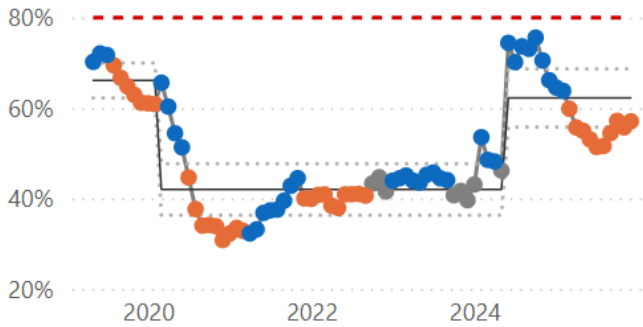
- Ongoing reviews of WAST resource escalation action plan (REAP) which identifies potential service pressures and is a system for managing and mitigating the impacts.
- Dynamic review of demand and area specific pressures using the clinical safety plan. Clinical safety plan provides a framework for WAST to respond to situations where the demand for services is greater than the available resources.
- 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.
- 111 press 2 assisting WAST clinicians to support the management of mental health patients.
- Porth Preseli and Eastgate clinical streaming hubs staffed with Advanced Paramedic Practitioners supporting multidisciplinary approach to admission avoidance and to support equitable coverage in Pembrokeshire and Carmarthenshire. Improvements being made with uplifting cover as additional APPs complete necessary training.
- WAST resourcing reviews and targeted overtime allocation
- Wait 45 initiative implemented, which will reduce length of ambulance wait times

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



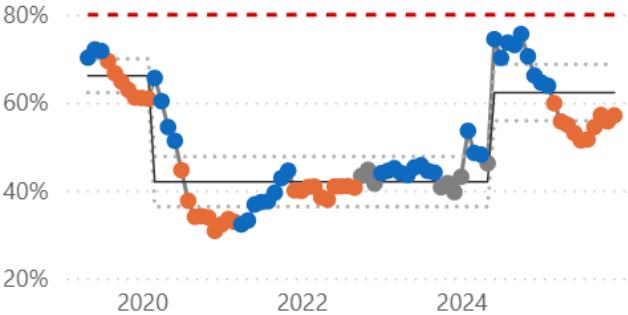
>45 Minutes handovers:

Latest data is showing improving variation
813 handovers > 45 minutes out of a total of 2,160 handovers.

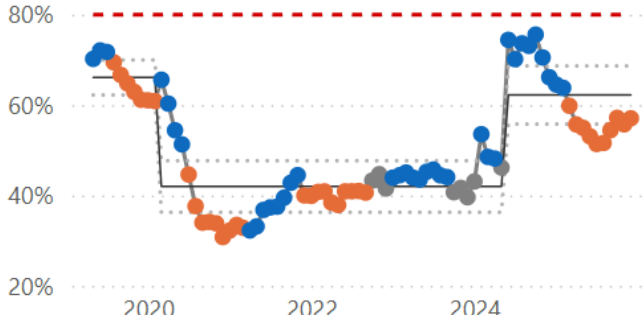
>4 hours handovers:

Latest data is showing improving variation. 195 handovers > 4 hour out of a total of 2,160, 9%.

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.
72% of patients were seen within 4 hours, 10,270 out of 14,264 new attendances.

Waits > 12 hours:

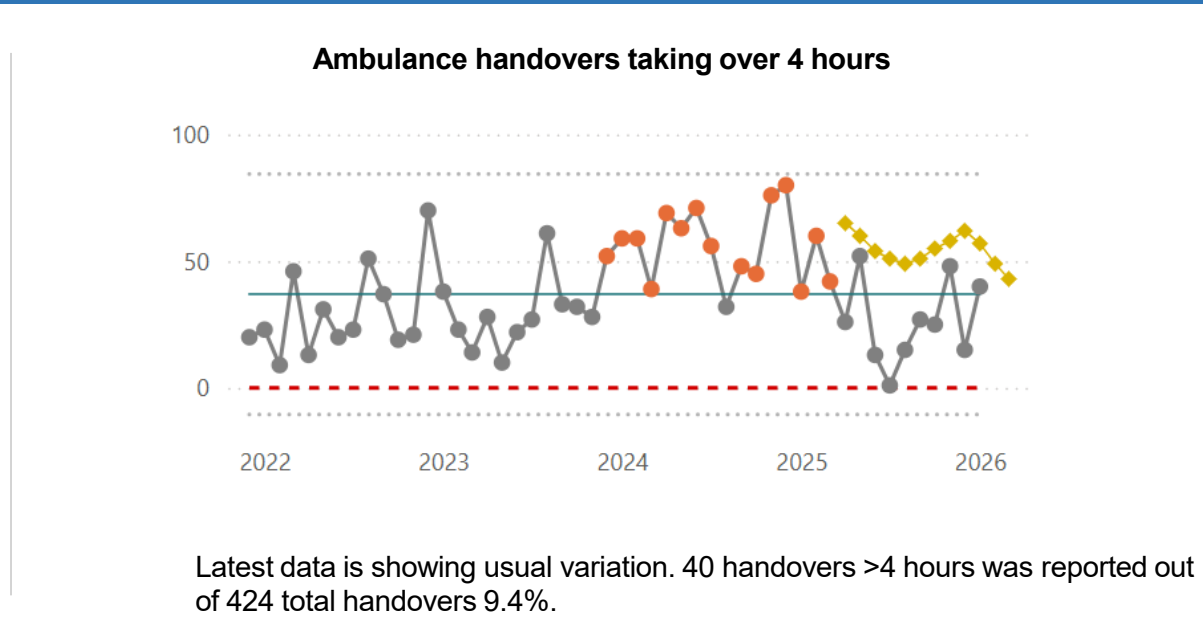
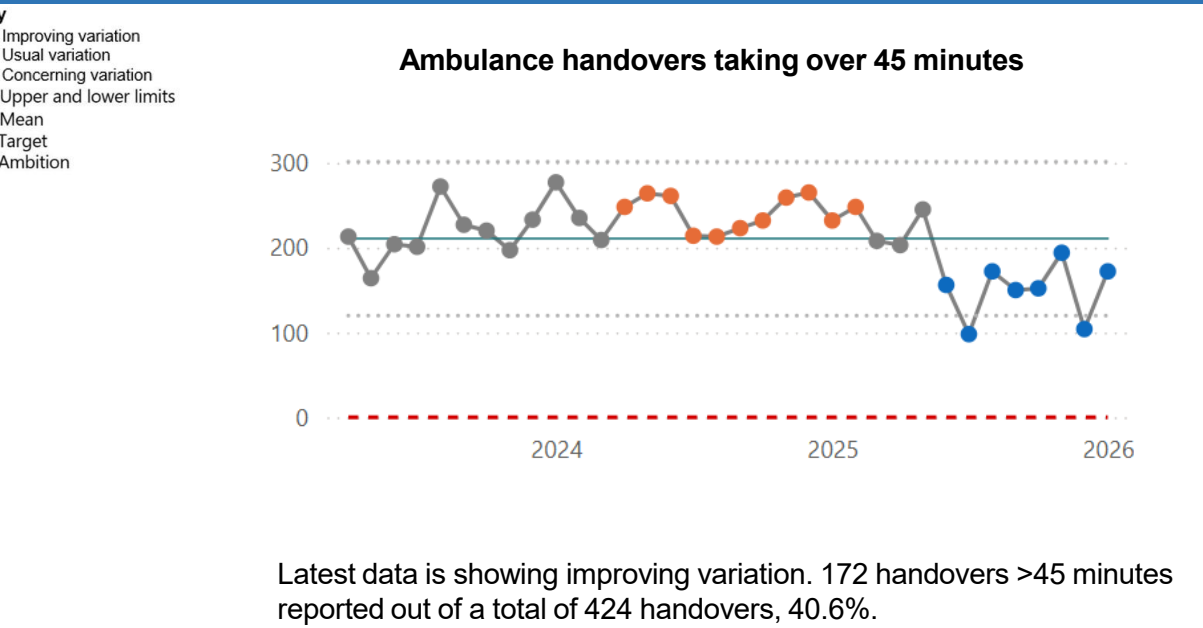
Latest data is showing concerning variation.
1,368 patients waited over 12 hours, out of 14,264 new attendances, 10%.

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. Welsh Government asked all health boards to take urgent, focused action to improve patient flow and reduce delays to discharge of patients from our care. The first Early and Weekend Discharge Winter Sprint Fortnight ran from 8–22 December and aimed 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. A second Winter sprint is planned for 21 January – 4 February 2026, allowing us to apply learning from the 1st sprint to those areas maintained, those that deteriorated and allowing a focus to sustained improvement.

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](#)
- [Prince Philip Hospital](#)
- [Glangwili Hospital](#)
- [Withybush Hospital](#)

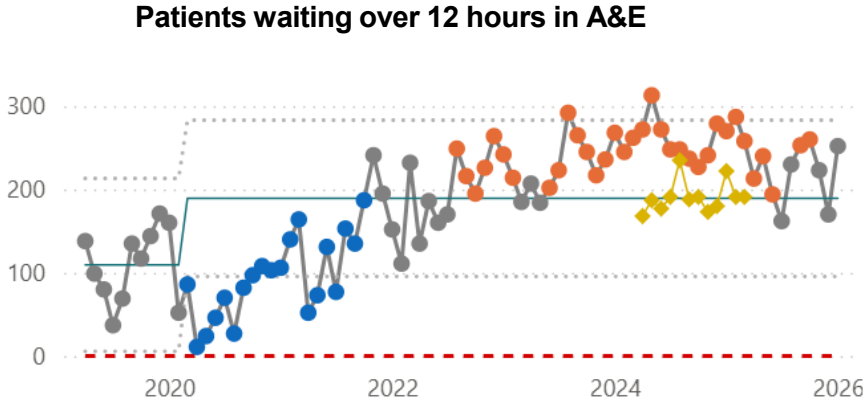
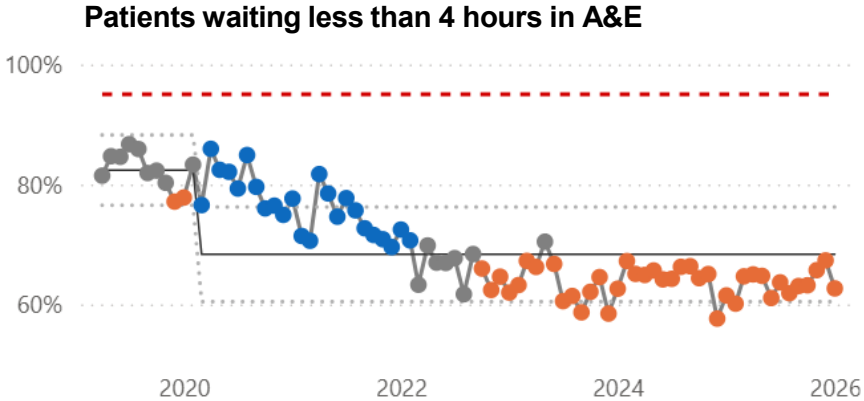


Key challenges / issues	Key actions / initiatives	Due date
- Persistent overcrowding within the emergency department, with limited space to receive ambulance handover of patients. - Staffing shortages leading to delayed decision making, insufficient numbers of clinical staff and senior decision makers contribute to slower patient assessment. - Delays in patient flow due to lack of available capacity across the Ceredigion acute and community system. - Physical space constraints limiting ability to treat patients in a timely manner therefore leading to delays in ambulance handover and onward admission. - Barrier patients due to infection control demand. Lack of side rooms across the site can often mean that patients have to remain in side rooms in majors/minors (emergency department).	- Second winter sprint initiative held 21 January – 4 February 2026. Review outcomes and learning to support further improvement actions Embedded improvement actions - Targeted 45 minute ambulance handover plan. - Ongoing monitoring and adjustment of processes to support patient flow. - Optimisation of all community capacity with proactive daily management of all clinically optimised patients (no longer requiring acute care) via integrated working across the Ceredigion acute and community system. - Clinical Steaming Hub vetting all medical referrals from GP Surgeries to avoid admission where possible	28/02/26

Page 335

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



Key challenges / issues

- Sustained high volume of bed occupancy, surge (pressure above capacity) and boarding at risk patients throughout January.
- Lack of physical space within the emergency department (ED) to allow rapid handover of ambulances.
- Early repatriation of pathway patients from referring hospitals continues to encounter delays.
- High volume of clinically optimised patients across ward areas.
- Barrier patients due to infection control demand. Lack of side rooms across the site can often mean that patients have to remain in side rooms in majors/minors (emergency department).

Key actions / initiatives

- Second winter sprint initiative held 21 January – 4 February 2026. Review outcomes and learning to support further improvement actions.
- Pilot to explore a pop up Same Day Urgent Care (SDUC) on the Bronglais hospital site

Due date

28/02/26
28/02/26

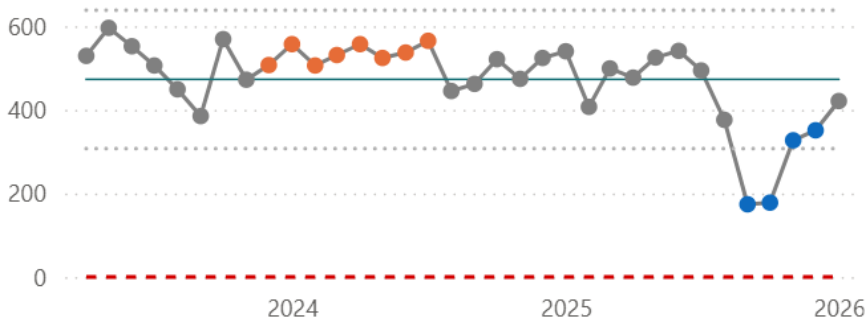
Embedded improvement actions

- Targeted 45 minute ambulance handover plan.
- Ongoing monitoring and adjustment of processes to support patient flow.
- Optimisation of community capacity with proactive daily management of all clinically optimised patients.
- Clinical Streaming Hub taking medical referrals from GP Surgeries to avoid unnecessary admissions where possible. Decision made to embed this permanently.

Key

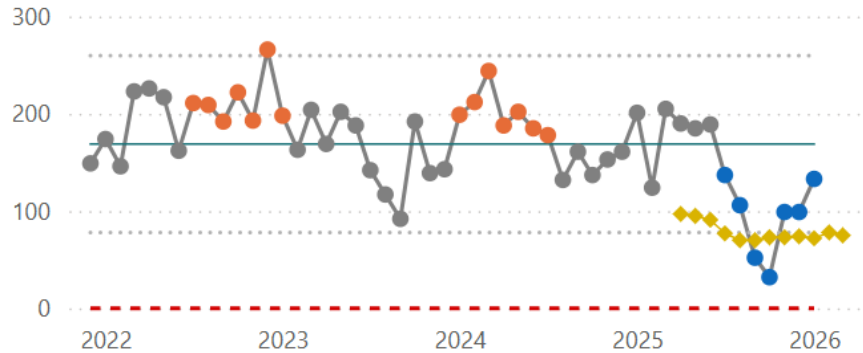
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



Latest data is showing usual variation. 421 handovers >45 minutes reported out of a total of 806 handovers, 52.2%.

Ambulance handovers taking over 4 hours



Latest data is showing improving variation. 133 handovers >4 hours reported out of a total of 806 handovers, 16.5%.

Key challenges / issues

- Emergency Department remains at high risk due to overcrowding and continues practice of corridor care.
- Boarding high number of non-ED patients within the département, which leads onto lack of physical space to handover patients in a timely manner.
- There has been a growing medical staffing deficit. High reliance on locum staff to fill the shifts (when possible).
- Increase prevalence in infection, prevention & control (IP+C) cases, which has blocked cubicles. It needs to be recognised cleaning of such cubicles when vacated takes longer than usual.
- There has been an increase in the demand this year than last year.
- The Carmarthenshire system has not had the Advanced Paramedic Practitioners navigator to review the ambulance stack on a consistence basis due unfilled rotas
- GGH declared risk escalation of 25/5 BLACK (the highest level of operational escalation) on many occasions throughout the month of January 2026

Key actions / initiatives

- Second "Winter Sprint" actions in progress. Will review data and the report from the NHS Wales performance and Improvement Team
- Same Day Emergency Care (SDEC) has increased opening hours 8am to 8pm, Monday to Friday

Due date

06/02/26
27/02/26

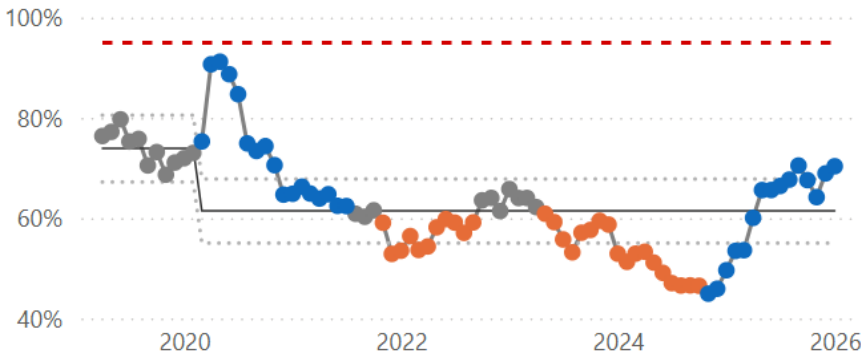
Embedded improvement actions

- Medical staffing deficits being reviewed daily. All leave scrutinised, balancing the need of the service without causing staff "burnout."
- Targeted 45mins handover plan with ongoing monitoring, to support patient experience and flow.
- Maintaining close working relationship with WAST, community, local authority and primary care. To aid in the process of sign posting patients to the correct care provider.
- Working collaboratively with Health Board patient flow unit to add in patient flow and repatriation of patients to the correct hospitals

Key

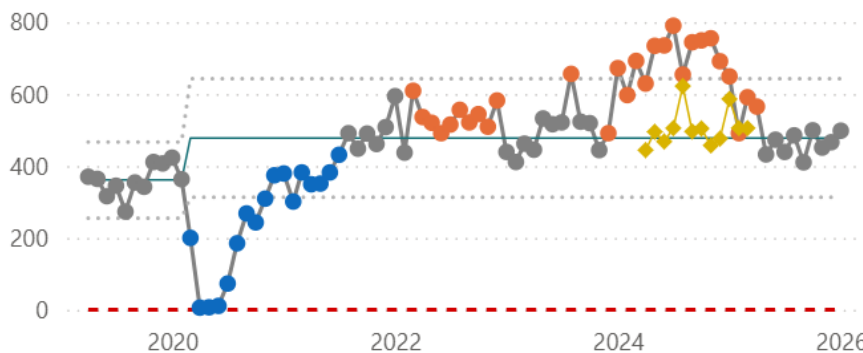
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E



70.3% reported for January, 1,315 breaches out of 4,434 new attendances. Chart is showing improving variation.

Patients waiting over 12 hours in A&E



498 breaches out of 4,434 new attendances, 11.2%. The chart is showing usual variation

Key challenges / issues

- Overcrowding in the department has reduce the physical space for the teams to see and treat patients in a timely manner.
- GGH has declared risk escalation of 25/5 BLACK (the highest level of operational escalation) on many occasions throughout the month of January.
- ED staff deficits and skill mix overnight have proved challenging contributing to lengthy waits for ED Clinician.
- The wards have surged and boarded to their full capacity.
- Lost beds noted throughout the month of January due to IP+C outbreaks, loosing capacity to transfer patients out of ED.
- Hight number of clinically optimised patients across all ward areas.

Key actions / initiatives

- Ambulance REDLINE protocol completed and to be presented to the next Carmarthenshire system Governance meeting. Protocol ensures patient receives right care for their needs.
- Embedding the Miya Flow pull model. Miya Flow is now being actively used to support real-time pull from ED, improving visibility and patient movement.

Due date

31/03/26

28/03/26

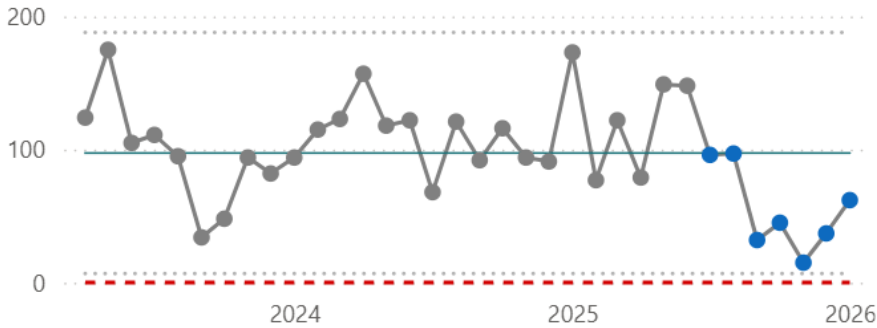
Embedded improvement actions

- Ongoing recruitment process being followed.
- BLACK action and de-escalation plan developed and followed.
- IP+C outbreak meetings held to scrutinize the situation.
- Page 338 it completed regarding boarding patients.

Key

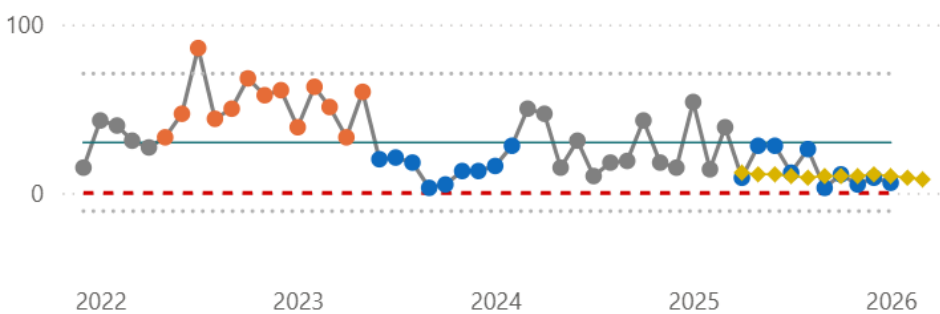
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Ambulance handovers taking over 45 minutes



Latest data is showing improving variation. 62 handovers >45 minutes reported out of a total of 289 handovers, 21.5%.

