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| Date | **2026-10-27** |
| Time | **09:30 - 12:30** |
| Location | **Microsoft Teams Meeting; HDD Picton - Dolau Cothi** |

# Finance and Performance Committee

## HDD_Finance and Performance Committee

NHS Wales

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**09:30, 0 Mins**

# 1 - GOVERNANCE

1.1 **09:30, 0 Mins**

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## 1.1 - WELCOME AND APOLOGIES

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

1.2 **09:30, 0 Mins**

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# 1.2 - DECLARATION OF INTERESTS

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

HDdUHB Register of Board Members Interests 2026-27

1.3

**09:30, 0 Mins**

# 1.3 - MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 AUGUST 2026

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

For approval

### Attachments

1.3 2026-08-27 - Finance and Performance Committee - Minutes.pdf

**UNAPPROVED MINUTES OF THE**
**FINANCE AND PERFORMANCE COMMITTEE MEETING**

| | |
|---|---|
| **DATE OF MEETING:** | **9:30 AM, Thursday 27 August 2026** |
| **VENUE:** | **Dolau Cothi Meeting Room, Corporate Headquarters Picton Terrace/Microsoft Teams Meeting** |

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

**IN ATTENDANCE:**
Lisa Gostling (Hywel Dda UHB – Director of Workforce & OD/Deputy CEO) (part)
Huw Thomas (Hywel Dda UHB - Director of Finance)
Siân Jenkins (Hywel Dda UHB - Deputy Director of Finance)
Andrew Spratt (Hywel Dda UHB – Deputy Director of Finance)
James Severs (Hywel Dda UHB – Executive Director of Allied Health Professions and Health Science)
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

**ALSO PRESENT:**
Bruce Bolam (Hywel Dda UHB - Deputy Director Public Health/Consultant in Public Health) (VC) (part)
Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience) (VC) (part)
Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning) (part)
Rhian Evans (Hywel Dda UHB - Principal Project Manager (VBHC) (VC) (part)
Ardiana Gjini (Hywel Dda UHB - Executive Director of Public Health) (VC) (part)
Mark Henwood (Hywel Dda UHB - Executive Medical Director) (VC) (part)
Carly Hill (Hywel Dda UHB - Assistant Director) (VC) (part)
Keith Jones (Hywel Dda UHB – Director of Operational Planning & Performance) (VC)
Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning) (VC)
Charlotte Wilmshurst (Hywel Dda Health Board - Assistant Director of Assurance and Risk)
John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat)

| MINUTES REF. | ITEM | ACTION |
|---|---|---|

**FPC(26)076 WELCOME AND APOLOGIES**

UNAPPROVED

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

No apologies had been received.

**FPC(26)077 DECLARATION OF INTERESTS**

There were no declarations of interest.

**FPC(26)078 MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 JUNE 2026**

The minutes of the FPC meeting held on 30 June 2026 were reviewed and agreed as an accurate record of proceedings.

**Decision:** The minutes of the Finance and Performance Committee meeting held on the 30 June 2026 were **APPROVED** as a correct record of proceedings.

**FPC(26)079 MINUTES OF EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JULY 2026**

The minutes of the Extraordinary FPC meeting held on 27 July 2026 were reviewed and agreed as an accurate record of proceedings.

**Decision:** The minutes of the Extraordinary Finance and Performance Committee meeting held on the 27 July 2026 were **APPROVED** as a correct record of proceedings.

**FPC(26)080 REVIEW OF FINANCE AND PERFORMANCE COMMITTEE TABLE OF ACTIONS**

The FPC Table of Actions was reviewed and the following updates were provided to the meeting:

**FPC(26)032 ('Q1 2026/27 Planned Care Trajectories'):** Mr Keith Jones advised that that NHS Wales Performance and Improvement review and assessment feedback had not yet been received and would be circulated to members of the Committee once it had been. It was agreed to leave the action open pending completion.

UNAPPROVED

**FPC(26)052 ('Risk and Assurance Report'):** Mr Jones advised that the review of operational risks with a high score of 25 was currently being undertaken and would be presented to the FPC meeting on 26 October 2026. Ms Wilmshurst noted that the overview of risks was covered in the Assurance and Risk Report on the current agenda and that the item could be closed.

**Decision:** The Finance and Performance Committee **REVIEWED** and **NOTED** the Finance and Performance Committee Table of Actions.

**FPC(26)081 FINANCE AND PERFORMANCE COMMITTEE SELF-ASSESSMENT UPDATE REPORT 2025/26**

Mr Huw Thomas introduced the FPC Self-Assessment Update Report to the Committee to provide the Committee with an update to the actions agreed by the Committee in response to the Committee Self-Assessment 2025/26 process.

Mr Thomas noted that the Chair's expectations about the delivery of concise presentations and focussed responses should be circulated with each 'Call For Papers' to ensure that report authors and presenters were aware of the Committee's expectations for reports and presentations.

**Decision:** The Finance and Performance Committee **RECEIVED ASSURANCE** from the progress made against the actions being undertaken to improve its effectiveness.

**FPC(26)082 ASSURANCE AND RISK REPORT**

Ms Charlotte Wilmshurst presented the Assurance and Risk Report to the Committee and noted that many of the areas contained within the report would be covered in the Escalation Response section of the agenda.

Ms Wilmshurst advised that Corporate Risk 2326 ('Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding') has been raised since the production of the report from 20 to 25 and that Corporate Risk 2380 ('Risk to delivery of Single Cancer Pathway performance due to diagnostic capacity gaps, funding uncertainty and pathway fragility') has been updated to reflect funding uncertainty in the current financial year.

UNAPPROVED

Ms Wilmshurst noted that 57 audit recommendations remained overdue and 1 Ministerial Directive (MD), WG21-59 ('The Directions to Local Health Boards and NHS Trusts in Wales on the Delivery of Autism Services 2021') was overdue despite evidence of progress having been provided, however compliance had not yet reached the required standard with lengthy waiting times remaining an issue.

Mrs Eleanor Marks observed that it was difficult to prioritise what work was required to be undertaken first due to the significant number of competing priorities facing the Health Board, including financial sustainability, planned care and the Single Cancer Pathway.

Mrs Marks noted the quantity of overdue audit recommendations within the responsibility of the Community and Integrated Medicine (CIM) Clinical Care Group (CCG). Mr Andrew Carruthers advised that as part of a review into the CIM CCG being undertaken the number of overdue audit recommendations would be examined as part of the review. Mr Carruthers noted the barriers being experienced within Urgent and Emergency Care (UEC) to progressing actions within those risk areas and noted that the Audit and Risk Assurance Committee (ARAC) had reviewed the overdue audit recommendations in depth at its meeting on 13 September 2026 and anticipated that the majority of overdue actions would be completed by the next review at FPC on 26 October 2026.

In response to a question from Cllr Rhodri Evans on the number of overdue audit recommendations with no completion date assigned to them, Mr Wilmshurst advised that conversations were taking place with operational colleagues to provide a target completion date for those without one.

Mr Neil Prior believed that there needed to be consistency between FPC and ARAC and the People, Organisational Development and Culture Committee (PODCC) who has expressed similar concerns on the number of overdue audit recommendations and believed that FPC could not take assurance due to the number of overdue audit recommendations and the absence of a clear narrative for why those recommendations were overdue. Mr Prior believed that the Committee could not receive assurance where the overdue audit recommendations lacked a convincing narrative for why they remained overdue, did not have revised target completion dates or lacked visible progress to completion.

Ms Wilmshurst believed that there was a need to distinguish between the corporate risk position and the separate concerns relating to overdue audit recommendations.

Mr Imperato believed that a corporate risk with a score of 25 should automatically trigger an alert to the Board.



UNAPPROVED

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

**RISK MANAGEMENT**

- **RECEIVE ASSURANCE** that there are processes in place to oversee corporate risks to ensure these are being managed effectively.

**AUDITS, INSPECTIONS AND REGULATORY REPORTS**

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

**WELSH HEALTH CIRCULARS**

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

**Update Report to Board:** The Committee felt that the Board should be **ALERTED** to Corporate Risk 2326 ('Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding') having the highest possible risk score of 25 and to **STRONGLY ADVISE** the Board on the significant number of overdue audit recommendations with no clear narrative on why the recommendations remained overdue, lacked any visible progress being made to undertake the recommendations with many lacking a target completion date. The Committee wished to advise the Board that this would become an alert at a future date if progress is not made.

**FPC(26)083 ANNUAL PLAN 2026/27 AND ESCALATION PRIORITIES**

Mr Lee Davies presented the Annual Plan 2026/27 and Escalation Priorities report to the Committee as a preamble to the discussions to be undertaken within the Escalation Response section of the meeting and within the Finance Performance Assurance Report and the Integrated Performance and Assurance Report (IPAR).

Mr Davies advised that meetings had been held with Welsh Government (WG) colleagues since the last FPC meeting to



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clarify the expectations of WG with the report attempting to provide a summary of the progress of the Health Board against the key areas identified and believed that by the end of September 2026 the Health Board would be in a position to set out its plans to deliver against those WG expectations and evidence measurable improvements on financial delivery and UEC performance.