Ambulance handovers taking over 4 hours



Latest data is showing improving variation. 6 handovers >4 hours reported out of a total of 289 handovers, 2.1%.

Key challenges / issues

- Continued front door pressure resulting in very limited capacity at point of handover. Given the time of year, means area highly impacted with issues around IP&C (Infection Prevention and Control).
- We are continuing to maintain handover 45 handover internal 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. IPC also playing a part in delays as areas are required a deep clean more often.
- Prioritisation of medical patients in Minor Injury Unit (MIU) to come across to Acute Medical Assessment Unit (AMAU) remains, these patients are discussed daily in site flow calls and tracked until transferred
- 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.

Key actions / initiatives

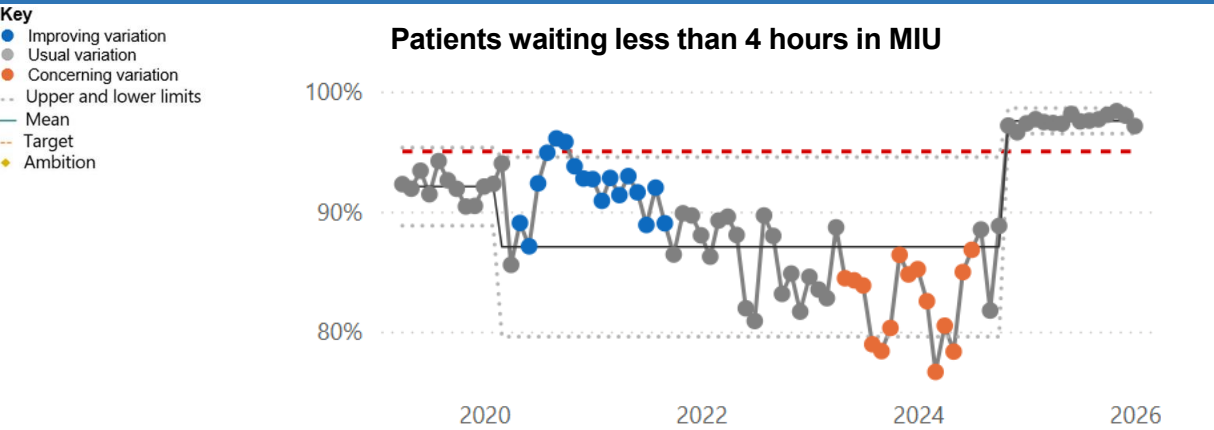
- SDEC (Same Day Emergency Care) continue to support AMAU/MIU to reduce pressure at the front door. SDEC has opened throughout 2026 on weekends to provide additional support.
- “Sprint” week data being collected for evaluation into processes around patient flow and how to minimise delay and surge but better understand and implementing plans around flow.
- AMAU acute medical model is now fictional (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. Development of training posts are being discussed with updates due in March.
- Transfer of patients from MIU to AMAU - meeting in relation to patient handover criteria to be discussed in February, to support this pathway and enhance flow of patients.

Due date

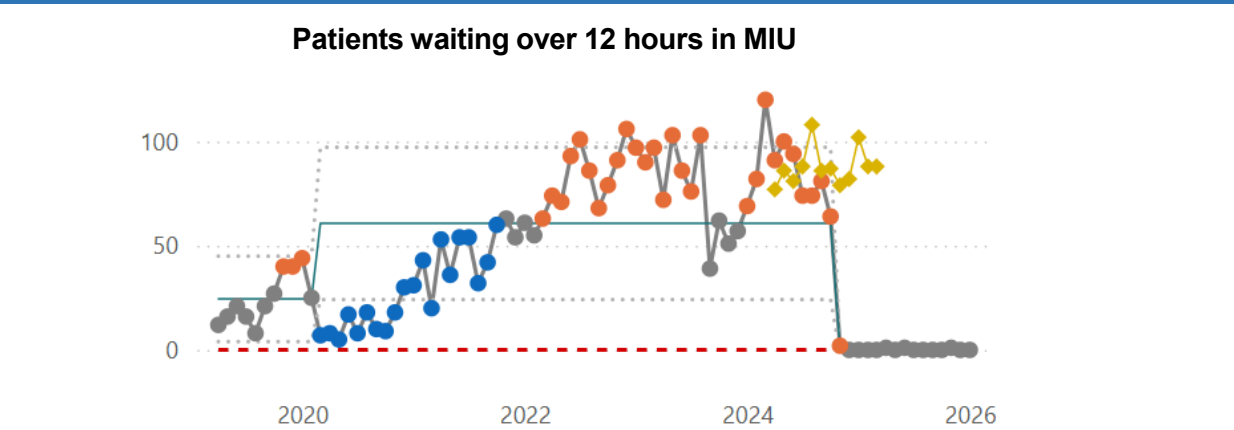
- 28/02/26
- 28/02/26
- 31/03/26
- 28/02/26

Embedded improvement actions

- Clear communication channels with the newly named PFU (Patient Flow Unit) team on site to support with hospital flow and patient transfer.
- Development and implementation of ‘Our next patient’ operation procedure now active in AMAU to ensure that each patient is assigned to the right ward so they can receive specialist care in a timely manner under the care of the appropriate team.
- Immediate ambulance release is still almost always supported only delay causes mentioned in key challenges change this



97.1% reported for January, 67 breaches out of 2,324 new attendances. Chart is showing usual variation performance trend. The control limits were adjusted from November 2024 due to change of front door model.



Zero breaches out of 2,324 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

- We continue to monitor numbers, and 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 although they do still happen on a regular basis. However, the overall decline in trend continues to be the case with a small number of medical patients presenting. Patient type is being monitored in our morning flow meetings.
- 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 patient group does have a negative effect on flow and impacts the ability to create flow through the hospital resulting in delays for patients in MIU requiring a bed.
- Medical “Hot Clinic” have grown in frequency with an additional general medicine hot clinic being added to the rota for each Monday in January to support with pressures.
- Given winter months clinical flow has been compromised through departments due to IT issues on a number of wards in 2026.

Key actions / initiatives

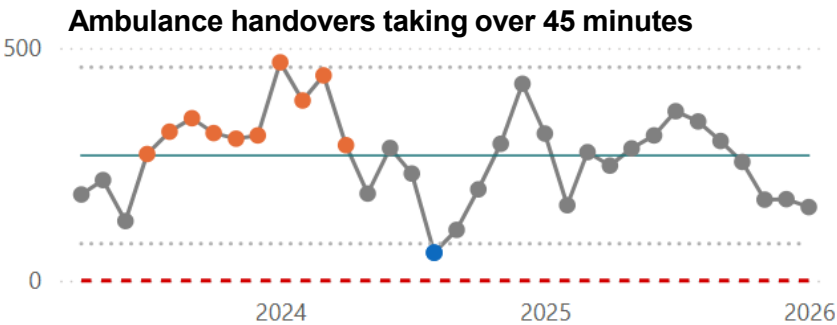
- Consultant Connect system went live on 1st September 2025 awaiting first data pull due early 2026, this remains the case.

Due date

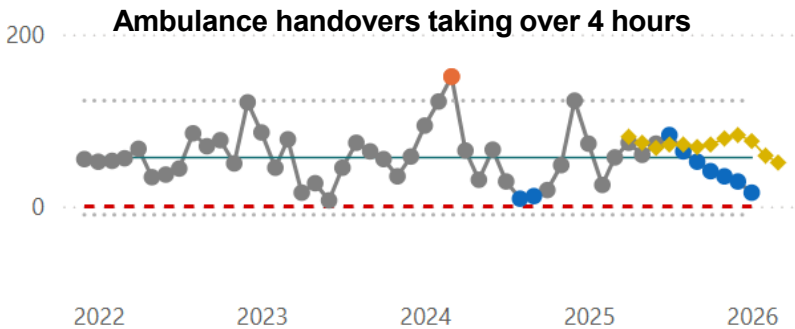
28/02/26

Embedded improvement actions

- Locum consultant has created weekly hot clinics. These allow for prompt treatment of patients through SDEC that supports hospital flow and admission avoidance. Additional General Medicine clinics extended into February.
- SDEC has been open throughout January on weekends to support acute medical take in both PPH and GGH. Agreed referral pathways between sites has been implemented.
- Ongoing work with community colleges in early discharge planning. The use of “Hospital at Home” to create a wraparound service enabling community GP’s to refer into SDEC out of hours / weekends for SDEC, to treat and refer back into the virtual ward.



Latest data is showing usual variation. 158 handovers >45 minutes reported out of a total of 641 handovers, 24.7%.



Latest data is showing improving variation. 16 handovers >4 hours reported out of a total of 641 handovers, 2.5%.

Key challenges / issues

Whole-system risk sharing to improve ambulance handovers
Teams across ED, Medicine, Wards and Site have worked together to share risk across the hospital, improving 45-minute handover performance, although this has increased internal surge and boarding.

Embedding the Miya Flow pull model
Miya Flow is now being actively used to support real-time pull from ED, improving visibility and patient movement.

Increased use of the discharge lounge
The discharge lounge is being used more consistently to create earlier flow and reduce ED congestion.

Additional General Medicine capacity
Short-term expansion of general internal medicine capacity (until end of February) is helping with earlier admissions and easing ED pressure.

Key actions / initiatives

- Evaluation of Miya utilisation at the end of March and consider quality improvement program of work to help embed product.
- Recruitment to Site Team (substantive) to help support daily operational flow.

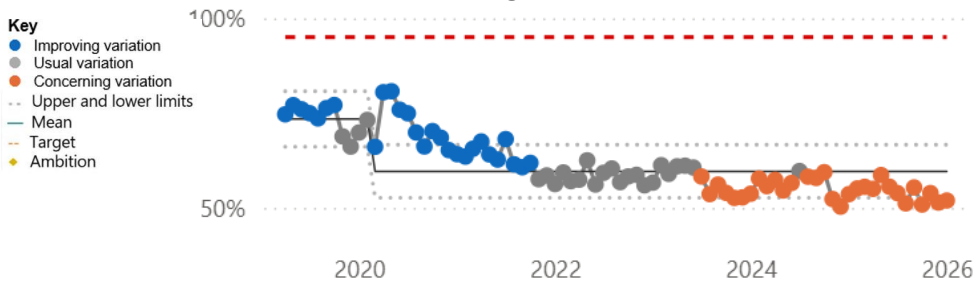
Due date

06/04/26
08/02/26

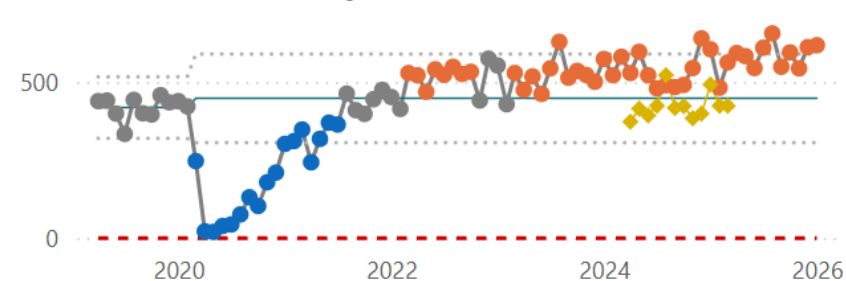
Embedded improvement actions

- Monitor impact of surge use and boarding on inpatient areas
- Site Team manager to provide daily early access to lounge before 1000hrs
- Confirmation of Ward 9 capacity until end of March.

Patients waiting less than 4 hours in A&E



Patients waiting over 12 hours in A&E



Key challenges / issues

Senior Clinical Decision-Maker Gaps

Insufficient Emergency Medicine senior doctors limits the department’s ability to carry out early senior triage and rapid redirection of patients. This directly affects the 4-hour performance, as early senior input is one of the strongest predictors of avoiding long waits. Upcoming additional gaps in the senior rota risk further deterioration.

Middle Grade Instability

Ongoing recruitment challenges at middle-grade level mean rota fragility continues. Middle grade doctors are essential to maintaining flow, particularly in evening and overnight periods when surges occur. Reduced middle-grade presence increases delays in assessments and treatment decisions, leading to:

- Breaches early in the day (due to morning backlog)
- Compounding effect across the full 12-hour pathway.

This is the single biggest driver of 12-hour breaches.

High Hospital Occupancy

Wards operating above safe occupancy (>95%) result in:

- Limited bed availability
- Slower admission turnaround
- Patients held in ED for hours awaiting a bed

Key actions / initiatives

Immediate Mitigation of Senior Gaps

- Secure short-term locum and agency senior clinical decision-maker cover to stabilise the rota and maintain safe senior presence at key times.
- Use site-level oversight to prioritise senior cover during peak arrival and high-risk hours.

Joint Consultant Recruitment with GGH

- Progress joint recruitment campaign with Glangwili General Hospital (GGH) for Emergency Medicine Consultants to strengthen cross-site resilience.
- Develop a shared promotional package and rota model to improve attractiveness of posts.

Middle Grade Recruitment & Alternative Models

- Re-advertise middle grade posts with updated advert and improved offer.
- In parallel, develop alternative staffing models, including:
 - Advanced Clinical Practitioners (ACPs)
 - Specialty and Associate Specialist (SAS) doctors
 - Senior decision-maker support via cross-cover arrangements
 - Enhanced nursing roles for front-door streaming

Implementation of Miya Flow to Support Pull Model

- Fully implement and champion the Miya Flow digital visibility tool (patient journey) to support real-time demand (pull) from ED to inpatient wards.
- Train all wards on utilisation and embed the “your next patient” pull principle to reduce boarding and improve patient progression.

Additional General Medicine Capacity

- Maintain expanded General Medicine bed capacity (open until end of February) to relieve ED congestion and reduce admission delays. Use this temporary capacity to:
 - Reduce ED boarders
 - Improve time to inpatient bed
 - Reduce 12-hour breach risk

Due date

03/03/26

20/04/26

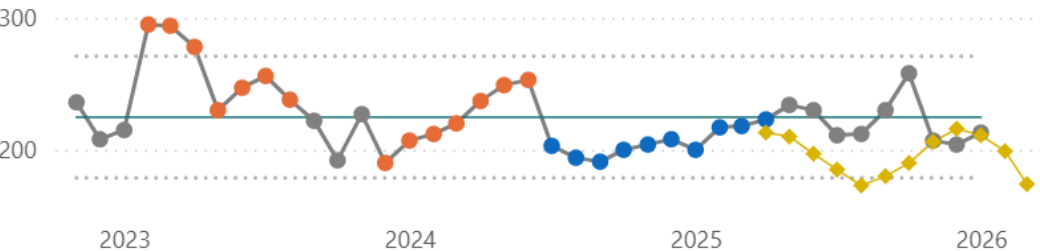
13/02/26
30/03/26

02/03/26

28/02/26

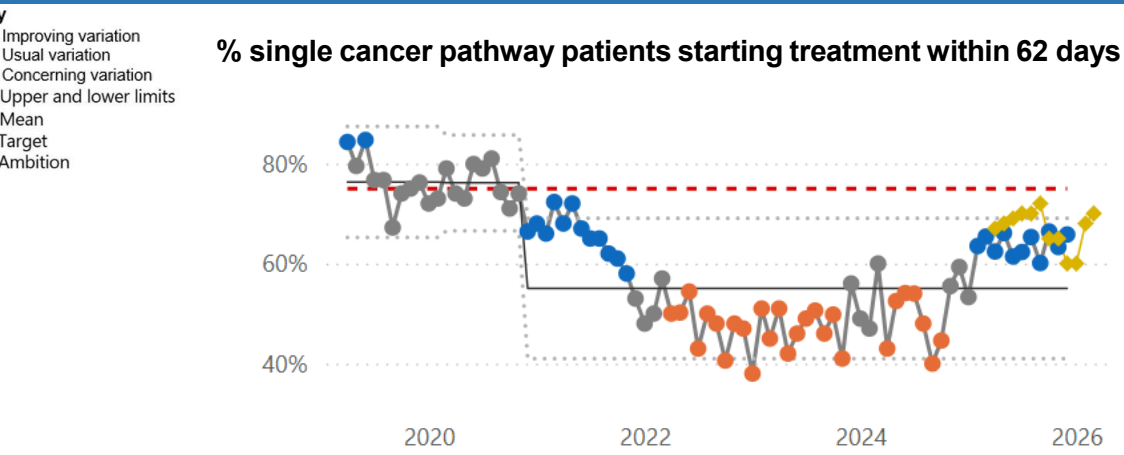
28/02/26

Total number of pathways of care delayed discharges (non-MH + MH & LD)



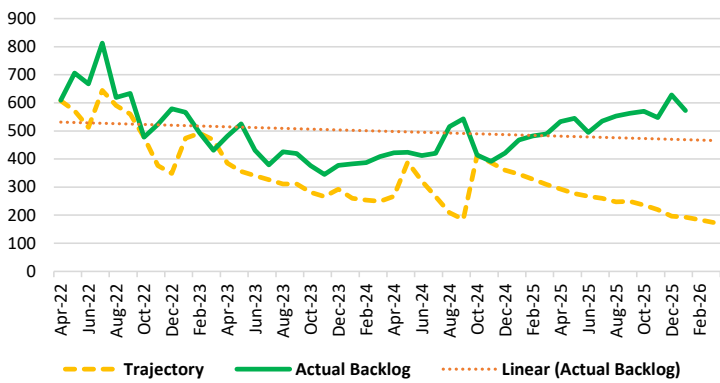
- Number of pathway of care delays as at 21st January 2026 census was 213 patients and the chart shows usual variation.
- The total days delayed for non-mental health decreased for the third consecutive month in January to 7,633 days.
- Mental health and learning disability delays decreased from 1,244 in December to 787 in January.
- Assessment delays remain the largest proportion of delays.
- The census count is based on any patients delayed in one of our hospitals, regardless of their area of residence i.e. will include patients living outside of Carmarthenshire, Ceredigion and Pembrokeshire.

Key challenges / issues	Key actions / initiatives	Due date
Non-mental health • Wider system pressures, both in-hospital and in the community, combined with staff sickness and infection prevention and control measures have impacted on PoCD. • High levels of acuity, patient and family/ carers expectation driving the need for nursing, joint and continuing healthcare assessments. • Acuity, hospital acquired deconditioning and limited access to the appropriate level of rehabilitation due to allied health professions (AHP) staffing position in hospital sites across the health board are contributing to the number of patients needing AHP assessments, reablement and new packages of care to support hospital discharge. • Availability of care home beds in the community for nursing, residential and dementia care, and timely visits/assessments by care home managers to provide and outcome remains a challenge. Mental health & learning difficulties The Mental Health & Learning Disability Clinical Care Group, Pathway of Care Delay (PoCD) census count for January 2026 is 17, this is an improved figure of 1. This includes 18 discharges from last month, 5 who remain PoCD and 12 new patients identified as medically optimised. The patients are categorised as follows, older adult 12, a decrease of 2, adult 5, an increase of 1 and 0 for learning disability, which is unchanged from last month.	Non-mental health • Winter Resilience Incident Management Group In-hospital Cell working with hospital sites and local authorities to support timely hospital discharges. • Welsh Government monies being utilised by local authorities to increase social work, reablement, and domiciliary care capacity across the system. • Task and finish group established to drive forward TA audit recommendations. • Carmarthenshire rehabilitation pathway being developed MH&LD The position in respect of patients who have a length of stay over the 90 and 100 day threshold for Mental Health is a significantly improved position, there are now 2 patients who are above this threshold, there were 5 last month. In summary, there are 17 medically optimised patients which is an improved position as there were 18 patients discharged last month. There is also a significantly improved position in respect of patients breaching the 90- and 100-day length of stay threshold.	28/02/26 28/02/26 31/03/26 31/03/26 31/03/26
Embedded improvement actions		
Non-mental health • Optimise and embed trusted assessor (TA) models- especially around mental capacity. • Ongoing focus on preventing hospital-based deconditioning • Way of Care Action plan being reviewed and integrated PoCD Steering group in place		



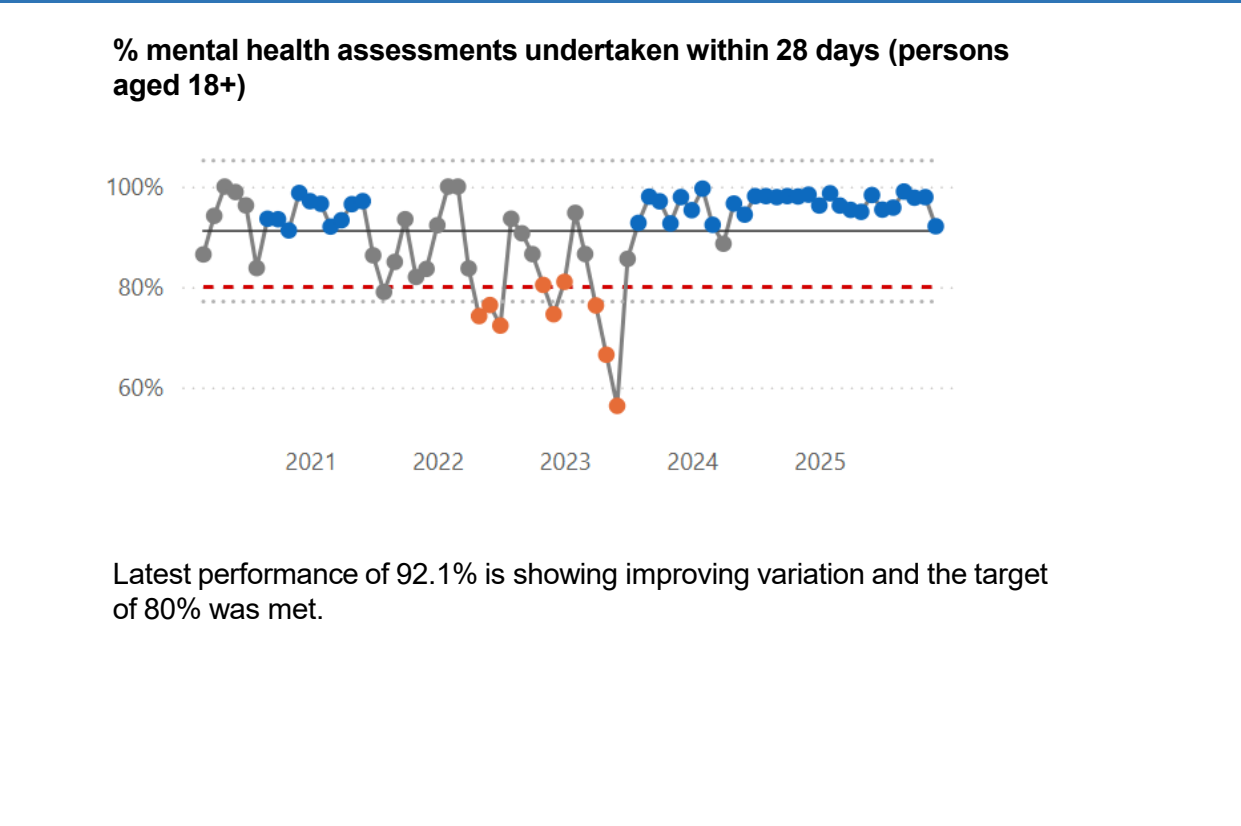
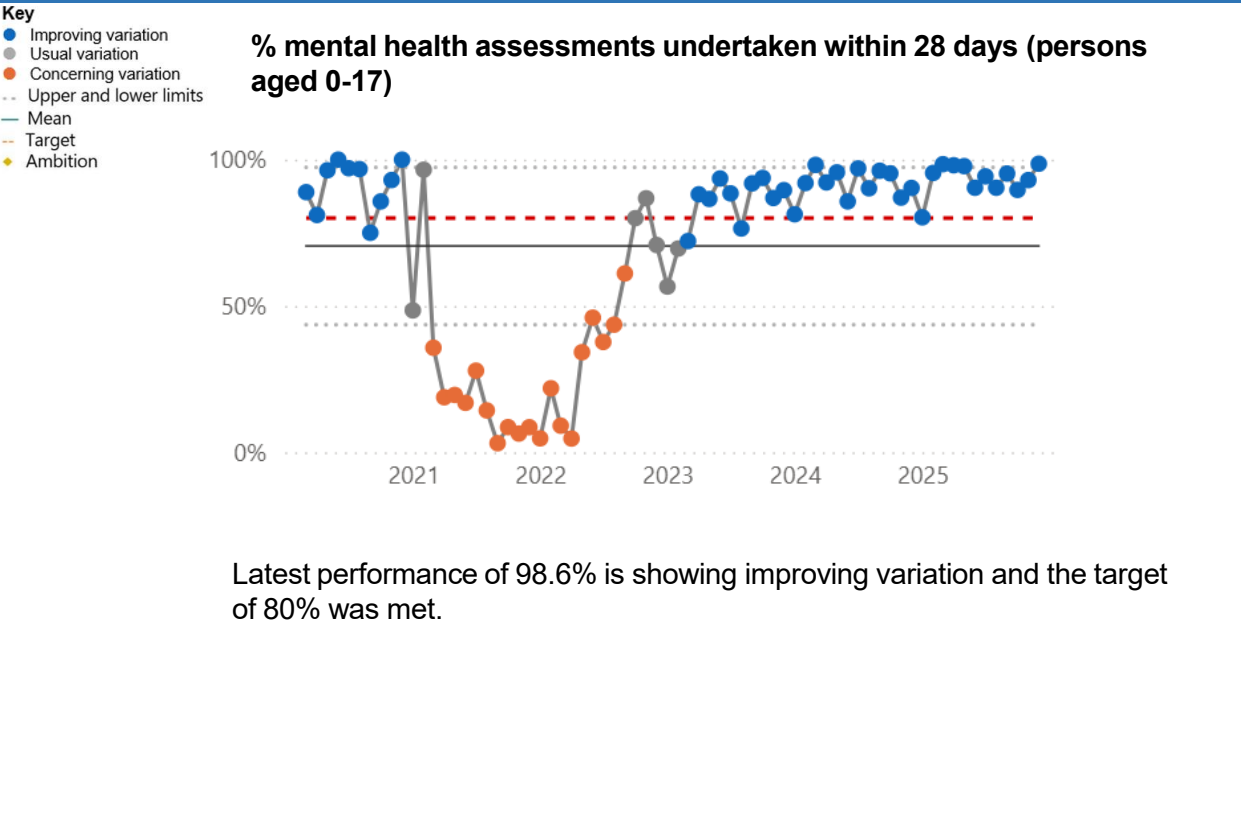
In December 2025, performance was 65.8% against the trajectory of 60%. Urology continues to be our most challenged pathway with 285 patients waiting over 62 days. 290 patients were waiting in excess of 104 days for investigations or treatment (where needed). It is important to note that not all patients waiting will have a confirmed cancer diagnosis.

Number of single cancer pathway patients waiting over 62 days
Single cancer pathway backlog

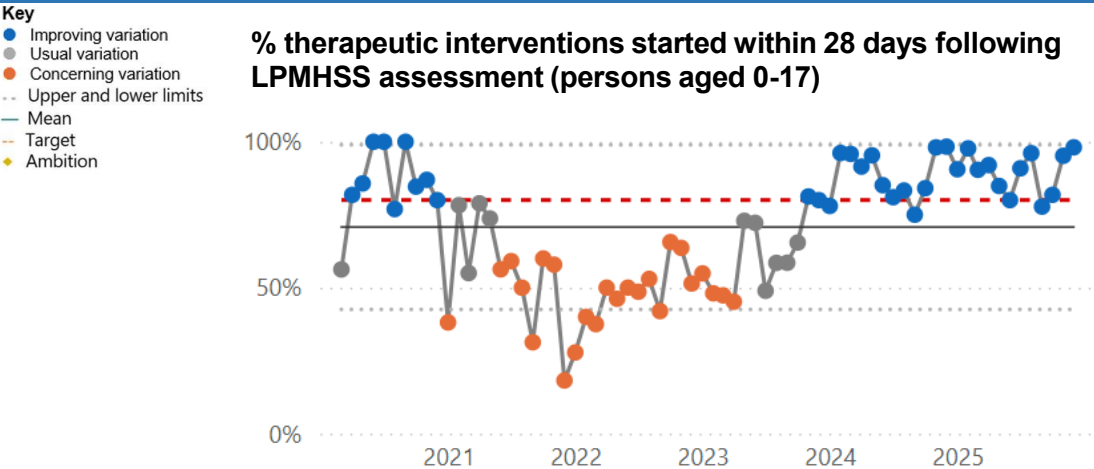


In January 2026, 573 patients were waiting over 62 days on the single cancer pathway. Improvement trajectories have not been met for over 12 months.

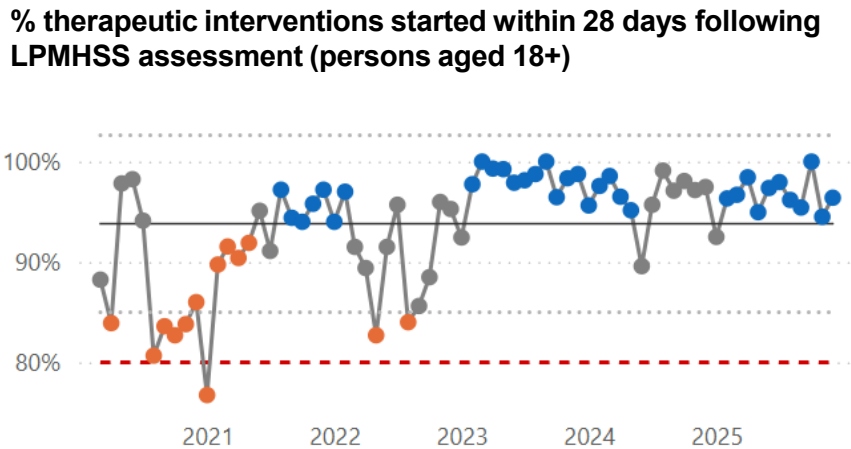
Key challenges / issues	Key actions / initiatives	Due date
Single cancer pathway Overall treatment activity in December: 256 patients started treatment within 62 days, 133 patients were waiting over 62 days. First treatment rates decreased by 36 patients.	Outsourcing MRI scans for prostate patients started in November 2025. This equates to 20 patients a week with a 3-day turnaround reporting time. The ongoing impact on the waiting times is currently being assessed.	31/03/26
Backlog and Diagnostics To meet the 28-day diagnostic target, the testing components of the pathway must be provided within 7 days.	Piloting the use of the Galeas Bladder Test – 300 patients. Delayed from January 2026 to February 2026	28/02/26
In December 2025, the implementation of the new Radiology IT system caused delays at the reporting stage leading to a 2-week backlog of outsourced MRI scans.	Outsourcing CT scans until March 2026. This equates to 260 CT scans a month, with a 7-day reporting turnaround.	31/03/26
Capacity within the Pathology service was constrained due to workforce challenges. Recruitment has taken place which is expected to improve activity.		



Key challenges / issues	Key actions / initiatives	Due date
% mental health assessments undertaken within 28 days (persons aged 0-17): 98.6% (73 of 74) assessments undertaken within target, an improvement on the previous month. Two staff members have returned from maternity leave. % mental health assessments undertaken within 28 days (persons aged 18+): We have seen an increase in referrals across our Carmarthenshire and Ceredigion teams along with a more complex patient profile which is increasing assessment time or requirement for follow up assessment appointments. This has impacted on the compliance percentage with a drop noted from last month.	% mental health assessments undertaken within 28 days (persons aged 0-17): Planned pilot of the “One At A Time” approach in the coming months with support from NHS Performance and Improvement. This is a structured intervention that provides meaningful support in one session. Embedded improvement actions % mental health assessments undertaken within 28 days (persons aged 18+): We have gone out to recruitment for practitioner posts in both Carmarthenshire and Ceredigion to mitigate issues resulting from increased referrals and patient complexity. A review of assessment time slots will be undertaken to support increase in complex presentation in the meantime.	30/06/26



Latest performance of 98.1% is showing improving variation but the target of 80% was met.



Latest performance of 96.4% is showing improving variation and the target of 80% was met.

Key challenges / issues

% therapeutic interventions started within 28 days following LPMHSS (Local Primary Mental Health Support Service) assessment (persons aged 0-17)
98.1% (53 of 54) interventions commenced within target in December showing sustained compliance. This is supported by two staff members who have returned from maternity leave.

% 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, however, whilst the prediction in the decrease in compliance this month was correct, it remained above the 80% target. Estates access continues to be challenging across the three counties.

Key actions / initiatives

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17)
Planned pilot of the One At A Time approach in the coming months with support from NHS Performance and Improvement.

% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+)
We have gone to recruitment for practitioner posts in both Carmarthenshire and Ceredigion to mitigate some of the issues above.

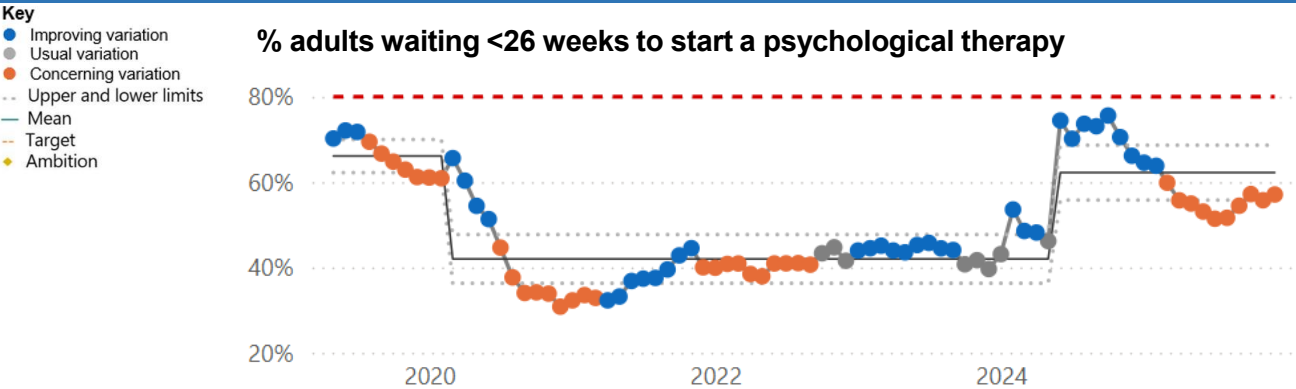
Due date

30/06/26

31/03/26

Embedded improvement actions

% 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, SilverCloud digital options and our Primary Care Liaison Service which is operating across the three counties with positive outcomes of reducing potential referrals to LPMHSS, along with a focus on group inter



Performance in December of 57.1% shows concerning variation and the target of 80% was not met.

- 427 out of 777 (55%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 7 out of 13 (53.8%) were waiting <26 weeks to start an adult psychology assessment;
- 43 out of 69 (62.3%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

Key challenges / issues

Adult Psychology Mental Health (AMH)

The percentage of patients waiting under 26 weeks for treatment improved in December. An improvement was expected following the successful recruitment of a Practitioner Psychologist who commenced on 6th October, based in an area in Carmarthenshire where there was no community provision.

Learning disabilities (LDs)

Long-term sickness, maternity leave and vacancies, particularly across Pembrokeshire and Ceredigion, are resulting in service fragility which is covered by other areas of the service as needed. There is a growing demand for complex Court of Protection work which is intensive and resource heavy. The reduction in skilled workforce in other areas, notably social workers/social care, has a significant impact in the increased workload within our field. Highly specialist complex assessments requiring therapeutic input and complex behaviour challenging assessment and treatment/intervention contributes to waits over 26 weeks.

Integrated Psychological Therapies Service (IPTs)

IPTS have seen an increase in compliance by 1% which is directly linked with the transition to the new service model. It has been identified that stabilisation and impact from the stepped model approach to high intensity will continue to support an improved trajectory moving forward.

Key actions / initiatives

AMH

- All four clinicians are providing consultations to other services, decreasing referrals to AMH.
- Grow Your Workforce plans are in place.

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 (CoP) 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 into as part of our organisational change process.
- Develop the Memory Clinic pathway and the Behaviour that Challenges pathway which aim to upskill other colleagues to reduce lower-level demands on Psychology and Behaviour specialists.

Due date

31/03/26
31/03/26

31/03/26

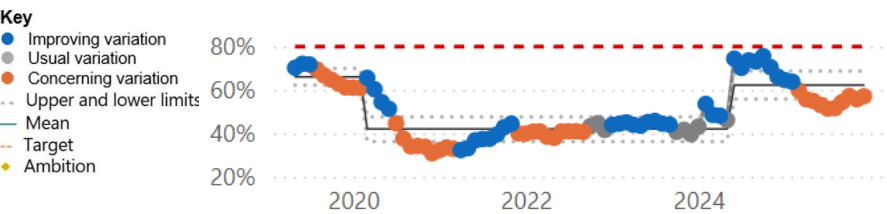
31/03/26

Embedded improvement actions

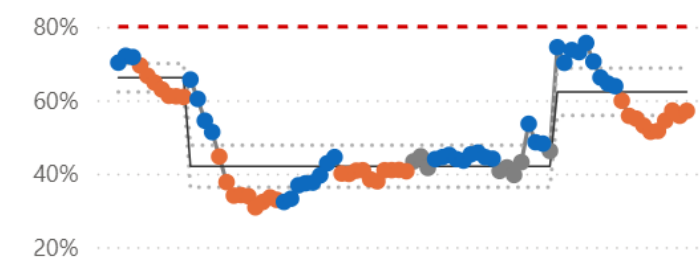
IPTS

- A number of high intensity evidence-based interventions are now in place with caps in therapy session in place.
- All therapists have job plans that are reviewed and updated to increase capacity of service where possible.
- Processes are in place to reduce potential impact from staff obtaining new posts in key areas.

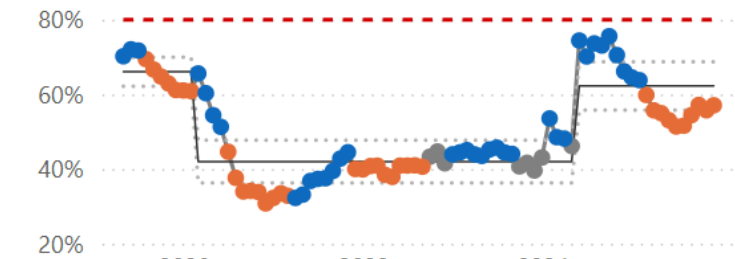
% children & young people waiting < 26 weeks to start a neurodevelopmental assessment



% 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 December 2025 of 20.5% shows improving variation but the target of 80% was not met. Performance is driven by ASD, where 525 of 3,578 (14.7%) patients were waiting for an assessment <26 weeks. 421 of 1,032 (40.8%) were waiting for an ADHD assessment <26 weeks.

Key challenges / issues

Attention Deficit Hyperactivity Disorder (ADHD)

The longest wait for an ADHD assessment is currently 99 weeks with 162 waiting more than 52 weeks. 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. Long term solutions are being explored as part of the Bandi appeal and the reconfiguration of Puffin Ward.

Autism Spectrum Disorder (ASD)

As of December 2025, there are 3,053 children and young people waiting more than 26 weeks for an ASD assessment. Demand continues to outstrip capacity. There are 2,442 individuals waiting more than 52 weeks. Demand for assessment remains consistently high with referrals averaging 114 per month. During 2025, 1,372 referrals were received. 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.

Key actions / initiative

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. Funding streams being sought to support the purchase of additional devices.
- Successfully appointed into a Locum Consultant Post at Bronglais General Hospital, awaiting confirmation of start date.
- Continue to manage clinic capacity flexibly and maximise through rigorous job planning.

ASD

- Outsourcing contract in place from 6th February which will enable the completion of 585 assessments by 31st March to eradicate 3-year waits.
- Review of administrative processes ongoing to ensure efficiency.
- Review of service specification to ensure appropriate use of resources.
- Data Sharing Provision with Pembrokeshire Local Authority in place with plans to expand across HB catchment area to improve relationships across teams and the overall quality of assessments.

31/03/26

31/03/26

31/03/26

31/03/26

31/03/27

31/03/26

31/03/26

31/03/26

Embedded improvement actions

ASD

- Pilot of Magic Notes AI scribe to support production of structured case notes due to commence on 9th February.
- Three fixed-term posts have been made substantive. Waiting list Co-ordinator appointed and in post from 1st February.
- Review of all clinical caseloads to ensure assessment process is completed in a timely manner.
- Adverts for an Occupational Therapist lead and Neurodevelopmental practitioner live.

Key

-- Upper and lower limits
— Mean
--- Target
● Ambition

Variation - how are we doing over time

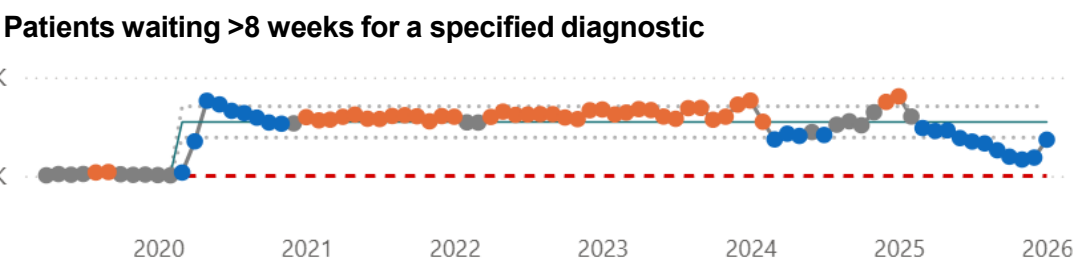
- Improving variation
- Usual variation
- Concerning variation

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



Latest performance is showing improving variation with 3,669 breaches in January 2026, highest breach position since June 2025.

Diagnostic	Latest period	Latest actual	Variation	Assurance	Trajectory
All	Jan 2026	3,669	●	□	n/a
Radiology		2,858	●	□	n/a
Cardiology		357	●	□	n/a
Endoscopy		356	●	□	n/a
Imaging		71	●	□	n/a
Phys measure		27	●	□	n/a
Neurophysiology		0	●	□	n/a

Key challenges / issues

Radiology

- 2,931 breaches in total as of 6th February: Increase of 1,475 breaches since last update. In month increases in all modalities. Ultrasound experienced the largest 1,369.
- Demand exceeding capacity for timely investigations and reporting. Cancer and inpatient reporting is being prioritised.
- New Radiology system went live 01/12/25 causing decrease in activity, to allow for installation of system and staff training (urgent suspected cancer/emergency activity unaffected).