Mr Davies noted that WG's initial emphasis had been focussed on the 45-minute ambulance handover target however the escalation discussion had been re-centred on the formal escalation criteria of one-hour ambulance handovers and 12-hour Emergency Department (ED) delays, with the 12-hour ED delays presenting the greater area of concern within the Health Board.

Mr Davies advised that the aim of the report was to make the linkages to items such as workforce and diagnostic issues to provide the Committee with a clear strategic response as opposed to repeating detail that is explored in greater depth in the escalation response section of the meeting.

Mr Davies noted that the five areas that WG were expecting the Health Board to address to support deescalation and therefore expected FPC to focus its scrutiny on were:

- Finance and Savings
- Variable Pay and Agency Usage
- Urgent and Emergency Care
- Diagnostics
- Planned Care

Mrs Marks believed that the test of the Health Board would be whether the organisation could deliver all five areas of challenge concurrently and whether the organisation had sufficient leadership capacity to facilitate progress.

Mr Imperato believed that the report presented the expectations of the Health Board in stark and clear terms and that the role of the Committee was to scrutinise and challenge whether the organisation's trajectories within the five key areas was credible.

**Decision:** The Finance and Performance Committee:

- **SCRUTINISED** the deliverability of the five areas at slide 12 (within the respective plans), and in particular whether the actions behind the financial plan and the actions behind the performance plans can be delivered in conjunction with each other; and
- **ENDORSED** a single combined view of savings schemes, staffing dependency and clinical risk to the September Board, so financial and operational exposure were read together.

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**FPC(26)084** **PERFORMANCE DEEP DIVE: RADIOLOGY DEMAND AND CAPACITY AND SERVICE SUSTAINABILITY**

Mr Andrew Carruthers introduced the Performance Deep Dive into Radiology Demand and Capacity and Service Sustainability to the Committee and believed that previous challenges relating to the quality of the data used to measure the performance had been addressed by the Task and Finish Group formed to undertake had been completed by 31 July 2026 and enabled a robust and reliable demand and capacity analysis of the radiology service.

Mr Keith Jones believed that the work of the Task and Finish Group gave greater confidence in the demand and capacity assessment and of the gap identified with the report focussing on the in-year bridging solution and the long-term question of service sustainability. Mr Jones advised that the report outlined what a sustainable future of the radiology service looked like with work on workforce sustainability already in progress with the Clinical Services Plan (CSP) anticipated to stabilise the service with a possible longer-term solution being on a regional basis to shape the future of radiology services in south west Wales.

In response to a question from Mr Imperato on where the issue of productivity sat within the solution of providing a sustainable radiology service, Mr Jones believed that one strand of the solution was demand management and how referrals into the service were assessed and triaged, and despite workforce challenges work was being undertaken between the Health Board and its strategic digital partner to explore digital opportunities to improve productivity and efficiency.

Mr Jones advised that the other focus was on how the Health Board processed its radiology workload and how its waiting lists were managed across the Health Board as a whole as opposed to individually at four separate acute locations.

Mr Jones believed that the ability of the service to unlock additional productivity was challenged due to the workforce challenge and the lack of digital opportunities and believed that there were significant productivity gains able to be achieved.

In response to a question from Cllr Evans on the elimination of 8-week wait breaches being dependent on the WG funding and what alternatives were considered should funding not be received, Mr Jones believed that without WG funding there was no mitigation plan to close the performance gap by 31 March 2027 and that the Health Board was completely dependent on receipt of the WG funding to transact the solutions to eliminate the 8-week wait breaches.

Mr Jones questioned whether workforce stabalisation on the progression of the CSP was sufficient for the Health Board to get

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to a desired position within radiology and believed that it was possible that the Health Board was dependent on the development of a regional solution to meet its desired performance position.

In response to a question from Mr Winston Weir on whether this was a unique challenge to Hywel Dda University Health Board (HDdUHB) and what actions other Health Boards in Wales were taking, Mr Jones believed that the diagnostic challenges were common across other Health Boards in Wales however were greater within HDdUHB due to historic and geographic factors with learning from other Health Boards used wherever appropriate.

In response to a question from Mrs Marks on what demand modelling over the next five years had been undertaken, Mr Jones confirmed that an evaluation of future demand levels had been undertaken with a recurrent workforce stabalisation plan for radiology having been presented to Board with £3.5 of recurrent funding having bene approved based on a commitment to address future levels of demand. Mr Jones believed that digital approaches were designed to mitigate an extend of future demand and underpinned the CSP development work.