Endoscopy

- Gastrointestinal endoscopy breaches relating to the diagnostic conversions generated additional outpatient activity with no internal capacity to accommodate – circa 500 patients.
- Capital replacement programme for old/fragile endoscope equipment.
- Increase in Cystoscopy volume: additional insourcing of outpatient appointments and increasing referrals, inflating the waiting list by 300.

Cardiology

- Cardiac Myocardial Perfusion Imaging breaches decreased in January.
- Increased Echocardiography breaches due to higher levels of staff sickness and list cancellations due to adverse weather.
- 322 Echocardiogram breaches in January.
- Breach increase in consultant-led Dobutamine Stress Echocardiogram and Transoesophageal Echocardiogram.

Key actions / initiatives

Radiology

- Computed Tomography staffing difficulties have resulted in a decrease in activity. Locum extension expected to ensure performance is maintained. Van procured for additional 6 weeks
- Computed Tomography Van extended with additional funds to scan 250 additional patients per month.

Endoscopy

- Insourcing due to commence late February to uplift Gastrointestinal and Urology endoscopy / cystoscopy capacity – to accommodate the additional demand generated from the insourcing activity.
- Galeas test for Bladder cancer in contract stage. Looking to go live at the end of February. This trial will alleviate the need for up to 25 Cystoscopies per week.

Cardiology

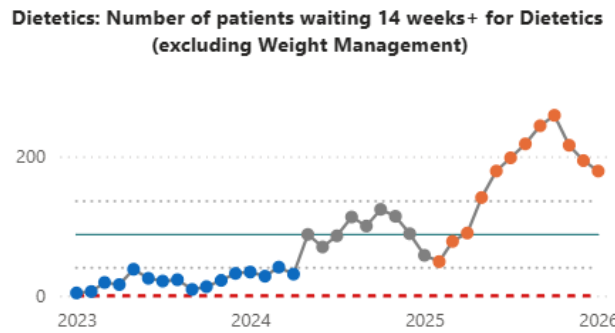
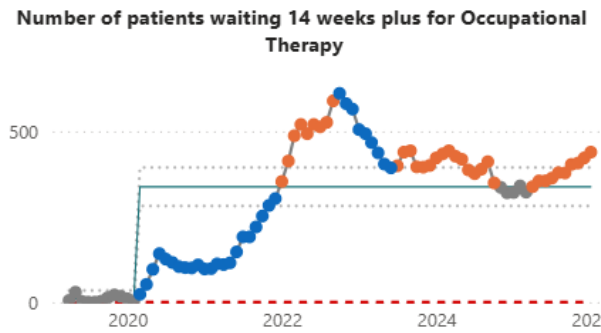
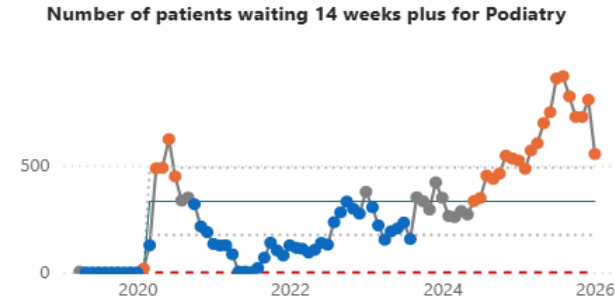
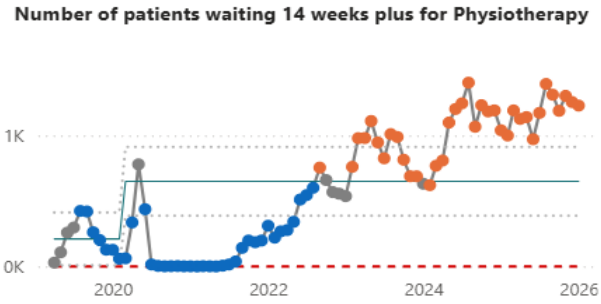
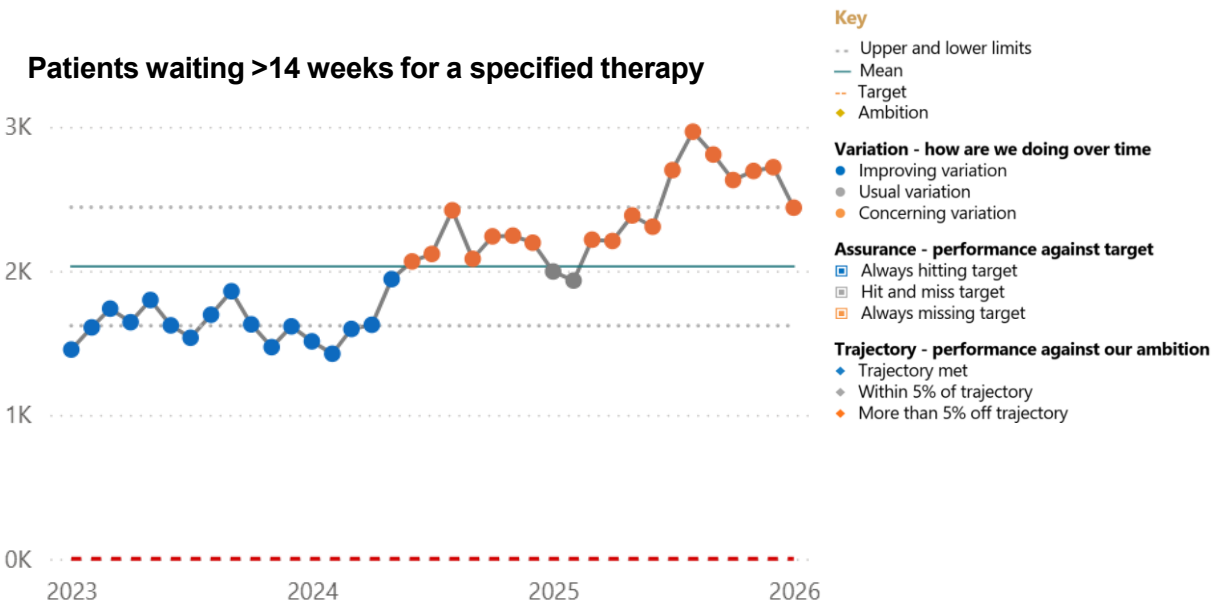
- Combined core and additional outsourcing commenced 18 September in partnership with Singleton Hospital. Working closely with teams to sustain and further reduce breach position.
- Dobutamine Stress Echocardiogram: Breaches have increased. Continuing to collaborate across all sites to further reduce the breach position.
- Additional outpatient project, commenced on 10 January aiming to deliver 1,344 additional patient appointments supporting stage 1 recovery and improve patient access.

Embedded improvement actions

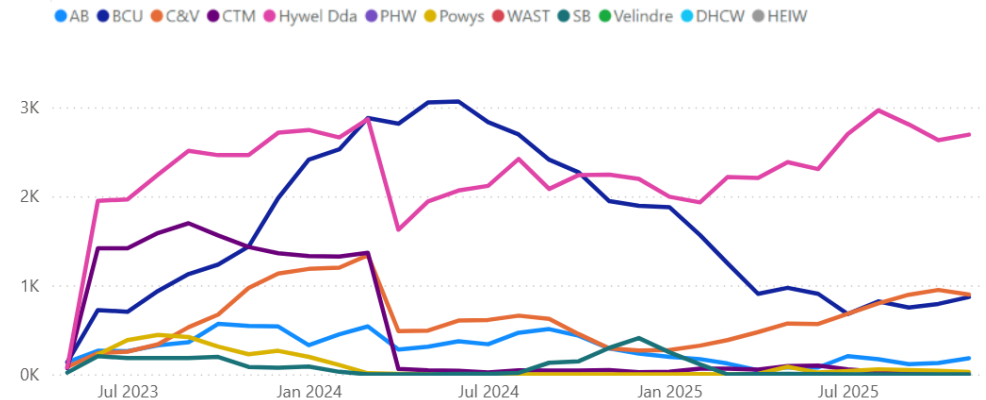
Radiology

- Non-Obstetric Ultrasound contract extended and additional capacity has been sought. Additional sonographers starting 02/02/26. Validation of waiting list is being undertaken, potentially 25% of patients may be removed.
- Magnetic Resonance Imaging – 2 staffed scanners on site, one producing increased activity due to undertaking less-comp

Latest performance is showing concerning variation with 2,438 breaches in January 2026, lowest figure since June 2025

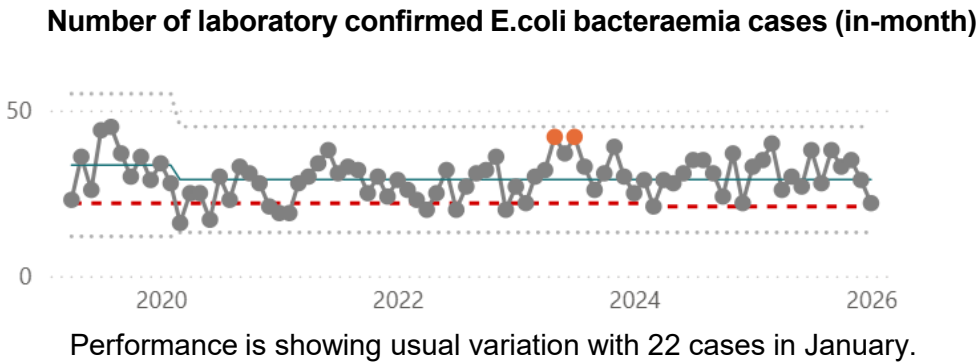
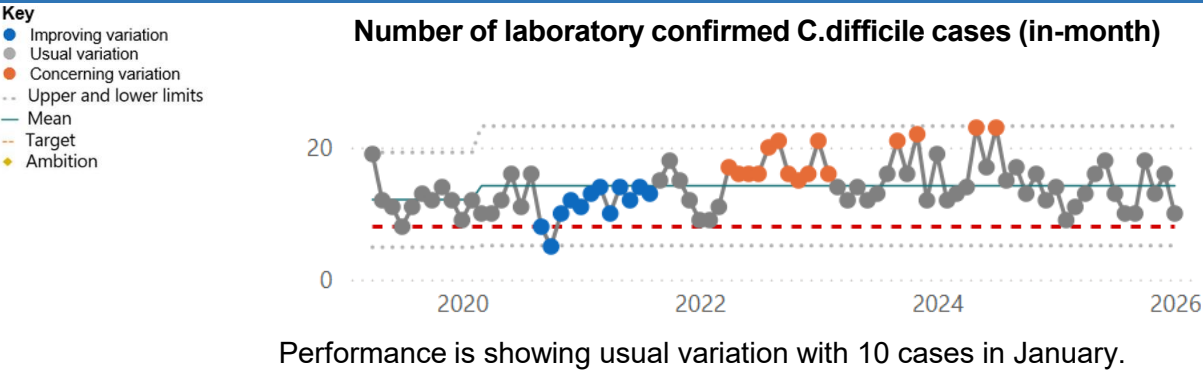


Patients waiting 14 weeks or more for a specified therapy: Welsh Health Boards (November 2025)



Therapy	Latest period	Latest actual	Variation	Assurance	% children waiting < 14 weeks
All	Jan 2026	2,438	●	▣	58.6%
Physiotherapy		1,229	●	▣	95.8%
Podiatry		554	●	▣	70.2%
Occupational Therapy		439	●	▣	14.4%
Dietetics		179	●	▣	41.7%
Art therapy		34	●	▣	n/a
Speech & Language Therapy		3	●	▣	100%

Therapy waits over 14 weeks (continued) (Ministerial priority)		Therapies
Key challenges / issues	Key actions / initiatives	Due date
Physiotherapy: 90% of breaches are within Musculoskeletal (MSK) specialty as demand is growing and is greater than capacity. 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. 9% of the remaining breaches are within community services and 1% in paediatrics. Podiatry - New patient referrals have increased by around 40% in the last six years without any additional funding while patient complexity has increased, evidenced by around a 15,000 decrease in patient contacts in same period. - Podiatry is first point of contact/triage service for Orthopaedics and Vascular services. - To meet modern expectations for timely assessments and interventions, the service now includes 7 Independent Prescribers and 5 Ultra sonographers, achieved through internal reconfiguration without additional funding. 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 reviewing performance improvement plans. Dietetics: - Paediatric selective eating increased demand remains predominant reason for service waiting time breaches. - Diabetes service vacancies have impacted.	Physiotherapy - A standard operating procedure (SOP) for a targeted telephone triage pilot, for patients who could be signposted towards supported self-management has been developed. Further refinement of this process is now planned using PDSA (plan-do-study-act) cycles in order to test the effectiveness of clinical risk stratification and patient activation tools to broaden the scope of the project. - 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. Occupational therapy (Paediatrics): - Exploring ways to increase clinic capacity to reduce travel time across 3 counties and increase new activity. - Continuing to explore options to increase capacity internally to manage current waiting list. - Team increasing the number of sensory workshops for parents to improve volume of flow through the service - Reviewing job plans within the service to maximise direct clinical capacity Dietetics: - Paediatrics: Work underway reviewing access criteria and service review (under new service leadership) to make long term recommendations for sustainable recovery. - Diabetes: Recruitment complete, performance will improve following full induction.	31/08/26 15/02/26 28/02/26 28/02/26 30/03/26 30/03/26 28/02/26 31/03/26
	Embedded improvement actions	
	Physiotherapy Full MSK service review being undertaken in collaboration with National MSK Network. Draft report received on 3rd November 2025, with a request from Health Board to review and comment. The latter has now been completed.	
	Podiatry - In depth demand and capacity review indicated that the service was efficient, all staff on 10 session templates booked by office with electronic rota together with strong discharge and eligibility procedures in place. - Significant skill mixing undertaken. Service review undertaken to strengthen management structure to maximize efficiency. - Capacity: Basic demand and capacity analysis submitted which recommends three additional staff, with evidence base included to prove value of these additions. This information has been shared with Welsh Government via the Director of Operational Planning and Performance and Chief Operating Officer.	
	Dietetics: Paediatrics: Requirements to meet increased demand submitted as part of annual planning cycle.	
Page 351		



Key challenges / issues

C. difficile:

- Antibiotic Stewardship: Inconsistent completion of Start Smart Then Focus (SSTF) audits; vacancies in Antimicrobial Pharmacy team risk impacting stewardship.
- Delayed Infection Prevention Control Actions: Recognition, isolation, and diagnosis delays noted in some cases.
- Environmental Cleaning: Challenges with routine and deep cleaning due to staffing shortages and surge capacity pressures, increased demand on deep cleaning in December and January due to outbreaks.
- Compliance Gaps: Lapses in hand hygiene and bare below the elbow standards across staff groups during Infection Prevention Control observation.
- Mandatory Training: Level 2 Infection Prevention Control compliance at 73.33%, below the 85% target and a reduction from the previous month.

E. coli:

- Infections remain primarily community-onset, linked to urinary tract and some catheter-related infections.
- Most cases occur in the 80–89 age group.
- Non-compliance observed in hand hygiene and bare-below-the-elbow practices across staff.
- Health Board aseptic non-touch technique compliance stands at 83.80%.

Key actions / initiatives

C. difficile:

- Learning & Governance: Healthcare associated infections cases reviewed monthly at Assurance Group; learning shared via Clinical Care Groups. Issues escalated through governance structures. This requires all members of the multi disciplinary team in attendance.
- Enhanced Cleaning: hydrogen peroxide vapour available at three acute sites, Fourth site coming online soon- awaiting training for Withybush.
- Close monitoring of infection rates to understand January's reduction.

E. coli:

- Health & Wellbeing booklet under final review and pending publication.
- Healthcare associated infections cases reviewed monthly at Assurance Group; learning shared via Clinical Care Groups.
- Monthly hand hygiene audits by Ward Managers, monitored and reviewed.
- Ongoing review of hand hygiene products and promotional posters.
- Close monitoring of infection rates to understand January's reduction.

31/03/26

01/04/26

28/02/26

28/02/26

28/02/26

28/02/26

31/03/26

28/02/26

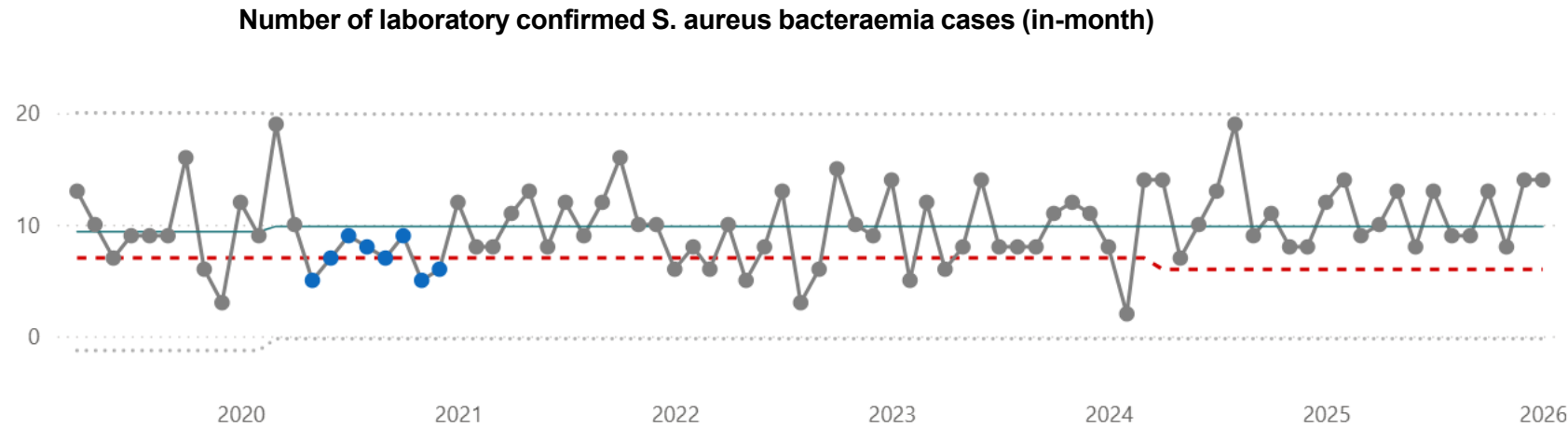
Embedded improvement actions

C. difficile:

- Auditing: Environmental/ observational audits ongoing; Audit management and tracking of infection prevention control audits awaiting to be piloted when Infection Prevention Control team capacity allows.

Key

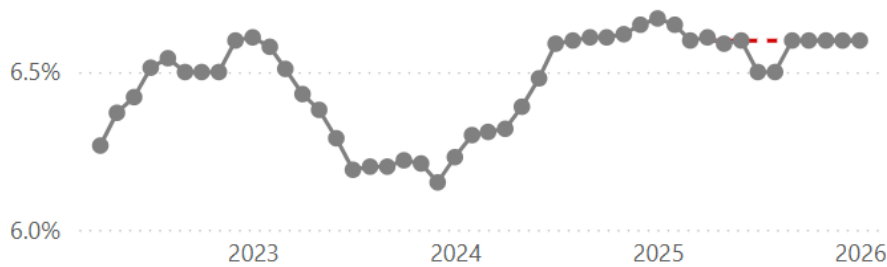
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



Performance is showing usual variation with 14 cases in January

Key challenges / issues	Key actions / initiatives	Due date
S. aureus: - Aseptic non-touch technique compliance inconsistent; E-learning completion at 83.80%. - Environmental/equipment contamination contributing to transmission due to cleaning challenges and surge. - Infection burden remains community-based, primarily from wounds. - Ongoing lapses in hand hygiene and bare-below-the-elbow compliance across staff.	- Aseptic non-touch technique compliance and competency assessments shared via Clinical Care Group Quality Health & Safety meetings; proposal to make competency mandatory via Electronic Staff Record- awaiting feedback. - Healthcare associated infections cases reviewed monthly at Assurance Group; learning and high-rate areas shared with Clinical Care Groups. - Hand hygiene validation and observational audits conducted based on senior nurse monthly audits. - Ongoing review of hand hygiene products and promotional posters. - Close monitoring of infection rates to understand January's reduction.	31/03/26 28/02/26 28/02/26 31/03/26 28/02/26

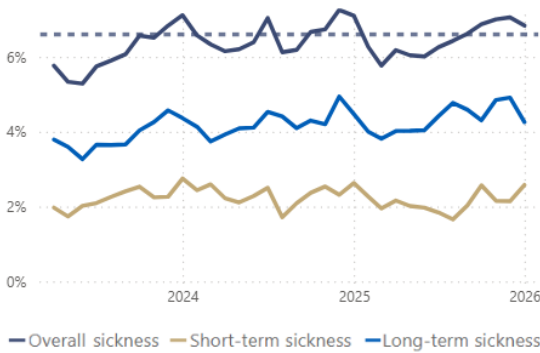
% staff sickness rate (12 months rolling)



Held at 6.6% for the last 5 months.

% staff sickness rate (in-month)

January 2026 = 6.8%
Short-term sickness = 2.6%
Long-term sickness = 4.3%



Services with 60+ staff with the highest levels of in-month sickness rates in January 2026:

Team	Staff	R12m %	In-month %
Glangwili Domestic Services	137 staff	14.0%	15.6%
Sunderland Ward	74 staff	12.3%	15.9%
Cleaning services Bronglais	60 staff	12.2%	15.9%
Health Protection – Immunisation Team	69 staff	11.3%	15.1%
Prince Philip AMAU	71 staff	11.0%	8.2%
PDT - Domestic	139 staff	10.5%	11.3%

Glangwili Domestic Services breakdown:

January 2026: 4% ST, 11.6% LT = Total: 15.6%. 12-month rolling: 14%

January 2025: 5.4% ST, 11.4% LT = Total: 16.8%. 12-month rolling: 14.3%

Key challenges / issues

Absence rates attributed to anxiety, stress and depression (34.7%) continues to account for the highest reasons for absences across the Health Board. Absence attributed to cold, cough, flu is increasing (11%) and is the second highest reason for absence.

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 to employee relations matters.

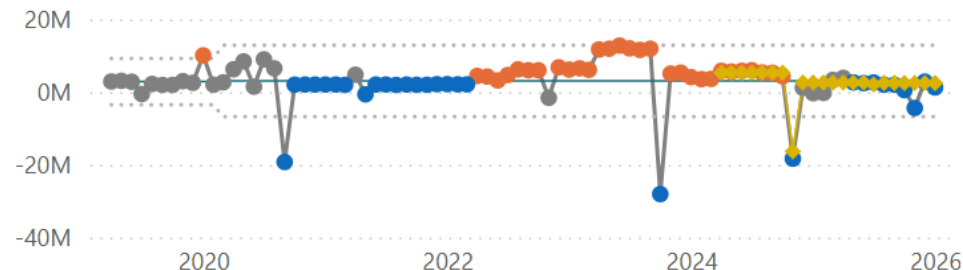
Embedded improvement actions

- Targeted support for sickness absence:
- Successful recruitment of 2 sickness absence advisors to facilitate more focused support for sickness absence management.
 - Ongoing focused support from the Workforce teams in collaboration with Senior Managers with a focus on hot spots across all Clinical Care Groups.
 - Deep dives of data and analysis to ensure underlying issues are identified and appropriate support is in place.
 - Designated support from Workforce continues to be utilised to help address sickness absence aligned to employee relations matters.

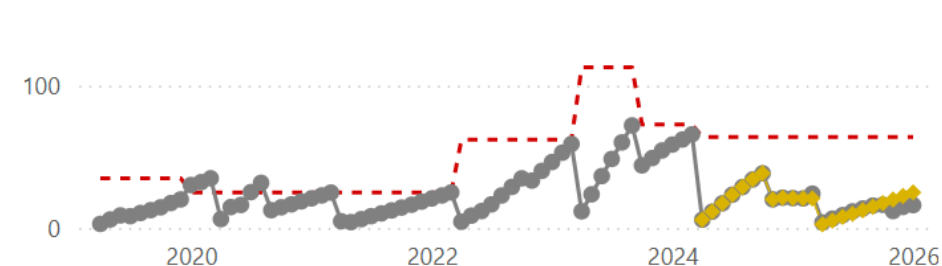
Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Financial in-month deficit



Financial deficit (£m) – year to date



Key challenges / issues

Shift Supply and Demand - Demand and absence pressures led to staffing issues in January 2026. Market supply of Medical and Nursing agency was unable to meet the necessary demand, to cover the shortfalls in Withybush, Bronglais and Glangwili and Pathology. Further increases are anticipated following the opening of surge beds in January and approved recruitment plans in Bronglais Emergency Department. This is a risk to the start of the new financial year.

Reactive savings planning and underspend conversion - Conversion of remaining schemes to Green. Further to the initial amber savings scheme created in M5 of £6.0m, £1.0m remains as a balance covering February and March 2026. The underspend conversion rate in month is £0.9m.

Confirmation of Non-Recurrent savings conversion required as part of 26/29 Financial Plan - Consistent with the principles agreed at Executive Team, each Executive Director and delegated budget holder is asked to confirm agreement with the total projected non-recurrent savings in the financial year 26/27. Without justification for nonagreement, alternative rebuttable proposals are required.

Medical pay - Additional cover at premium costs - Continuing use of additional medical cover, including premium locum and agency in Bronglais, Planned Care and Mental Health.

Nurse agency usage - Additional cover at premium costs - An 11% increase due to ongoing breaches within roster management outside of our standard operating procedure.

Key actions / initiatives

- Service leads to review requests for additional shifts and fill rates to reduce the risk of the health board requesting agency cover above available capacity in the market.

- Recognition to convert Amber scheme to Green based on evidenced track record.

- Under urgent review in conjunction with Finance Business Controllers.

- Urgent update required on Medical Stabilisation.

- Further controls required to mitigate increased spending and clinical variation.

Due date

Overdue

Overdue

13/02/206

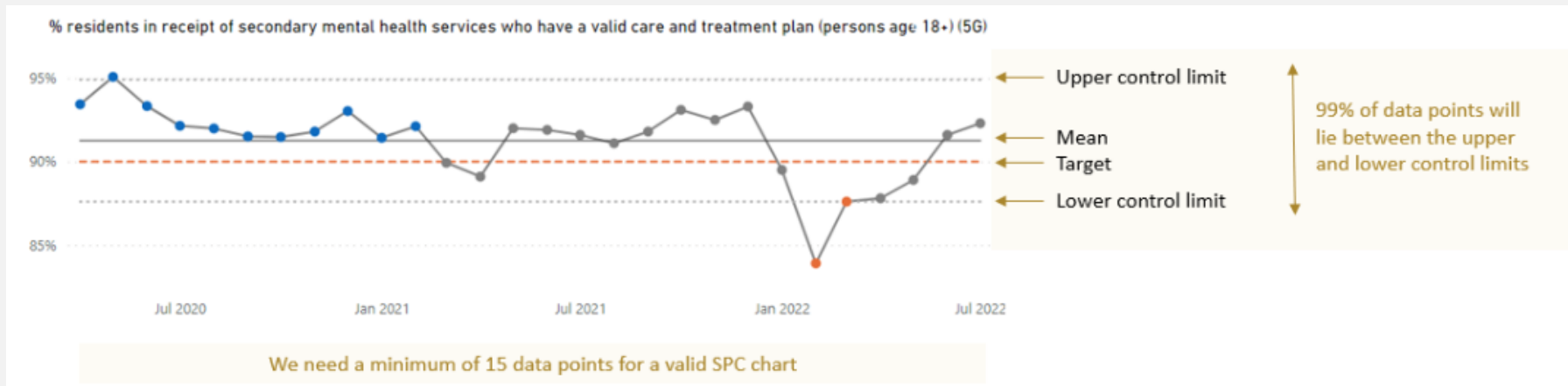
Overdue

Overdue

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.

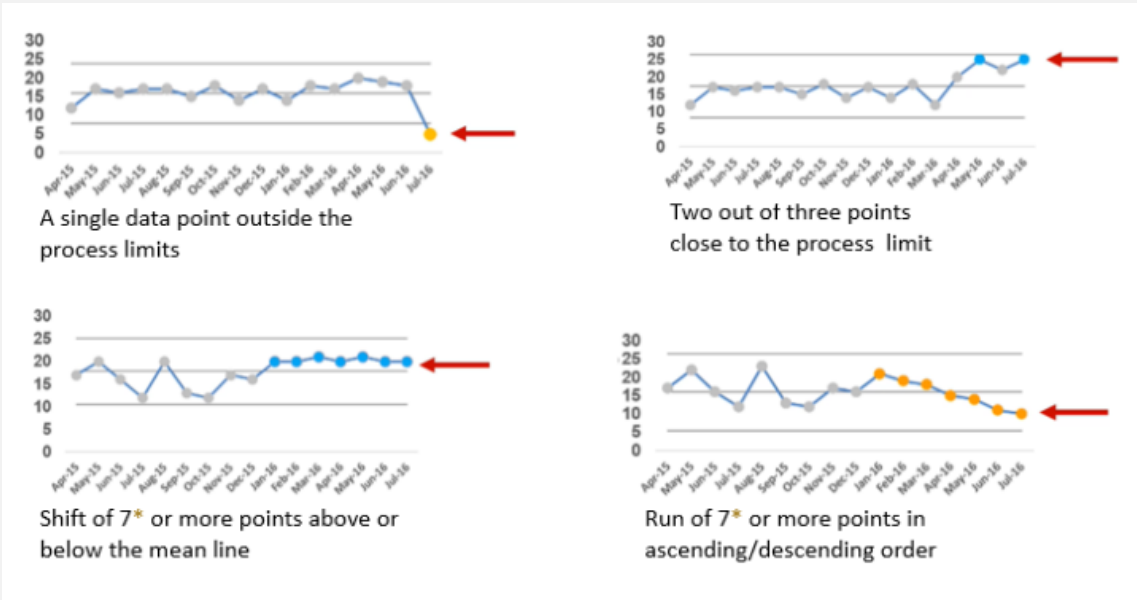
Anatomy of a SPC chart



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 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

12:40 PM, 5 Mins

5.2 - NWSSP PERFORMANCE REPORT QUARTER 3 2025/26

*Huw Thomas (Hywel
Dda UHB - Director
of Finance)*

| For assurance

Attachments

[NWSSP Performance Report Q3 2025-26 FPC 24 February 2026.pdf](#)

[HDdUHB NWSSP Summary Performance Report Q3 2025-26.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership (NWSSP) Performance Report Quarter 3 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 with summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 31 December 2025 (Quarter 3 2025/26).

The Finance and Performance Committee is requested to receive an assurance from the content of the NWSSP Performance Report for Quarter 3 2025/26.

Cefndir / Background

The NWSSP is hosted and governed by the 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 31 December 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 3 2025/26	20	1		
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:

Audit and Assurance – Audits reported to agreed Audit Committee (Excluding External Factors)

Performance driven by both HDdUHB and NWSSP shows the organisation missing the following KPI:

- **Audits reported to agreed Audit Committee: Target 80%**

Performance: 67%

What is happening?

Audits reported to agreed Audit Committee failed the 80% target reporting 67% during December. 10 of the 15 reports were submitted on time.

What is NWSSP doing about it?

Heads of Audit discuss any delays directly with the health organisations and are made aware of any revised timings of reports and submissions to committees.

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 31 December 2025.

Other Points to Note

Medical Examiner Service (MES)

Included in the winter planning risk register is the risk that *there will be an increase in time in death certification process impacting on mortuary capacity and subsequently hospital flow*. As part of the mitigation the Chief Medical Officer requested Health Boards to produce draft contingency plans. NWSSP has requested that these be shared so that they can be assessed for process or operational changes within Health Boards to enable NWSSP to maximise efficiencies. Plans are yet to be shared.

Health Boards are also reminded to update their websites to ensure accurate and consistent messaging regarding death certification.

Summary Assessment by NWSSP

The Quarter 3 performance for the organisation was good with 20 out of 21 KPIs showing as green. The time to hire target was achieved in December.

Further action will continue to be taken forward to address the performance in areas of underperformance.

1 KPI did not achieve the target - this is a combination of NWSSP and Health Board responsibility. NWSSP continues to support the organisation in relation to audit performance.

Appendix 4 shows the Outcome measures that NWSSP has been working on at the end of December 2025 to highlight and report the impact and importance of what it does.

Extra tables and charts have been included by NWSSP 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 3 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 31 December 2025.
Rhestr Termiau: 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)

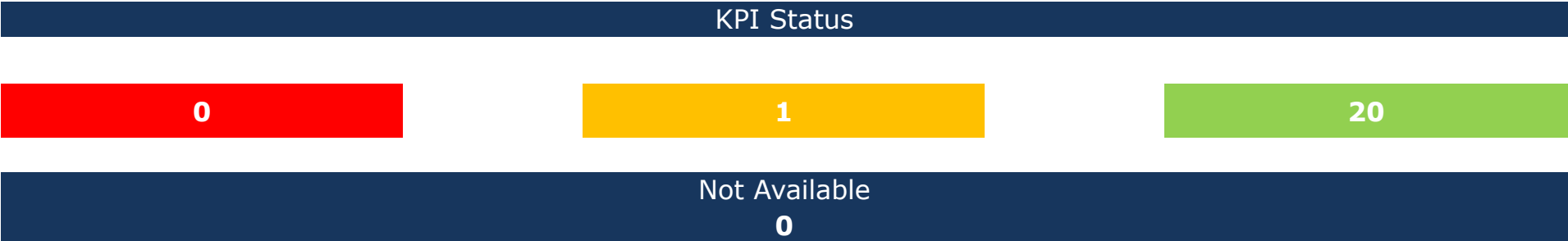
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	NWSSP was established to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners.

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 October 2025 – 31st
December 2025**



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 31st December 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 3 performance for the organisation was good with 20 out of 21 KPIs showing as green.

The time to hire target was achieved in December.

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 audit performance.

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 – December 2025 for the organisation is £7.3M with the breakdown in the following table.

Service	YTD Benefit £m
Specialist Estates Services	0.15
Procurement Services	5.30
Legal & Risk Services	1.26
Accounts Payable	0.31
Oxygen Finance – PSP	0.02
Counter Fraud Services*	0.24
Total	7.3

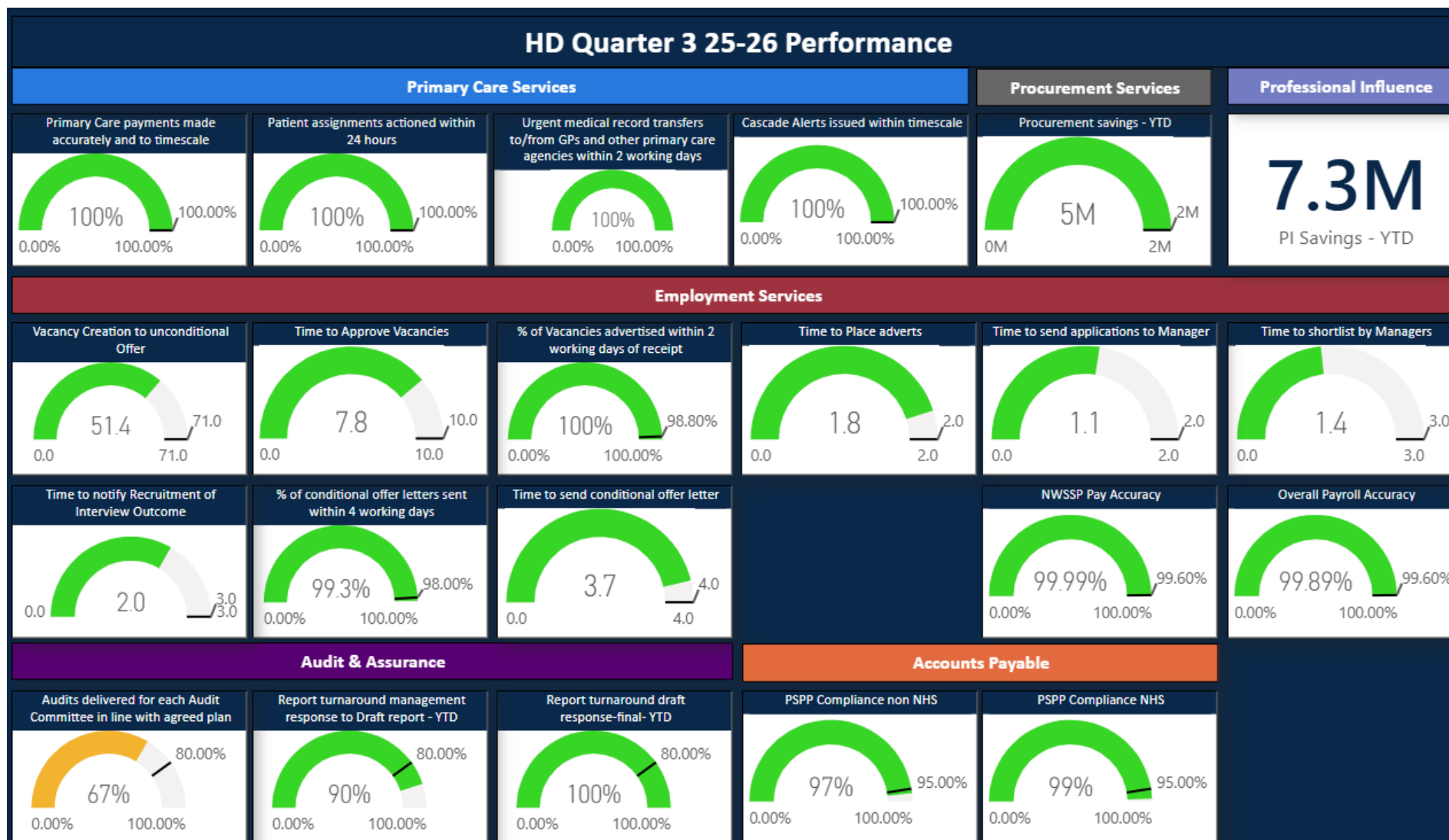
* Q1 & Q2 only

Appendix 1 provides the December performance for your health organisation against the Lead indicators with comparison data for the rolling twelve-month period to 31st December 2025.

Appendix 2 provides December performance against All Wales KPIs which cannot be attributed to a specific health organisation, these report an All-Wales position with comparison data for the rolling twelve-month period to 31st December 2025.

Appendix 3 highlights the position for all health organisations at the end of December 2025.

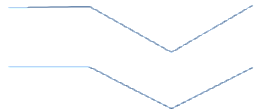
Appendix 4 highlights the Outcome measures reporting at the end of December 2025 along with some supporting information.



Action Plan for Lead Indicators

There was no KPI showing as red for the in-month December position.

There was one KPI showing as amber for the in-month December position.

HD High Level - KPIs Dec 2025	Target	31/03/2025	30/06/2025	30/09/2025	31/12/2025	Trend
Audit & Assurance						
Audits reported to agreed Audit Committee (Excluding External Factors)	80%	74%	Not Applicable	88%	67%	
% of audit outputs in progress		13%	16%	27%	14%	
Report turnaround management response to Draft report - YTD	80%	81%	Not Applicable	86%	90%	
Report turnaround draft response-final- YTD	80%	100%	Not Applicable	100%	100%	

What is happening?

Audits reported to agreed Audit Committee failed the 80% target reporting 67% during December. 10 of the 15 reports were submitted on time.

What are we doing about it?

Heads of Audit discuss any delays directly with the health organisations and are made aware of any revised timings of reports and submissions to committees.

Supplementary Information - All Wales Audit & Assurance performance at the end of December 2025.

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	35.7%	21.4%	90.00%	100.0%	50.0%	100.0%
Betsi Cadwaladr	35	40.0%	31.4%	91.67%	100.0%	54.5%	100.0%
Cardiff & Vale	36	33.3%	19.4%	63.64%	100.0%	77.8%	100.0%
Cwm Taf Morgannwg	33	21.2%	30.3%	57.14%	100.0%	33.3%	100.0%
DHCW	13	46.2%	38.5%	100.00%	100.0%	50.0%	100.0%
HEIW	12	66.7%	16.7%	90.00%	100.0%	100.0%	100.0%
Hywel Dda	29	44.8%	13.8%	66.67%	100.0%	90.0%	100.0%
Joint Commissioning Committee	4	0%	25.0%	100.00%			
NHS Wales Performance & Improvement	4	25.0%	50.0%	100.00%	100.0%	0%	100.0%
NWSSP	18	33.3%	33.3%	83.33%	100.0%	66.7%	100.0%
PHW	12	50.0%	25.0%	87.50%	100.0%	100.0%	100.0%
Powys THB	23	39.1%	13.0%	77.78%	100.0%	87.5%	100.0%
Swansea Bay	27	40.7%	18.5%	80.00%	100.0%	42.9%	100.0%
Velindre	17	35.3%	23.5%	100.00%	100.0%	60.0%	80.0%
WAST	20	40.0%	35.0%	80.00%	100.0%	80.0%	100.0%
Total	311	37.6%	24.4%	80.56%	100.0%	68.1%	98.9%

Medical Examiner Service

Below is an extract from the winter planning risk register. The mitigation demonstrates that MES implemented robust plans and available evidence confirms these have been effective. The mitigation refers to the CMO’s request for Health Boards to produce draft plans, which are being followed up and expanded. We request that these plans are shared with NWSSP so we can review them and assess any process or operational changes Health Boards have introduced, enabling us to maximise efficiencies.

To date, these plans have not been shared; however, as part of lessons learned and continuous improvement, we would welcome the opportunity to review them in full.

In addition, the Strategic Oversight Board established by Welsh Government last year developed standardised communications and leaflets for the death certification pathway and all Health Boards were asked to update their websites to ensure accurate and consistent messaging. Some Health Board websites still contain outdated or inaccurate information and we would ask that websites are reviewed and updated in line with the Board’s recommendations.