In response to a question from Mr Prior on what were considered the greatest risks to the radiology service, Mr Jones believed that the greatest risk lay within the workforce challenge although there was a lesser risk relating to radiology equipment capacity and the age of the equipment and advised that there was a national programme in place to address radiology equipment challenges.

Mr Carruthers believed the greatest risk to sustainability was the workforce fragility and the infrastructure challenge with service configuration particularly within emergency pathways contributing to the challenges within workforce fragility. Mr Carruthers believed that digital opportunities mitigated the service configuration challenges.

*Mrs Lisa Gostling joined the meeting*

Mr Jones provided an update on the CSP with early indications from the implementation plan specifically within the radiology service in progress with incremental progress anticipated within the next few years as opposed to waiting until the end point of th CSP implementation process to make changes to the wider service delivery model.

In response to a question from Mr Imperato on when the diagnostic and trajectory expectations of WG would be addressed, Mr Jones believed that there were clear trajectories in place to address the demand and capacity gap by 31 March 2027 however believed that the solution to achieve the closure of that gap was not a sustainable solution.

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The Committee were reassured by the trajectories and the oversight of the demand and capacity gap with the plan in place t stabilise the service however were concerns that these plans were dependent on the continued receipt of external funding to ensure the stable delivery of the service was maintained in the longer term.

Mr Thomas reinforced the scale of the underlying challenge with an estimated 10 percent overall growth in demand within the radiology service anticipated and the challenge within diagnostics of a 33 percent growth in magnetic resonance imaging (MRI) scanning demand and a 15 percent growth in computed topography (CT) scanning demand growth. Mr Thomas believed that the challenge within the 2027/28 budget setting was that radiology would require a significant uplift in resources even with the maximisation of productivity opportunities.

Mr Thomas believed that there was a need to test out how the service would address its demand management and capacity with the need to produce a plan that did not rely on repeated requests to WG for additional resources.

**Decision:** The Finance and Performance Committee:

- **RECEIVED ASSURANCE** that the RAD+ rules and records have been reviewed and residual gaps remain after validation;
- **SUPPORTED** the trajectory which depends on timely capacity and non-obstetric ultrasound delivery and funding confirmation; and
- **ENDORSED** the principle of incremental funding through Annual Planning to maintain delivery of the stabalisation programme into Year 3.

**Update Report to Board:** The Committee were **ASSURED** on the robustness of the demand and capacity data used to measure performance within the radiology service and were reassured by the measures in place to meet Welsh Government expectations for 2026/27 dependent of receipt of Welsh Government funding. The Committee noted the need for a significant uplift in resources to be allocated within the 2027/28 budget setting and to maximise productivity opportunities and to develop a longer term plan for the stabilisation of the radiology service that addressed workforce fragility and service configuration challenges and the longer term exploration of a regional radiology solution.

**FPC(26)085 FINANCE DEEP DIVE: WORKFORCE GRIP AND CONTROL AND WORKFORCE IMPROVEMENT PROGRAMME**

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Mrs Lisa Gostlin g presented the Finance Deep Dive into Workforce Grip and Control and Workforce Improvement Programme to the Committee and noted that the programme had six themes contained within the programme:

- Sickness Absence Management
- Band 7 to 9 Workforce Growth
- Administration and Clerical Workforce Growth
- Variable Pay Reduction
- Workforce Controls (Establishment Controls)
- Recurrent Savings Delivery

Mrs Gostling reported that sickness absence within the Health Board had continued to rise resulting in an immediate focus on the 10 areas of the Health Board where long and short-term sickness absence was highest and was also driving the increase in the levels of variable pay.

Mrs Gostling noted the increase in the number of Band 7 to 9 workforce roles with an investigation being undertaken into the growth in non-clinical roles compared to clinical roles with the outcome of the investigation being used to inform future workforce planning.

Mrs Gostling advised that variable pay reduction was a most significant single workstream and had been sub-divided into five categories:

- Medical Workforce
- Nursing and Healthcare Support Workers (HCSWs)
- Ancillary and Estates Workforce
- Allied Health Professions and Health Sciences
- Administration and Clerical

Mrs Gostling advised that establishment controls were designed to ensure that budgets aligned with the workforce compliment and that the recurrent savings delivery was aligned to finance and stated that future organisational change processes (OCPs) proposed has a 5 percent recurrent improvement expectation build into them.

Cllr Evans commended the headline figures relating to sickness and variable pay and noted that variable pay for the nursing workforce had remained stable and questioned how the workforce remained stable if sickness rates were increasing however nursing variable pay was not increasing. Mrs Gostling advised that nurse agency usage had been significantly reduced however noted that while agency expenditure had reduced, bank and additional hours had increased and that while this was financially preferable to agency expenditure increasing there was no planned nurse agency usage except in exceptional circumstances to ensure the quality and safety of services. Mrs Gostling noted that the new

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intake of nursing appointments in Autumn 2026 would further reduce the need tor nursing agency usage.

Mrs Marks acknowledged the on-going tension between reducing agency usage, delivering financial savings and delivering improved performance and questioned whether the Health Board was trying to meet these expectations with staff that it had not yet recruited. Mrs Gostlng advised that contrary to recent reports in the media, there was no nursing recruitment issue within HDdUHB and that newly qualified nurses could have roles available within the Health Board if they so wished. Mrs Gostling believed that recruitment would result in a reduction in variable pay and an improvement in quality and safety.

Mrs Gostling acknowledged that medical workforce recruitment was more challenging due to the Health Board's ability to recruit. Mrs Gostling believed that clinicians were willing to join the Health Board and that would enable agency usage to be reduced with the availability of substantive staffing.

In response to a question from Mr Imperato on which of the six themes was the most significant potential driver of improvement, Mrs Gostling identified variable pay reduction as the principal driver, especially within the medical workforce, and highlighted long-term sickness reviews as another area already showing movement and noted that the number of employees absent through long-term sickness had been reduced by over 70 through the application of greater attention to individual cases to offer assistance to return to work through occupational health follow-ups, return to work interviews and discussions on offering alternative roles within the Health Board.

In response to a question from Mr Prior on what the short-term risks and implications to were staffing from any actions being taken, Mrs Gostling believed that nothing contained in any workforce plans created any tension wish measures to reduce long term sickness not linked to the termination of any employees' contracts. Mrs Gostling noted that any staff absent through long-term sickness required agency backfilling and advised that conversations with staff were based on what was in the best interests for those staff and their future and included a review of any working restrictions placed on staff on sickness absence or when returning to work to best support those staff.

In response to a question from Cllr Evans on the timescale of the investigation into rostering, Mrs Gostling advised that there would be a cessation of paper-based payroll processes from 1 October 2026 and an assessment of where rostering should be introduced within Therapies and Health Science.

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**Decision:** The Finance and Performance Committee **RECEIVED ASSURANCE** that work is underway to address the grip and control gaps.

**Update Report to Board:** The Committee were **ASSURED** of the work that was being undertaken to ensure workforce grip and control was being undertaken and that the Workforce Improvement Programme was in the process of implementing measures that would improve the ability of the Health Board to deliver effective patient care and manage within its resources and to ensure that it has a sustainable workforce. The Committee has requested that it receive an update on the progress of the Workforce Grip and Control and Workforce Improvement Programme at its meeting on 27 October 2026.

**FPC(26)086 FINANCE DEEP DIVE: MEDICAL VARIABLE PAY**

*Mr Mark Henwood and Ms Carly Hill joined the meeting*

Mr Mark Henwood introduced the Finance Deep Dive into Medical Variable Pay and highlighted that the Health Board continued to have a reliance on medical variable pay and agency spend linked to predictive activity with the agency spend further related to fragile services.

Mr Henwood noted that the majority of the affected services were not addressed through the CSP such as acute medicine, psychology and haematology although there was a current strategy for addressing the acute medicine challenges within Emergency Departments (EDs) through the A Healthier Mid and West Wales Business Case

Ms Carly Hill explained the position within medical temporary staffing and noted that medical variable pay has overtaken agency expenditure as the most significant challenge with approximately £3.30 being spent on variable pay for every £1.00 spent on medical agency staffing.

Ms Hill believed that the review into medical variable pay demonstrated that the Health Board was facing a structural workforce affordability problem as opposed to simply a reliance on agency with variable pay having become embedded in the delivery of services. Ms Hill suggested that the next step would be to quantify the savings opportunities contained within implementing a recovery plan through the Medical Workforce Stabalisation Programme.

In response to a question from Mr Imperato as to why the issue has been allowed to continue despite having been identified, Ms Hill agreed that it had been a known issue however the



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implementation of the revised medical rate card and the roll-out of the Allocate software system had given rise to a greater understanding of the scale of the challenge.

Mr Henwood believed that the problems were cultural and deeply ingrained within the Health Board on how healthcare was delivered and medical staff were renumerated. Mr Henwood advised that a high level of variable pay was linked to predictable activity with holiday absence historically covered by variable pay with the challenge on how to address such predictable absences in a substantive manner.