Risk Title	Overview	Likelihood Jan 26	Impact Jan 26	Mitigation	WG Risk Owner
Increase in time in death certification process	Increase in time in death certification process impacting on mortuary capacity and subsequently hospital flow			CMO commissioned MDs to create action plans including winter contingency planning if increases in time to certification occur. These are currently being followed up and expanded on Review of current death certification processes and timeliness conducted August-Sept 2025 with recommendations due to be shared with key system partners Medical Examiner Service (MES) now sharing live data with health boards around process step timings, enabling greater knowledge on bottlenecks and areas for action MES have developed winter staffing plans to provide more staff sessions at key weeks/months MES have created clear escalation plan for work processes if capacity concerns are observed.	Ben Brown

Appendix 1 – Performance for the period to 31st December 2025

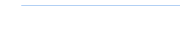
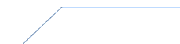


GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Shared Services
Partnership

HD High Level - KPIs Dec 2025	Target	31/03/2025	30/06/2025	30/09/2025	31/12/2025	Trend
Financial Information						
Professional Influence Savings - YTD		£18.171 m	£2.217 m	£4.398 m	£7.271 m	
Employment Services						
Payroll Services						
NWSSP Pay Accuracy	99.6%	99.96%	99.98%	99.98%	99.99%	
Overall Pay Accuracy	99.6%	99.89%	99.93%	99.91%	99.89%	
Organisation KPIs Recruitment						
% of vacancy creation to unconditional offer within 71 days		80.0%	92.4%	86.6%	86.8%	
Vacancy creation to unconditional offer	71	50.8	49.6	52.2	51.4	
% of vacancies approved within 10 working		79.5%	81.5%	91.5%	84.8%	
Time to Approve Vacancies	10	7.4	9.0	5.9	7.8	
% of vacancies shortlisted within 3 working		92.5%	95.1%	90.4%	90.8%	
Time to Shortlist by Managers	3	1.2	1.1	1.7	1.4	
% of interview outcomes notified within 3 working		91.3%	80.9%	88.5%	79.7%	
Time to notify Recruitment of Interview Outcome	3	1.6	2.3	1.6	2.0	
NWSSP KPIs Recruitment						
% of Vacancies advertised within 2 working of receipt	95.00%	100.0%	100.0%	100.0%	100.0%	
Time to Place Adverts	2	1.8	1.6	1.8	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	1.1	1.2	1.1	1.1	
% of conditional offer letters sent within 4 working	95.00%	100.0%	100.0%	100.0%	99.3%	
Time to send Conditional Offer Letter	4	3.8	3.2	3.6	3.7	
Procurement Services						
Procurement savings - YTD		Target £3.012m Actual £4.784m	Target £0.983m Actual £1.983m	Target £2.046m Actual £3.973m	Target £2.284m Actual £5.300m	
Accounts Payable						
PSPP Compliance non NHS	95%	96.4%	96.8%	96.2%	96.8%	
PSPP Compliance NHS	95%		80.2%	85.8%	98.9%	
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%	74%	Not Applicable	88%	67%	
% of audit outputs in progress		13%	16%	27%	14%	
Report turnaround management response to Draft report - YTD	80%	81%	Not Applicable	86%	90%	
Report turnaround draft response-final- YTD	80%	100%	Not Applicable	100%	100%	

Appendix 2 – All Wales Performance for the period to 31st December 2025

ALL WALES KPIS		31/03/2025	30/06/2025	30/09/2025	31/12/2025	Trend
Primary Care Services						
Prescription - Payment Month keying Accuracy rates	99%	99.84%	99.69%	99.81%	99.23%	
Prescriptions processed (Apr - Oct)		73.1m	7.03m	42m	50m	
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%	98.9%	98.9%	98.4%	99.3%	
CTeS						
P1 incidents raised with the Central Team are responded to within 20 minutes	80%	100%	100%	Not Applicable	Not Applicable	
BACS Service Point tickets received before 14.00 will be processed the same working day	92%	100%	100%	99%	100%	
Digital Workforce						
DWS % Calls Handled	85%	96%	96%	98%	96%	
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%	100%	100%	100%	100%	
Pharmacy 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%	94%	94%	97%	98%	
Microbiological contact failure points	85%	97%	97%	95%	95%	
Number of pieces of returned linen by customer not meeting quality standards	<100	0	0	0	0	

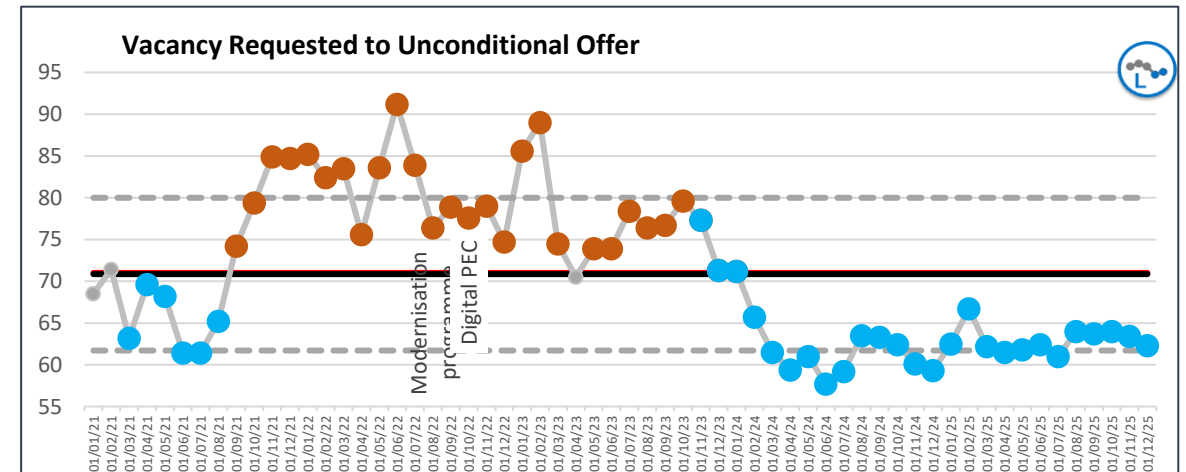
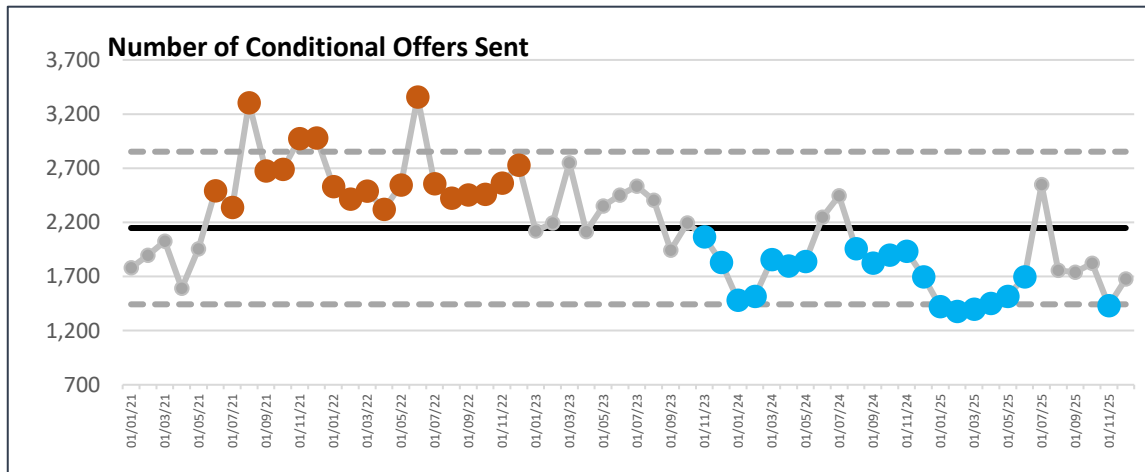
Appendix 3 – Health Org Performance comparison 31st December 2025

KPIs Dec 25	KFA	Target	SB	AB	BCU	C&V HEALTH ORG KPIs Financial Information	CTM	HD	PHW	PTHB	VEL	WAST	HEIW	DHCW
Professional Influence Savings- YTD	Our Value		£57.461 m	£27.608 m	£19.310 m	£17.394 m	£19.645 m	£7.271 m	£0.391 m	£0.818 m	£1.952 m	£2.182 m	£0.069 m	£0.307 m
Employment Services														
Payroll Services														
NWSSP Pay Accuracy	Our Services	99.6%	99.97%	99.99%	99.99%	99.95%	99.93%	99.99%	99.89%	100.00%	99.92%	99.96%	100.00%	100.00%
Overall Pay Accuracy	Our Services	99.6%	99.82%	99.89%	99.82%	99.79%	99.65%	99.89%	99.82%	99.86%	99.72%	99.78%	99.74%	99.84%
Calls Handling % Quarterly Average	Our Services	95%	98.7%											
Organisation KPIs Recruitment														
Vacancy creation to unconditional offer	Our Services	71 days	81.1	56.8	65.5	90.1	76.8	51.4	49.9	69.2	48.3	77.1	60.7	45.9
Time to Approve Vacancies	Our Services	10 days	27.3	7.1	2.6	24.4	19.6	7.8	3.4	2.6	0.3	11.7	5.0	0.3
Time to Shortlist by Managers	Our Services	3 days	6.4	8.4	5.0	5.0	8.7	1.4	9.3	9.8	14.0	3.6	5.8	12.3
Time to notify Recruitment of Interview Outcome	Our Services	3 days	7.0	3.5	2.3	2.4	3.7	2.0	3.8	3.9	5.6	5.5	3.3	6.6
NWSSP KPIs Recruitment														
Time to Place Adverts	Our Services	2 days	1.5	1.5	1.6	1.6	1.5	1.8	1.7	1.8	1.5	1.8	1.7	1.6
Time to Send Applications to Manager	Our Services	2 days	1.0	1.2	1.0	1.0	1.0	1.1	1.0	1.0	0.8	1.0	1.0	1.0
Time to send Conditional Offer Letter	Our Services	4 days	3.6	3.6	3.9	3.4	3.6	3.7	3.4	3.6	3.5	3.8	3.8	3.0
Calls Handling % Quarterly Average	Our Services	95%	99.2%											
Procurement Services														
Procurement Savings- YTD	Our Value		Target £3.224m Actual £4.949m	Target £5.552m Actual £9.726m	Target £3.847m Actual £7.450m	Target £4.908m Actual £7.305m	Target £3.226m Actual £5.539m	Target £2.284m Actual £5.300m	Target £0.009m Actual £0.067m	Target £0.245m Actual £0.667m	Target £0.262m Actual £1.426m	Target £0.005m Actual £0.426m	Target £0.001m Actual £0.047m	Target £0.000m Actual £0.000m
Accounts Payable														
Call Handling% - Quarterly Average	Our Services	95%	98.0%											
PSPP Compliance non NHS	Our Services	95%	96.8%	97.4%	97.1%	93.5%	95.3%	96.8%	97.2%	92.5%	95.7%	97.7%	97.7%	98.6%
PSPP Compliance NHS	Our Services	95%	87.2%	96.2%	90.2%	89.7%	60.0%	98.9%	94.0%	87.9%	86.0%	96.1%	98.9%	96.6%
Audit & Assurance														
Audits reported to Agreed Audit Committee (Excluding External Factors)	Our Services	80%	80%	90%	92%	64%	57%	67%	88%	78%	100%	80%	90%	100%
% of Audit outputs in progress	Our Services		19%	21%	31%	19%	30%	14%	25%	13%	24%	35%	17%	39%
Report turnaround (15 days) management response to Draft report - YTD	Our Services	80%	43%	50%	55%	78%	33%	90%	100%	88%	60%	80%	100%	50%
Report turnaround (10 days) draft response-final- YTD	Our Services	80%	100%	100%	100%	100%	100%	100%	100%	100%	80%	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 transfers 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

Employment Services – Recruitment

For information - All Wales performance in relation to recruitment time to hire for the last 12 months ending December 25.

Recruitment		Vacancy Creation to Unconditional Offer												Trend
Org	Target	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	
AB	71	70	64	64	58	59	61	58	62	60	68	63	57	
BCU	71	58	58	56	60	58	63	68	64	65	62	62	66	
CV	71	81	88	95	88	86	94	102	104	98	107	116	90	
CTM	71	74	76	74	70	68	70	71	70	69	71	74	77	
HD	71	56	48	51	48	49	50	49	55	52	48	50	51	
HEIW	71	61	66	47	60	48	58	63	55	49	49	55	61	
DHCW	71	57	53	32	34	58	46	48	59	57	47	47	46	
NWSSP	71	61	56	61	58	54	58	42	52	57	54	48	51	
PTHB	71	76	70	81	65	68	71	58	68	64	72	78	69	
PHW	71	52	59	63	55	59	58	59	55	53	61	61	50	
SBU	71	68	71	72	76	73	70	70	80	73	85	79	81	
VEL	71	49	67	54	55	50	54	50	57	63	54	44	53	
WAST	71	77	76	76	84	96	76	78	63	72	74	88	77	
All Wales	71	63	67	62	62	62	62	61	64	64	64	63	62	



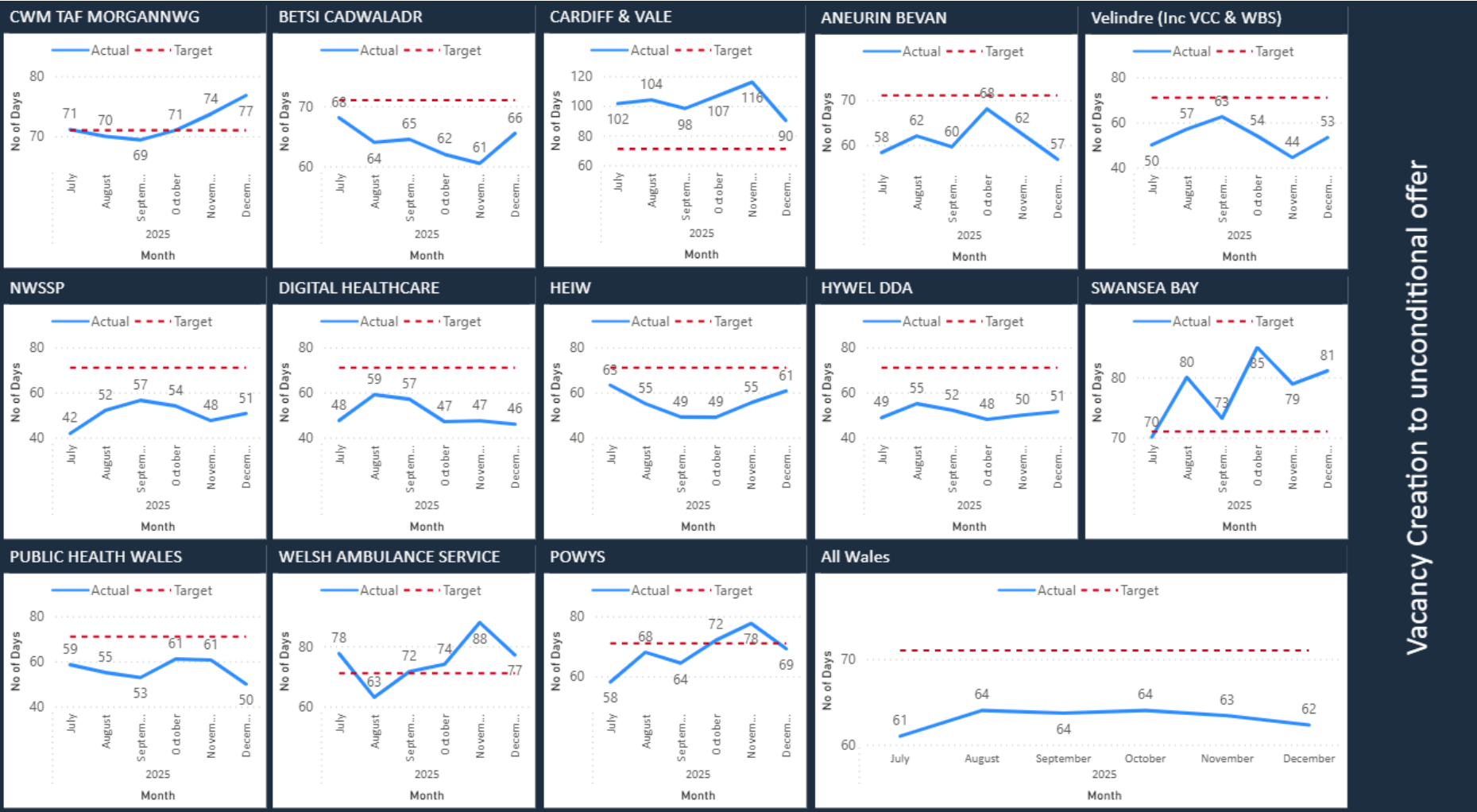
Employment Services – Recruitment



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Shared Services
Partnership

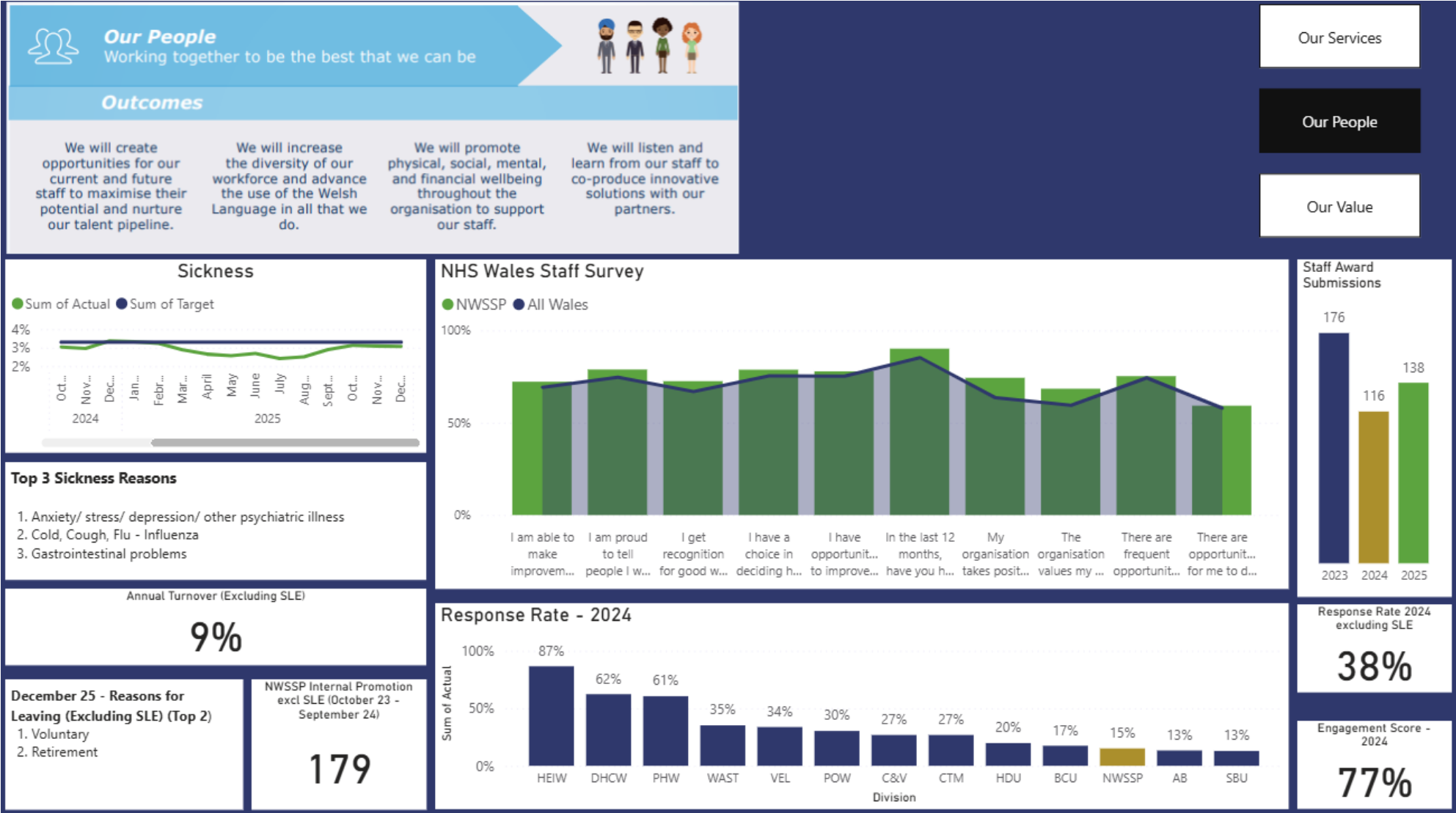
For Information - The charts below shows the time to hire performance for the individual organisations July – December 25.