In response to a question from Mr Imperato on the pace of change, Mr Henwood advised that there was a 90-day cycle that had commenced on 1 August 2026 with recruitment being balanced with staff whose pay would reduce through a reduction in their renumeration for variable pay being managed in a compassionate manner and advised that recruitment took time although anticipated that a proportion of the £30m a year spent on variable and agency pay would be reinvested in basic service provision.

Mr Carruthers noted that on structural inefficiency, the implementation of the revised medical rate card had identified that variable pay had been used to support elective work with the cost driving core capacity and not to provide additional services.

Mr Carruthers highlighted that in some cases, the Health Board had theatre staff and surgeons available but had to rely on variable pay or agency to secure the anaesthetist needed to run the list to avoid losing the theatre staff or surgeons. Mr Carruthers also highlighted the challenge of service configuration, observing that a safe 24-hour rota might conventionally require 10 clinicians, whereas some rotas were built with 8 and funded as if only 4 were available. Mr Carrithers observed that that created both fragility and poor attractiveness for recruitment.

Mr Carruthers linked the issue directly to operational flow, and believed that the lack of timely senior decision-makers was one of the biggest causes of patients remaining in Emergency Departments and therefore had a quality, performance and financial effect.

Mr Weir asked what immediate opportunities existed for action, where longer-term strategic solutions would be needed, and what the split was between consultants and Resident Doctors, and whether alternative workforce models could substitute for some of the work now done by medical staff. Mrs Gostling believed that the work currently under discussion concerned tasks that only doctors could lawfully or safely undertake, although noting there were wider workforce-model opportunities.

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Mr Henwood believed that planned care transformation work was examining medical productivity more closely, including outpatient-clinic efficiency and missed appointments. Mr Henwood noted that outpatient non-attendance rates were around 8 percent across the Health Board and that each clinic would soon carry one additional patient from 1 October 2026 to offset that level of expected non-attendance and that the change expected to enable around 9,000 additional new patients to be seen in a year.

Cllr Evans questioned what the financial saving was realistically expected from the current work, given the 90-day programme cycle. Mr Thomas believed that the trend was showing continued growth in medical temporary staffing cost and said the critical test would be whether the run rate could be brought down.

*Mr Lee Davies, Mr Mark Henwood and Ms Carly Hill left the meeting*

**Decision:** The Finance and Performance Committee:

- **NOTED** the findings of the financial deep dive.
- **RECOGNISED** that medical variable pay represents the principal driver of temporary staffing expenditure.
- **ENDORSEE** targeted intervention in the highest-spend specialties and services, particularly Anaesthetics, General Medicine and Pathology.
- **REQUESTED** specialty-level recovery plans for the top expenditure areas.

**Update Report to Board:** The Committee wished to **ADVISE** the Board that medical variable pay was considered a significant challenge to deliver the required levels of savings without causing an adverse consequential impact on performance despite the Committee being assured by the controls implemented to improve the oversight of medical variable pay through the adoption of the revised medical rate card, the deployment of the Allocate roster software system, the Medical Workforce Stabalisation Programme and enhanced financial and workforce reporting. The Committee requested that further update be presented to the 15 December 2026 so that the Committee could scrutinise and seek assurance from the progress.

**FPC(26)087 FINANCE DEEP DIVE: CLINICAL CARE GROUP SAVINGS PLANS**

Mr Jones presented the Finance Deep Dive into the CCG Savings Plans and believed that there had only been incremental progress made since the last update with an improved position of just under £1m with he overall operational savings position remaining £10.5m short of its target.



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Mr Jones noted that monthly underspends had been transacted as non-recurrent savings that improved the in-year savings position however did not address the underlying deficit with the immediate focus on converting the outstanding blue and red savings schemes within the operations function that was valued at £7.5m and that existing amber and green savings schemes had been revisited to ascertain if any greater value could be derived from their existing savings delivery.

Mr Jones advised that Executive-lead reviews had been undertaken that had led to additional scrutiny arrangements being introduced with two CCGs currently in Level 4 of internal escalation that resulted in weekly review sessions with the Deputy Chief Operating Officer and Director of Operational Planning and Performance to explore how their blue and red savings schemes could be converted into amber and green savings schemes.

Mr Jones advised that work was being progressed to explore opportunities that spanned more than one CCG alongside closer integration with the Workforce Improvement Programme and the Medical Workforce Stabalisation Programme to extract additional value in-year.

In response to a question from Cllr Evans on what value was derived from the additional weekly scrutiny meetings for CCGs in Level 4 of internal escalation, Mr Jones advised that the aim of the meetings was to explore how the CCGs could undertake the enabling actions required to convert their blue and red savings schemes to amber and green and to identify and resolve any obstacles solitary CCGs had in undertaking the savings conversions.