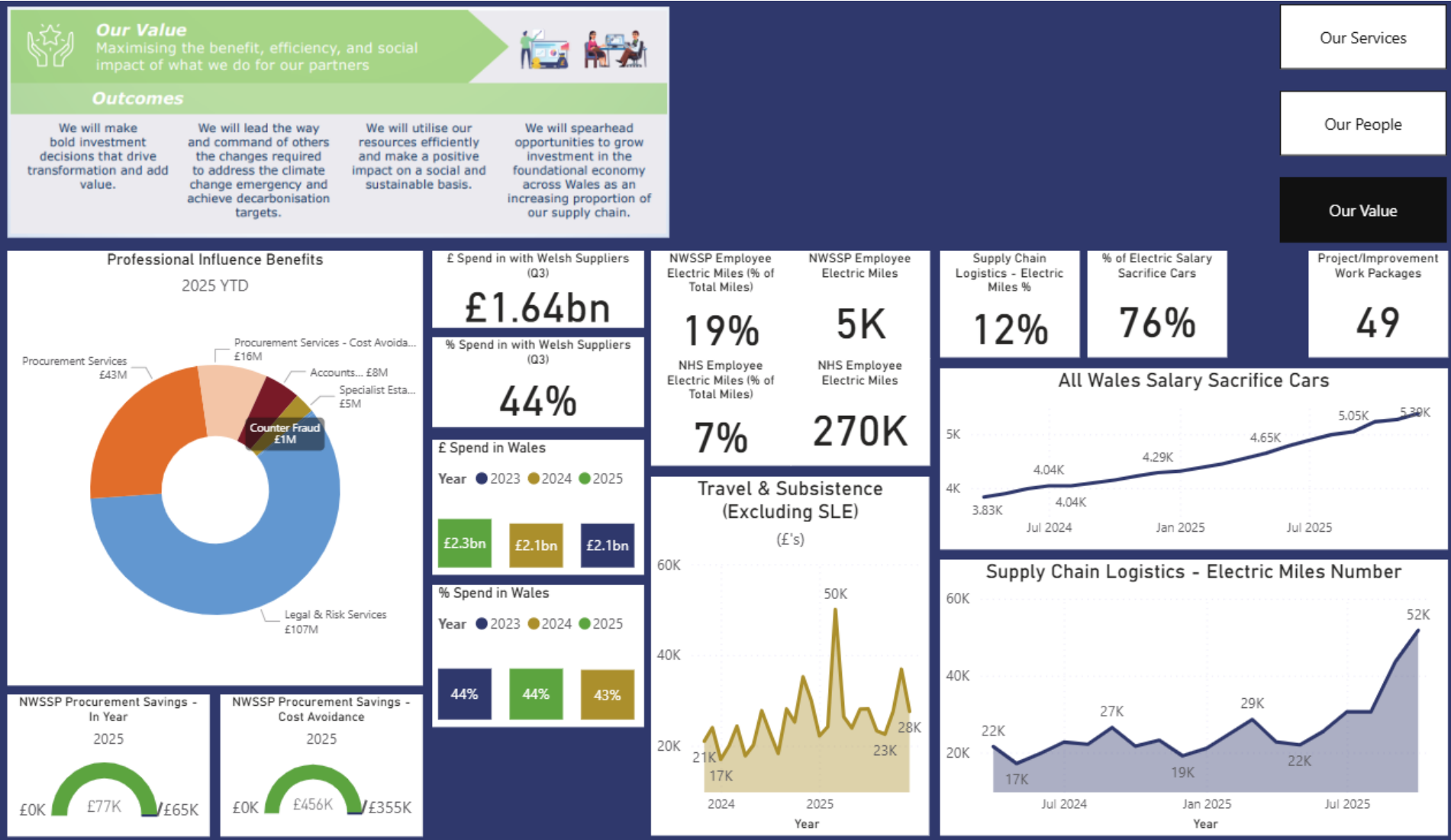
Appendix 4 – Outcome Reporting (Our Services)



Appendix 4 – Outcome Reporting (Our People)



Appendix 4 – Outcome Reporting (Our Value)

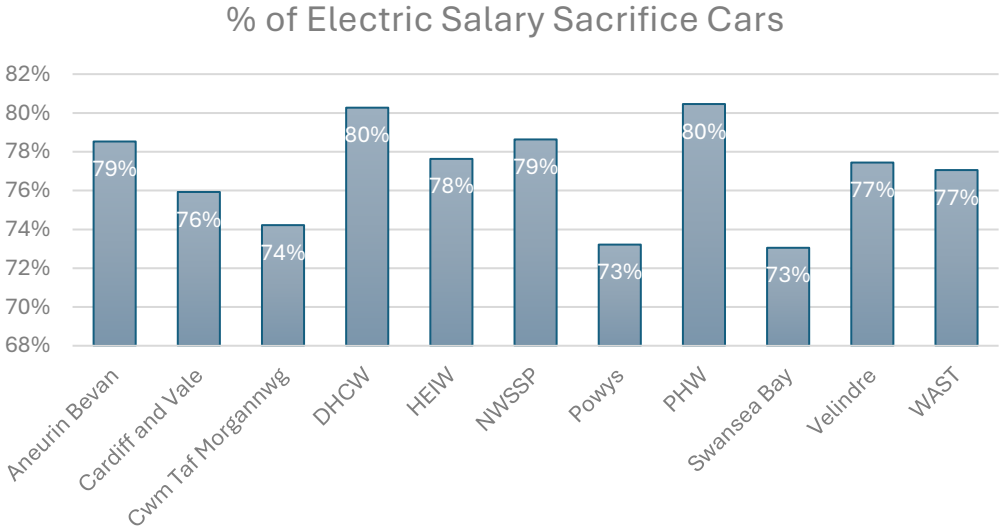


For information - The table below provides an overview of the total mileage claims by organisation, along with the proportion that are electric miles in December 2025.

Organisation	Total Miles Claimed	Electric Miles	
		Claimed	Electric Miles %
Cardiff & Vale	210,318	12,856	6%
WAST	192,630	21,062	11%
DHCW	11,672	2,849	24%
CVB	7,723	-	0%
Public Health	80,955	8,112	10%
AB	440,044	37,382	8%
NWSSP SLE	385,474	13,723	4%
NWSSP exc SLE	26,513	5,140	19%
BCU	673,838	61,602	9%
Powys	206,703	13,068	6%
HEIW	14,306	2,568	18%
Hywel Dda	523,106	35,212	7%
Cwm Taf	442,957	33,849	8%
Velindre	19,027	22	0%
Swansea Bay	384,660	22,129	6%
Total	3,619,927	269,575	7%

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 December 2025.

Organisation	Total Cars	Live Electric	Live Hybrid	Live Petrol	% Electric
Aneurin Bevan	1,006	790	189	27	79%
Cardiff and Vale	1,026	779	204	43	76%
Cwm Taf Morgannwg	927	688	196	43	74%
DHCW	147	118	25	4	80%
HEIW	76	59	15	2	78%
NWSSP	337	265	72	-	79%
Powys	112	82	25	5	73%
PHW	174	140	31	3	80%
Swansea Bay	987	721	215	51	73%
Velindre	133	103	27	3	77%
WAST	462	356	94	12	77%
TOTAL	5,387	4,101	1,093	193	76%



NWSSP does not provide salary sacrifice cars to Hywel Dda as the Health Board run their own scheme.

For Information - The following table highlights the All Wales performance in relation to P2P as at the end of December 2025.

All Wales Accounts Payable data - July to Dec 2025																										
July to December 2025	AB		BCU		C&V		CTM		DHCW		HEIW		HD		POWYS		PHW		SBU		VEL		WAST		TOTAL	
	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec	End of July	End of Dec
Number of Invoices on Hold	6,077	5,912	8,176	7,832	7,169	7,409	6,412	6,635	167	124	442	444	3,085	3,261	841	856	1,440	855	5,686	4,408	2,422	1,732	541	563	42,458	40,031
Value of Invoices on Hold £m	10.145	14.574	18.128	14.574	24.440	25.458	14.918	15.310	2.184	3.857	6.618	4.608	7.690	11.370	8.937	14.820	17.162	4.796	13.789	14.586	7.635	8.654	7.011	2.545	138.656	135.152
No of Invoices on hold > 30 days	4,606	4,189	5,748	5,307	5,211	5,039	4,295	4,742	76	66	115	69	1,777	1,926	506	481	1,019	648	3,749	2,753	1,735	1,056	329	329	29,166	26,605
No of invoices on No PO No Pay Hold	985	754	727	915	288	368	1,158	879	7	19	6	14	95	101	100	105	121	106	1,141	608	127	198	62	106	4,817	4,173
No of NPNP invoices - Top 15 suppliers	509	174	297	318	74	107	748	295	2	5	2	3	16	6	19	22	26	22	642	255	31	34	12	15	2,378	1,256
No of invoice lines - Receipting hold	4,739	4,309	5,202	5,720	3,687	4,322	4,368	4,974	58	-	74	112	2,477	2,777	854	342	389	342	4,245	3,588	1,645	845	320	330	28,058	27,661
Priority Supplier - Rebate income	£14,767	£29,720	£39,112	£85,766	£17,522	£43,160	£43,509	£77,203	£1,706	£3,889	£413	£1,015	£11,806	£22,745	£1,896	£3,940	£1,447	£3,244	£36,078	£75,034	£21,512	£46,917	£18,538	£38,635	£208,306	£431,268

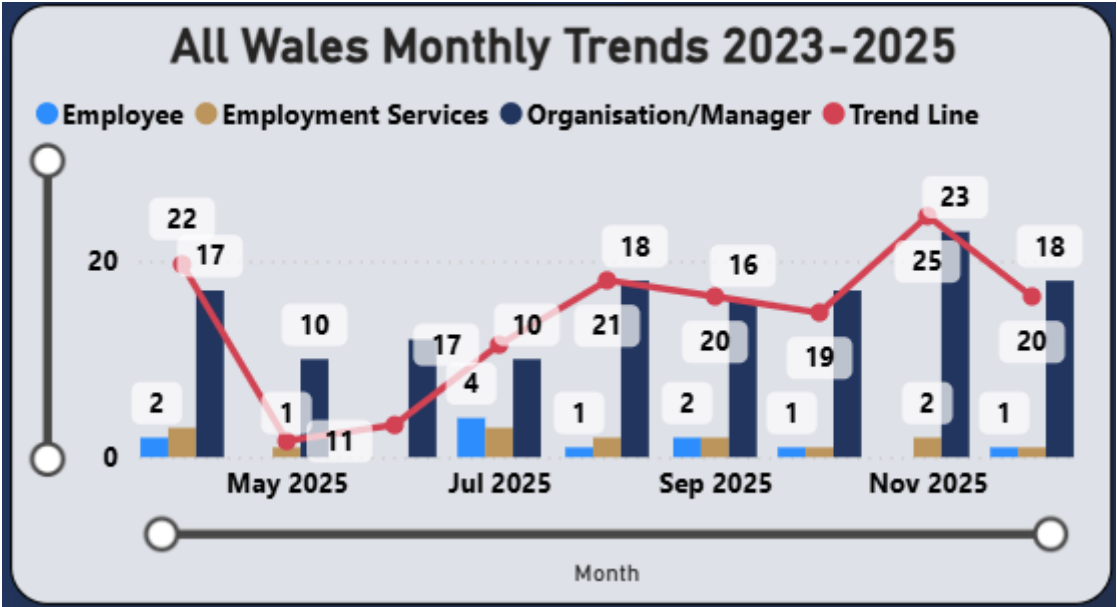
Key

- Deterioration on end of July position
- Same as end of July position
- Improvement end of July position

Supporting information for the Procurement savings - The table below provides an overview of the identified cash releasing procurement savings by procurement team for April – December 2025.

HB	HDT	
TEAM DELIVERING SAVINGS	Target	Actual
HYWEL DDA PROCUREMENT TEAM	£487,189	£1,417,609
NATIONAL - CLINICAL	£0	£262,963
NATIONAL - COMMISSIONING	£12,443	£12,443
NATIONAL - ENERGY	£1,179	£625
NATIONAL - HOTEL SERVICES AND TEXTILES	£33,094	£52,812
NATIONAL - ICT & OFFICE EQUIPMENT	£61,383	£104,459
NATIONAL - MAINTENANCE	£8,618	£54,783
NATIONAL - MEDICAL	£249,028	£331,427
NATIONAL - PHARMACY	£1,431,123	£3,047,358
NATIONAL - PROVISIONS	£0	£15,377
	£2,284,058	£5,299,855

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 December 2025.



Note: The data was recorded as at the end of December.



*Delivering
Value, Innovation and
Excellence through
Partnership*

6 - FOR APPROVAL

6.1

12:45 PM, 5 Mins

6.1 - FINANCIAL PROCEDURES

*Huw Thomas (Hywel
Dda UHB - Director
of Finance)*

| For approval

Attachments

[Financial Procedures FPC 24 February 2026.pdf](#)

[FP070 Hospital Travel Cost Scheme Procedure.pdf](#)

[FP070 Equality Impact Assessment.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
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 procedure has been reviewed and is presented to the Finance and Performance Committee for approval:

- **Financial Procedure 070 – Hospital Travel Cost Scheme**

The purpose of this document is to outline the key processes to be followed by Health Board staff in connection with the above-named financial procedure and to set out associated roles and responsibilities.

Asesiad / Assessment

- **Financial Procedure 070 – Hospital Travel Cost Scheme**

The financial procedure is 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 procedure:

- **Financial Procedure 070 – Hospital Travel Cost Scheme**

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 Termiau: Glossary of Terms:	Included within the body of the report.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	HDdUHB Finance HDdUHB Local Counter Fraud Service

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.

Hospital Travel Cost Scheme Procedure

Procedure information

Procedure number: 070

Classification: Financial

Supersedes: Previous Version

Local Safety Standard for Invasive Procedures reference: N/A

National Safety Standards for Invasive Procedures standards: N/A

Version number: 2.0

Date of Equality Impact Assessment:

Approval information

Approved by: Finance & Performance Committee

Date of approval:

Date made active:

Review date:

Extended by Finance & Performance Committee 21.10.2025 until end February 2026

Summary of document:

This document provides a clear process to be followed when eligible patients wish to claim for hospital travel costs.

Scope:

Hywel Dda University Health Board wide.

To be read in conjunction with:

[Standing Orders Hywel Dda University Local Health Board](#) (opens in new tab)

[Standing Financial Instructions](#) (opens in new tab)

[Counter Fraud Bribery and Corruption Policy](#) (opens in new tab)

[Financial Procedures](#) (opens in new tab)

Patient information:

Include links to [Patient Information Library](#)

Owning group:

Finance Directorate

10/11/2022

Executive Director job title:

Huw Thomas – Director of Finance

Reviews and updates:

1.0 – New Procedure

2.0 – Full Review

Keywords

Hospital, Travel, Cost, Scheme

Glossary of terms

NHS – National Health Service

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 AW Raising Concerns (Whistleblowing) Policy. 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 for further information.

Contents

Procedure information 1

Approval information 1

Introduction - 5 -

Scope - 5 -

Aim - 5 -

Objectives - 5 -

Roles and Responsibilities..... - 5 -

Eligibility for full or partial reimbursement - 5 -

Basis of Payment..... - 6 -

Payment of Fares - 7 -

Supporting Information for patients - 8 -

Monitoring and Review - 8 -

Appendix I..... - 9 -

Appendix II..... - 11 -

Appendix III..... - 14 -

Appendix IV - 17 -

Introduction

The Welsh Government website contains guidance on assistance available to certain NHS patients and visitors under the Hospital Travel Costs Scheme with the cost of travelling to and from hospital.

Scope

This procedure is Hywel Dda University Health Board wide.

Aim

The aim of this document is to:

- Ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses.

Objectives

The aim of this document will be achieved by the following objectives:

- To ensure there is a clear process for patients who need to reclaim their travel expenses should they be eligible.

Roles and Responsibilities

Procedure	Responsible Party
Obtaining & completing relevant paperwork for application	Patient
Checking for Eligibility	General Office Staff / NHS Business Services Authority
Reimbursement of expenses	General Office Staff / NHS Business Services Authority

Eligibility for full or partial reimbursement

Patients receiving (or who are dependent on someone receiving) Income Support, Disability Working Allowance (income based only), Family Credit, Income Based Jobseeker's Allowance, Working Tax Credit and/or Child Tax Credit, Pension Credit, Universal Credit, Employment & Support Allowance (income based only) or War Disablement Pension, may be eligible. (see Appendix II)

Patients who have been assessed as eligible for low-income (see Appendix III) help will hold a current entitlement certificate. There are two forms:

- HC2, eligible for a full refund, and
- HC3, eligible for a partial refund.

The journey undertaken must be made to receive services provided under Parts 1 and 2 of the National Health Service (Wales) Act 2006 in an NHS hospital for which the patient has been referred by a GP or dentist. (see link below).

The appointment must be on a separate visit to when the referral was made. This applies whether the treatment is provided at a different location (hospital or clinic) or on the same premises as where the GP or another health professional issued the referral.

Escorts will have their expenses refunded based on the eligibility of the patient.

Escorts will be funded if this is required for medical reasons, for example:

- Where the patient has a significant physical or mental disability that necessitates the support of another person to travel safely.
- Where the patient is undergoing a procedure or therapy that results in them requiring assistance to travel home.
- Where the patient is attending an appointment that involves self-management that a carer or relative will be undertaking on their return home.
- Where the patient lacks the mental capacity to take decisions or has a legal guardian.

Escorts may be funded in other circumstances where:

- The parent or guardian of a child under 16 years of age accompanies them to the hospital or clinic. Only the travel costs of one escort will be funded, unless a clinician determines a medical reason for the child to be accompanied by two adults. Siblings of the child patient who also travel with parent escort(s) will not be provided for under the terms of the policy.
- The patient is aged between 16 and 18 and requests a parent or guardian to accompany them.

Basis of Payment

Where patients or escorts meet the eligibility criteria as per above the amount of any NHS travel expenses to be reimbursed must be calculated by reference to the cost of the cheapest means of transport, which is reasonable, having regard to the patient's relevant circumstances.

The test of reasonableness is made on the basis that the patient should be able to reach the hospital in a reasonable time and without detriment to their health and well-being. When assessing a patient's claim, the health board should take into account issues such as:

- The distance that the patient has to travel
- How long the journey has taken to complete
- Whether the patient has to make the journey frequently
- The availability, suitability and accessibility of public transport
- The medical condition of the patient
- The age of the patient and
- The time of the appointment.

If the patient has a motor vehicle, and uses it to travel to hospital, the rate of reimbursement will be set by finance and will not be lower than the advisory fuel rates specified by HM Revenue and Customs for company cars, up to 2000cc as at the date of the appointment.

If the patient does not have a motor vehicle, the patient needs to consider public transport, community transport, a family member who could transport them. Please see travel line cymru link and other helpful links in Appendix I.

Only in exceptional cases taxi fares may be reimbursed where all other options have been exhausted as per above and evidence provided to the nearest bus stop or train station or for the whole journey if necessary. To be eligible the patient must be in receipt of a GP letter stating that they are unable to travel via Public Transport on health grounds, or they must provide sufficient evidence to demonstrate that an alternative form of travel would not have been reasonably practicable given their personal circumstances. Please see workflow in Appendix I.

Payment of Fares

Patients will need to complete a [Claim Refund Travel Costs Form HC5WT](#) (opens in new tab) to be reimbursed.

These can either be collected from the General Office on the Hywel Dda site that is being visited or printed out from the below link or at the following web address

[Claim a refund for travel costs to receive NHS treatment: form HC5W\(T\) | GOV.WALES](https://gov.wales/claim-refund-travel-costs-receive-nhs-treatment-form-hc5wt) (opens in new tab). <https://gov.wales/claim-refund-travel-costs-receive-nhs-treatment-form-hc5wt>

In addition to the completed form an attendance form completed by the Clinic[s] or an appointment letter from the clinic will be needed for proof of appointment along with receipts relating to the travel cost.

These will need to be posted to the relevant address see Appendix IV to claim the refund. Once approved reimbursement will be issued via cheque.

Alternatively, patients could be reimbursed in cash from the General Office petty cash. To do this, they will also need in addition to the HC5WT form and proof of attendance form the following proof of entitlement:

- a) Patients on Income Support, Income Based Jobseekers Allowance, Employment and Support Allowance (*income based only*), Universal Credit, Disability Working Allowance (*income based only*), Pension Credit or War Disablement Pension, will be in receipt of an **award letter** as proof of entitlement, which is issued by their Jobcentre Plus Office.

or

- b) Patients on Working Tax Credit or Child Tax Credit will be in receipt of an NHS Tax Credit Exemption Certificate, or in the case of dependants an **award letter** listing their dependants.

or

- c) Patients on low income can also apply for payment of fares by applying for a Low-Income Exemption Certificate from the Department of Social Security. If successful in this application, the patient will be given an HC2 (full refund) or HC3 (partial refund) **certificate** as proof of entitlement

The deadline for claiming reimbursement is 3 months following the date of appointment and can take up to 30 days to process the claim.

It is the responsibility of the designated officer in the General Office to ensure that payment is only processed where the above criteria have been met and that the patient has signed for the cash on the Proof of Payment form. This form is used to support Cash Imprest reimbursement.

The patients travel cash imprest is reimbursed in line with the [Cash Financial Procedure](#) (opens in new tab).

Supporting Information for patients

[National Health Service in Wales | Law Wales](#)

[Traveline Cymru - Journey Planning Wales](#)

Additional information in respect of public transport or community transport availability can be found on the Health Board's internet site on the following link [Patient transport - Hywel Dda University Health Board](#)

Monitoring and Review

The monitoring and review of this procedure is the responsibility of the Deputy Head of Core Accounting Team. 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 I

Patients who have been assessed as eligible for low-income help who has been referred by a GP or dentist (as per Parts 1 & 2 of the National Health Service (Wales) Act 2006) can claim cost of travel

[NHS Wales](#)

Yes

No

Unable to Claim Costs

Do I have a vehicle where I drive myself?

Yes

Complete HC5 form (14p per mile) for reimbursement

No

Can family or friend drive me to appointment?

Yes

Complete HC5 form (14p per mile) for reimbursement

No

Can I go by public Transport see link:

[Traveline Cymru](#)

Yes

Complete HC5 form for fare reimbursement

No

Can I go by Community or voluntary transport?

<https://hduhb.nhs.wales/patien>

Yes

Complete HC5 form for community transport fare for reimbursement

No

Can I go via a taxi? (see taxi operators) see link:

<https://hduhb.nhs.wales/patien>

Yes

Complete HC5 form to receive full refund of taxi the patient must have a Doctor's letter stating this or provide sufficient evidence to demonstrate that an alternative form of travel would not have been reasonably practicable given their personal circumstances otherwise only 14p per mile will be re-imbursed

14p per mile effective from 1st December 2025

Useful Links:

[National Health Service in Wales | Law Wales](#)

[Traveline Cymru - Journey Planning Wales](#)

[Patient transport - Hywel Dda University Health Board](#)

Appendix II

Qualifying benefits and allowances

Benefits providing automatic entitlement

Benefit	Eligibility criteria	Entitlement covers
Income Support	All patients in receipt of Income Support are entitled to payment of NHS travel expenses through HTCS.	Recipient, partner, and any dependents for whom the recipient or partner is responsible including children and young people under 20 named in the award. Some children and young people will not be included in the IS award. These will be covered by Child Tax Credit (CTC). Escorts Where deemed medically necessary by a doctor or other health care professional involved in the provision of services to a patient, the travelling expenses of escort(s) may also be claimed as part of the patient's cost. Where children under 16 are travelling for treatment escort costs may be paid for a parent or guardian attending the appointment with the child.
Income Based Employment and Support Allowance (ESA (IB))	All patients in receipt of Income based Employment and Support Allowance	Recipient, partner, and any dependents for whom the recipient or partner is responsible including children and young people under 20 named in the award. Some children and young people will not be included in the award. These will be covered by Child Tax Credit (CTC). Escorts Where deemed medically necessary by a doctor or other health care professional involved in the provision of services to a patient, the travelling expenses of escort(s) may also be claimed as part of the patient's cost. Where children under 16 are travelling for treatment escort costs may be paid for a parent or guardian

Benefit	Eligibility criteria	Entitlement covers
		attending the appointment with the child.
Income Based Jobseekers Allowance (JSA (IB))	All patients in receipt of Income Based Jobseekers Allowance	Recipient, partner, and any dependents for whom the recipient or partner is responsible including children and young people under 20 named in the award. If a child is no longer included, entitlement should be through Child Tax Credit (CTC). Escorts As for IS above.
Working Tax Credit (WTC) and Child Tax Credit (CTC)	Patients who are receiving or are named on an award certificate for: a) WTC with CTC; b) WTC with a disability element or a severe disability element, or c) CTC but is not eligible for WTC, provided that the relevant income of the person to whom the tax credit is awarded is not more than £15,276 on their award letter.	Recipient, partner, and any dependents including children and young people under 20 named in the award letter. Escorts As for IS above
Pension Credit – Guarantee Credit (PCGC)	All patients in receipt of PCGC. Pension Credit Savings Credit awarded on its own does not automatically provide entitlement through HTCS. However, patients in receipt of this benefit may qualify for full or partial payment of their travel expenses via the NHS Low Income Scheme (see below).	Recipient, partner, and dependents. Escorts As for IS above.

Benefit	Eligibility criteria	Entitlement covers
Universal Tax Credit	The roll-out of Universal Credit in Wales is ongoing and will replace some of the means tested benefits noted above. Universal Credit is being introduced in phases depending on where an individual lives and their personal circumstances. The earning thresholds are: ▪ A lower threshold of £435 net income per month for households with no dependent child and/or limited capability for work/disability, and ▪ A higher threshold of £935 net income per month for households with a dependent child and/or limited capability for work/disability.	

Appendix III

Passport to support	Eligibility criteria	Entitlement covers
People claiming on the grounds of low income	Patients who are not in receipt of a qualifying benefit but are on a low income and whose savings are less than £16,000 (or £23,500 if in a care home)² may be eligible for assistance with their NHS travel expenses. The calculation of a patient's entitlement is carried out by the Prescription Pricing Division (PPD). Where patients have not yet made an NHS Low Income Scheme claim they should be provided with the following for completion and forwarding to the Prescription Pricing Division (PPD): HC1 – assessment form HC1(SC) – assessment form if the patient is in a care home or supported by a local authority because they are 16 or 17 and have recently left local authority care. HC5W(T) – refund claim form if the patient has already made a claim but has yet to receive their certificate, they need only complete and forward the HC5W(T).	Recipient, partner and dependent children or young people under 19 whose names are shown on the notice of entitlement (known as a HC2W or HC3W certificate). Escorts Where deemed medically necessary by a doctor or other health care professional involved in the provision of services to a patient, the travelling expenses of escort(s) may also be claimed. Their costs should be added to the patient's costs, and it is the patient's income that will count, not the escorts.

Passport to support	Eligibility criteria	Entitlement covers
	Patients who might not consider themselves to be on a low income should be encouraged to make a claim if their savings are below the current limits. Where successful, they will be sent a certificate showing how much they would be expected to pay for their travel per week and would be entitled to a refund of anything above this amount.	
Persons living permanently in a care home or accommodation provided by a local authority	To qualify the claimant must reside in one of the following and have satisfied the local authority that he is unable to pay for that accommodation at the standard rate or, as the case may be, the full rate: ▪ a care home; ▪ residential accommodation provided by a local authority for persons aged 18 or over who by reason of age, illness, disability, or any other circumstances are in need of care and attention which is not otherwise available to them. ▪ residential accommodation for expectant and nursing mothers who are in	Claimant only.

Passport to support	Eligibility criteria	Entitlement covers
	need of care and attention which is not otherwise available to them.	
Asylum seekers for whom support is provided under Part VI of the Immigration and Asylum Act 1989	A person who is an asylum seeker for whom support is provided under Part VI of the Immigration and Asylum Act 1999.	Recipient and any dependents where a dependent is classified as someone in the UK who is: ▪ A spouse; ▪ A child of his, or of his spouse, who is under 18 and dependent upon him.

Appendix IV

NHS Business Authority
Bridge House
152 Pilgrim Street
Newcastle Upon Tyne
NE1 6SN

Telephone Number:0300 3301343

www.nhsbsa.nhs.uk/healthcosts

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	Huw Thomas, Finance
Service Area	Hywel Dda University Health Board wide

Title of Procedure, Project, Proposal, Policy being screened:	070 - Hospital Travel Cost Scheme Procedure
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Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

The aim of this document is to ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses.

The aim of this document will be achieved by the following objectives:

- To ensure there is a clear process for patients who need to reclaim their travel expenses should they be eligible.

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
- 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 EqlA must be undertaken: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

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: This policy will have a positive impact on eligible individuals who meet the criteria outlined within the policy.					
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: This policy will have a positive impact on eligible individuals who meet the criteria outlined within the policy.					
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 ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses. 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 therefore not relevant for this guidance.					
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: This policy will have a positive impact on eligible individuals who meet the criteria outlined within the policy.					
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 ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses. 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 ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses. 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 ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses. 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 ensure that patients attending appointments at any of Hywel Dda University Health Board's sites understand the process to claim back their travel expenses. 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: This policy will have a positive impact on eligible individuals who meet the criteria outlined within the policy.				
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: This policy will have a positive impact on eligible individuals who meet the criteria outlined within the policy.				
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: This document does not impact on a person's opportunity to use the Welsh language.					

If a negative impact has been identified, you are not required to complete this form as a full EqlA must be undertaken. A full EqlA template and guidance can be found on the following link: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

Screening Completed by:	Name	Sarah Morgan
	Title	Finance Analyst
	Contact details	sarah.morgan16@wales.nhs.uk
	Date	21/01/26
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	21.01.26
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	10/02/2026
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 EqlA and inform the D&I team.

7 - FOR INFORMATION

7.1

12:50 PM, 5 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 February 2026 FPC 24 February 2026.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 February 2026
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:

- Provide an update on performance against the 2025/26 Capital Resource Limit (CRL)
- Detail the current risk associated with delivery of 2025/26 CRL
- Provide significant 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)	33.360
Discretionary Programme* (DCP)	6.850
IFRS 16 Leases	1.877
Total	42.087

*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
Bronglais - Fire Precaution Upgrade Works - Fees	0.285	Funding for fees on preparing the business case for Fire Upgrade work at Bronglais
Major Infrastructure Investment Plan, Phase 1 BJC Fees	0.100	Funding for fees for production of the first tranche of business cases in the Major Infrastructure programme
End of Year Funding 2025-26	1.294	A tranche of End of Year funding relating to several estates and equipment items
Ultrasound Replacement	0.220	Funding for two ultrasound machine replacement
End of Year Digital Funding - December 2025	0.450	A tranche of End of Year funding for Digital items
End of Year Estates and Equipment Funding - December 2025	1.067	A further tranche of End of Year funding relating to several estates and equipment items
End of Year Funding - January	0.809	A further tranche of End of Year funding relating to several estates and equipment items
End of Year Digital Funding - January	0.300	A further tranche of End of Year funding relating to digital expenditure
End of Year Estates Funding - January	0.207	A further tranche of End of Year funding relating to several estates and equipment items
Backlog Maintenance 2024/25	(0.210)	Reduction in allocation due to underspend against BGH Lift Shaft scheme
IFRS16 – 2025-26 Tranche 2	0.850	Funding for new and renewed leases entered into through to December 2025
Total	5.372	

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-Jan £m	Spend Jan £m	Remaining balance £m
AWCP				
Glangwili - Fire Enforcement works - Phase 2 - Fees	0.779	0.825	0.041	-0.046*
Backlog Maintenance – (slippage from 2024-25)	1.004	0.707	0.125	0.297
Aberystwyth Sexual Assault Referral Centre	1.875	1.678	0.001	0.197
Block C, Picton Terrace, Carmarthenshire	2.488	1.965	0.250	0.523
Diagnostic Equipment - WGH Fluro & Chilled Water Plant	2.570	2.003	0.263	0.567
EFAB - Infrastructure	0.127	0.008	0.000	0.119

EOY Funding 24/25 – (Pentre Awel)	0.150	0.131	0.009	0.019
Targeted Estates Fund (TEF) - Fire	0.570	0.114	0.038	0.456
TEF - Infrastructure	2.294	0.261	0.031	2.033
TEF - Decarbonisation	0.050	0.000	0.000	0.050
TEF - Mental Health	1.684	0.041	0.003	1.643
TEF - Infection Prevention Control	0.569	0.437	0.018	0.132
TEF - Decontamination	0.546	0.382	0.165	0.164
Carmarthen Hwb - Equipment and Fit-out costs	2.318	0.150	0.073	2.168
Fishguard Health and Wellbeing Centre	0.067	0.047	0.005	0.020
DPIF - Digital Maternity Cymru System Programme 2025/26	0.198	0.059	0.006	0.139
Non-Radiology Ultrasound Replacement	0.761	0.406	0.000	0.355
DPIF – (RISP)	0.429	0.429	0.000	0.000
Aseptic Unit, Withybush Hospital	1.753	0.709	0.259	1.044
Gamma Camera Upgrade, WGH	0.481	0.009	0.000	0.472
Mental Health Quality and Safety Schemes	1.317	0.038	0.000	1.279
MRI Upgrade, GGH	1.324	0.021	0.000	1.303
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	0.781	0.377	1.315
Fire Enforcement WGH - Phase 2	0.912	0.420	0.161	0.492
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	0.001	0.001	0.629
Bronglais - Fire Precaution Upgrade Works - Fees	0.285	0.008	0.008	0.277
Major Infrastructure Investment Plan, Phase 1 BJC Fees	0.100	0.000	0.000	0.100
End of Year Funding 2025-26	1.539	0.764	0.014	0.775
Ultrasound Replacement	0.220	0.000	0.000	0.220
End of Year Digital Funding - December 2025	0.450	0.239	0.239	0.211
End of Year Estates and Equipment Funding - December 2025	1.067	0.202	0.202	0.865
End of Year Funding - January	0.809	0.000	0.000	0.809
End of Year Digital Funding - January	0.300	0.000	0.000	0.300
End of Year Estates Funding - January	0.207	0.035	0.035	0.172
Sub-total AWCP	33.727	12.880	2.324	20.847
Discretionary				
IT	2.919	0.814	0.141	2.105

Equipment	1.593	1.129	0.389	0.464
Estates – Statutory	0.450	0.240	0.038	0.210
Estates Infrastructure	1.196	0.853	0.044	0.343
Mental Health	0.060	0.000	0.000	0.060
Other	0.265	0.267	0.049	0.000
Sub-total Discretionary	6.483	3.303	0.661	3.180
IFRS 16	1.877	1.877	0.850	0.000
TOTAL expenditure	42.087	18.060	3.835	24.027

* Negative amount remaining for GGH Fire Enforcement Phase 2 relates to VAT recovery to be processed
Further details on the revenue consequences of these schemes are noted in **Appendix 1**.

The table above summarises the main capital scheme headings, however each heading often has a number of separate capital schemes which make up that funding allocation.

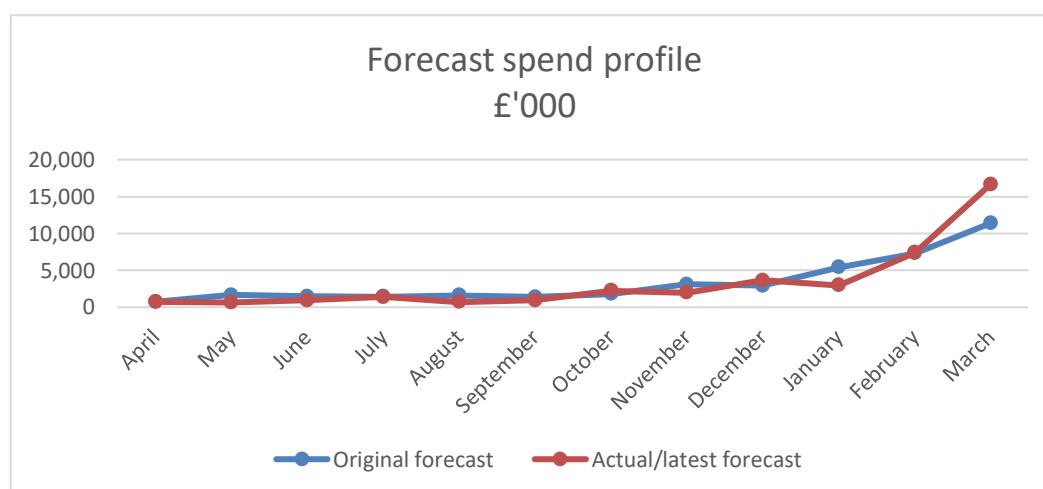
There are in excess of 250 individual capital schemes being managed within the 2025/26 capital programme.

Expenditure Profile Forecast

The below chart shows current forecast expenditure compared with the original forecast. Expenditure for January was lower than forecast due to:

- Diagnostic Equipment – Withybush Hospital (WGH) Fluoroscopy and Chilled Water Plant - (£0.237m)
- Targeted Estates Fund (TEF) – schemes (£0.672m)
- Non-Radiology Ultrasound Replacement – (£0.26m)
- Mental Health Quality and Safety Schemes – (£0.292m)
- MRI Upgrade, Glangwili Hospital (GGH) – (£0.43m)

Assurances have been provided by project managers that these slippages will not result in underspends by year end.



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 £24m is currently forecast for the period February – March.

Expenditure plans are being closely monitored to ensure that if there are any risks identified, mitigating measures are put in place to ensure that capital spend is maximised. Additional monitoring meetings have been held and further meetings arranged with colleagues responsible for delivery of expenditure.

In addition, enhanced detailed finance reports have been issued to track spend and plans, including highlighting contingency balances within schemes where relevant, and the overall level of contingency balance across relevant schemes.

January reporting through the Monthly Monitoring Returns to WG flagged up risks of underspend to the Carmarthen Hwb, Aseptic Unit and Gamma Camera Upgrade schemes; mitigation plans are in place to address these risks.

Operational Risk 2204

A risk has now been placed on our operational risk register to reflect the underspending against our CRL.

Equipment to be Vested / Bonded at Year-End

All suppliers have provided assurances to the Procurement team that any orders made can be fulfilled in full by the end of March, however given the high value of spend remaining there is a risk that transfer of title documents may need to be completed if suppliers experience issues in delivering before the 31 March 2026.

There is currently one capital scheme where transfer of titles will be required:

- Decarbonisation Project – LED lighting to be purchased in 2025/26 and enabling works will occur in 2026/27

CAPITAL SCHEME UPDATES (SCHEMES GREATER THAN £1M)

Withybush Fluoroscopy and Chiller

The Fluoroscopy scanner is in the process of being installed and is due to be operational by the end of the financial year.

Aberystwyth Sexual Assault Referral Centre (SARC)

The project construction works has achieved completion and unspent funds returned to WG. There remains some equipping, fees and non-works costs to transpire by 31 March 2026.

Cross Hands Health and Wellbeing Centre

Discussions are on-going with 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. This will rationalise the Health Board estate by reducing a number of freehold and leasehold properties which are currently being occupied. Scheme has progressed well with final account due to be settled imminently. There remains some equipping, fees and non-works costs to transpire by 31 March 2026

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, furniture and digital items which are in the process of being ordered/bought. Commissioning costs will be deferred to 2026/27 in line with the revised timescale for completion.

Aseptic Unit Withybush Hospital

A sustainable compliant Aseptic Unit will be built at WGH in advance of the development of a South-West Regional Aseptic Unit. This will ensure that the facilities and delivery of aseptic services within HDdUHB will meet the required regulatory standards.

Whilst there has been a slight delay to the original completion date, the scheme is progressing well with commissioning and occupation of the new unit due to occur towards the end of 2026.

Same Day Emergency Care (SDEC), Glangwili Hospital

Works to increase capacity in the SDEC service at GGH commenced in November 2025 and are scheduled to complete in March 2026. The project is on programme and within budget.

Decarbonisation Project

Funding has been provided towards several energy performance improvements across Health Board sites.

Fire Enforcement WGH - Phase 2

Phase 2 of the major Fire Precaution Upgrade works started on site in January 2026, with programme completion currently October 2027. Funding of £8.175m has been provided, with £0.912m in the current year, with the project currently forecast to be within budget, and expenditure to 31 March 2026 is in line with the current year allocation.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **ENDORSE** the actions taken to manage the CRL, including planned vesting of equipment.

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 Termiau: Glossary of Terms:	Explanation of terms is included in the main body of the report.
Partion / 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
Bronglais - Fire Precaution Upgrade Works - Fees	0.00	0.00	0.00
Major Infrastructure Investment Plan, Phase 1 BJC Fees	0.00	0.00	0.00
End of Year Funding 2025-26	0.00	0.00	0.00
Ultrasound Replacement	0.00	0.00	0.00
End of Year Digital Funding - December 2025	0.00	0.00	0.00
End of Year Estates and Equipment Funding - December 2025	0.00	0.00	0.00
End of Year Funding - January	0.00	0.00	0.00
End of Year Digital Funding - January	0.00	0.00	0.00
End of Year Estates Funding - January	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

12:55 PM, 5 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 18 December 2025.pdf](#)

Joint Commissioning Committee

Highlight Report from the Planning, Performance and Finance Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	27/01/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Assurance & Risk Officer
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, PPF Chair and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Stacey Taylor, Deputy Chief Commissioner and 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 has 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 public meeting on 18 December 2025.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted - [December 2025 - NHS Wales Joint Commissioning Committee](#))

Status	Update
Alert / Escalate	The NWJCC Finance Report - Month 8 2025/26 was received. The end of year forecasted financial deficit remains at £7.7m. An increase in lung transplants and activity costs for respiratory disease was noted. This is currently being managed but could become a risk if the increase continues. There is an expectation from Welsh Government that further in-year opportunities will be considered to improve the forecast position. Discussions highlighted the pending need for health boards and the NWJCC to declare their positions. A formal letter will be sent from the NWJCC to health board CEOs in respect to this.
Advise	The NWJCC Operational Performance Report was received. Discussions noted that work is ongoing to produce a meaningful integrated performance report. The complexity of the work and the capacity required to deliver the report was highlighted. It was acknowledged that whilst an updated report would be shared at Joint Committee in March 2026, which would provide greater assurance than at present, work would continue to refine the report over the following year. A session is scheduled in January with the NWJCC Senior Leadership Team to consider the necessary levers required to hold providers to account through their contracts, recognising the need to be far more robust around performance metrics, measures and management. The Managing Activity Brief was received which provided further financial detail, detail of risks and a plan of action for the three areas of opportunity to support an improvement in this year's financial position. It was noted that a detailed plan had been considered and approved at Joint Committee and is currently being actioned at pace. It was recognised that delivery of agreed actions agreed will have a significant impact on the capacity of NWJCC staff which would need to be managed. Further quality impact assessments will be undertaken as the work proceeds, acknowledging the direct impact of the actions on patients.
Assure	The PPF Organisational Risk Register (ORR) was received for review and scrutiny. It was noted that work to improve the ORR, that is fed into the Sub-Committees and the JC, remained ongoing. Risks were being redefined with commissioner-focused actions and mitigations that support mitigation of risks. A new risk was highlighted (Risk 94 – High-Cost Medicines). Whilst this risk was more significant for the NWJCC and its IPFR function. Additionally, it was noted that health boards had identified several high-cost drugs for transfer to the NWJCC which, if

Status	Update
	approved for transfer, would also have a financial impact for 2025/26 and beyond and would need to be managed.
Inform	Members received an update on the development of the NWJCC Integrated Medium-Term Plan, noting that feedback received at the JC meeting on 16 December 2025 would be used to develop the plan and that a detailed evidence-based review of the previously agreed 'Must Do's' would be undertaken. Work will continue with health boards throughout January with a view to developing the plan and ensuring alignment with health board IMTPs. This will include a session with Directors of Planning, a detailed review taking place at the extraordinary Collaborative Commissioning Leadership Group meeting of the 22 January. A further update will be provided at the JC meeting of the 27 January 2026.
Appendices	None.

3. 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
	No - Not Applicable

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	
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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: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / Equality Have you undertaken an Equality Impact Assessment Screening?	Yes: ☒	No: ☒
	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.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 2 of this report.

7.3

1:00 PM, 0 Mins

7.3 - FINANCE AND PERFORMANCE
COMMITTEE WORK PLAN 2025/26

*Huw Thomas (Hywel
Dda UHB - Director
of Finance)*

Attachments

[FPC Work Programme 2025-26 Draft.doc.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 Stabilisation 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
DW Daniel Warm
AJ Amorelle Jones
AL Angela Lodwick
TJ Timothy John
D Deferred

LG Lisa Gostling
AS Andrew Spratt
SHi Steph Hire
HTy Helen Tyler (JCC)
JM Jacqueline Maunder (JCC)
SJ Sian Jenkins

SA Shaun Ayres
GD Gemma Deverill
DB Debra Bennett
SH Sally Havard
RW Rachel Williams

RD Rhian Davies
KJ Keith Jones
LC Liz Carroll
VC Vicky Coppack
CSO Committee Services Officer

8 - ANY OTHER BUSINESS

9 - DATE OF NEXT MEETING

- **Thursday 30 April 2026; 09:30 - 12:30**