Mr Imperato questioned the progress and pace of the process. Mr Jones believed that there had been progress made in improving the CCGs' savings positions down to the current £10.5m position with the weekly escalation meetings anticipated to deliver further improvements. Mr Carrithers believed that there were conflicting pressures between the need to undertake activity to deliver and improve performance balanced against the associated additional staffing costs required to undertake that additional activity.

In response to a question from Mr Weir on the timescales involved given that issues such as changes to pathways were more medium to long-term plans as opposed to immediate changes to deliver savings, Mr Jones believed that it was important to reflect that many of the blue and red schemes were not only short-term solutions with many requiring a more longer term vision that resulted in a more acute need to maximise the in-year opportunities.

Mrs Marks believed that the report demonstrated encouraging progress however indicated a reliance on non-recurrent savings



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and questioned what actions could be undertaken to improve financial sustainability. Mr Thomas agreed that the progress was non a sustainable response to the savings challenge and highlighted that the Well-led Independent Review undertaken by NHS Wales Performance and Improvement that had identified shortcomings at another Health Board in Wales could similarly identify similar issues within HDdUHB.

Mr Thomas believed variable pay offered the greatest in-year savings opportunity with value and productivity needed to be examined throughout the system to maximise the potential benefits with a need to commence planning for 2027/28 at an early stage.

In response to a question from Mrs Marks on what could be done to inject pace into the savings delivery process given that less that a third of the savings schemes were recurrent savings with a lack of productivity schemes such as digital and pathway changes requiring strategic oversight. Mr Carruthers believed that there were attempts to increase the pace of the savings work despite the operational challenge to inject additional urgency. Mr Carruthers believed that there had previously been a focus on larger savings schemes at the expense of exploring what smaller savings schemes could be progressed to make more immediate gains.

**Decision:** The Finance and Performance Committee is asked to:

- **CONSIDER** savings plan progress to date achieved by Clinical Care Groups; and
- **NOTE** the actions required in support of Executive-led Finance Recovery reviews scheduled for 25 August 2026 at which further progress will be assessed.

**Update Report to Board:** The Committee wished to **ALERT** the Board that the current trajectory of Clinical Care Group savings did not meet the target savings position with insufficient detail on the desired outcomes described. The Committee requested that the Board test the Clinical Care Group savings position needed to be tested in a more rigorous manner to drive in-year savings to improve the trajectory.

**FPC(26)088 FINANCIAL PERFORMANCE ASSURANCE REPORT**

Mr Andrew Spratt presented the Month 4 2026/27 Financial Performance Assurance Report to the Committee and reiterated that to Corporate Risk 2326 (‘Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding’) had increased to the highest possible risk score of 25 as the Month 4 position had not improved



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with the year-to-date challenge indicating a need for greater strategic consideration.

Mr Spratt highlighted that the Finance Team was commencing an 8-week process to reassess the financial position to advise the Executive Team and the Board of the realistic in-year position with the intention to present an updated financial forecast through the governance process, at the earliest, for Month 6, to outline what the Health Board considered it was capable of delivering in 2026/27.

Mr Spratt advised that a refreshed three-year financial would be presented to an Extraordinary FPC meeting on 22 September 2026 ahead of consideration at the Board meeting on 24 September 2026.

Mr Thomas believed that the logical conclusion of the financial re-forecasting was that a route to the target £41m deficit position was being increasingly unrealistic with the current unmitigated figure deficit of £60.4m being £19.4m adrift of the £41.0m planned deficit. Mr Thomas believed that it was critical that the Health Board had exhausted all opportunities that was within its gift ahead of any potential update being given to Welsh Government.

In response to a question from Mrs Marks on whether the Health Board had a credible plan to deliver its financial targets and what would be the consequences, Mr Thomas believed that the financial position was not solely a result of a lack of delivery of savings plans and that there was also a cost control issue of the Health Board overspending against its core budgets, with an equal split between a lack of savings delivery and cost management.

Mr Thomas believed that there was a need to undertake an assessment of what was a reasonable measure of what efficiency could be extracted from the system, given the current configuration of the Health Board's four acute sites with the need to undertake a value and productivity self-assessment ahead of any discussions with WG.

In response to a question from Mr Imperato on what would provide assurance to WG that the Health Board was doing all that it could to meet its financial targets, Mr Carruthers believed that the Health Board currently did not have the budget to provide all of its services within the current configuration with a significant programme of structural change required to meet the Health Board's financial targets. Mr Carruthers believed that the challenge was not solely a financial challenge, with the required savings being able to be attained if the consequential impact on performance was palatable to WG.

Mr Carruthers highlighted that the two areas of WG priority was finance and UEC with the competing tension between the two highlighted by making £14m of savings within the CIM CCG that



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had oversight of UEC would have a consequence of reduced flow, performance and quality within UEC. Mr Carruthers further noted that if savings were made in planned care that reduced activity, then WG would seek to reclaim the additional funding it provided to the Health Board to support increased activity within planned care.

Cllr Evans questioned what the cash management consequences were for the Health Board. Mr Spratt advised that if the Health Board's deficit position was to deteriorate and could not be supported by WG then the cash position would become challenged in March 2027 and that a cash management strategy would be presented to FPC at its meeting on 23 February 2027.

In response to a question from Mr Imperato on what specific areas FPC needed to focus on to drive the financial improvements required, Mr Thomas advised that variable pay and choices would be presented to the Board meeting on 24 September 2026. Mr Prior questioned the efficiency of expenditure related to delayed pathways of care (DPoC). Mr Imperato requested that a financial deep dive into DPoC be undertaken at the FPC meeting on 27 October 2026. **CSO**

**Decision:** The Finance and Performance Committee is asked to:

- **SCRUTINISED** and **CHALLENGED** the Month 4 financial position and reported forecast deficit of £41.0m, recognising that delivery is assessed as high risk and depends upon £19.4m of further mitigating actions that are not yet sufficiently evidenced or confirmed.
- **CHALLENGED** whether the current recovery trajectory is sufficient to close the £13.0m savings identification gap, increase recurrent savings delivery, reduce operating expenditure and address the deterioration in the underlying recurrent deficit.
- **RECEIVED ASSURANCE** that the mid-year financial position assessment will provide a robust and evidence-based view of the likely year-end outturn, including the deliverability of further mitigating actions and the scope to convert non-recurrent benefits into sustainable recurrent improvement.
- **RECEIVED ASSURANCE** that clear and time-bound recovery actions are being implemented across all portfolios with Alert or Advise status, with appropriate operational ownership, executive accountability, capability and capacity.
- **RECEIVED ASSURANCE** regarding the implementation trajectory for the UEC and Streamlining Hub investments, including the management of associated patient-care, quality, performance and winter-resilience risks.
- **ENDORSED** the use of the mid-year assessment to inform the forecast reported to Welsh Government through the Month 6 financial reporting cycle.

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- **RECOGNISED** the material risks to financial sustainability, including the deterioration in the underlying recurrent deficit, reliance on non-recurrent measures, increased corporate risk score and the potential for the cash position to become unsustainable without further Welsh Government support.
- **NOTED** progress in developing the Three-Year Financial Roadmap to Breakeven, its planned consideration by the In-Committee Board in September 2026 and the proposed engagement with Welsh Government on the configuration-related deficit as a policy and planning choice for joint consideration.
- **NOTED** the latest position on in-year investment decisions approved through the relevant governance arrangements.

**Update Report to Board:** The Committee wished to **ALERT** the Board to the deteriorating financial position of the Health Board in Month 4 2026/27 and that it was currently considered a challenge for the Health Board to meet its £41.0m forecasted deficit position and sought Board attention to the £19.4m of further mitigating actions required to achieve the forecast deficit position and close the £13.0m saving identification gap by increasing the level of recurrent savings or reduce operating expenditure to reduce the underlying deficit to deliver financial sustainability.

**FPC(26)089 FINANCE DEEP DIVE: NURSING VARIABLE PAY**

*Mrs Sharon Daniel joined the meeting*

Mrs Sharon Daniel presented the Finance Deep Dive into Nursing Variable Pay to the Committee that built upon the Workforce Improvement Programme that had been discussed earlier in the meeting and focussed on the Nursing Workforce Stabalisation Programme that aligned with the broader grip and control work within the nursing workforce.

Mrs Marks asked if the nursing workforce was considered stabilised and what workforce pressures existed. Mrs Daniel believed the midwifery was currently fully established with 10 newly registered midwives anticipated to be joining the Health Board in February 2027.

Mrs Daniel advised that nursing vacancies had reduced by 76.2 percent with 128 newly registered nurses commencing employment with the Health Board in September 2026 that Mrs Daniel believed would reduce the reliance on nurse agency usage.

Mr Imperato queried whether the Nursing Stabalisation Programme was governance heavy. Mrs Daniel advised that the



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Nursing Stabalisation Programme was being superseded by the broader Workforce Improvement Programme being overseen by the Director of Workforce and Organisational Development with work on nursing workforce having been undertaken by Swansea Bay University Health Board (SBUHB) that HDdUHB would undertake learning from with the workforce stabalisation work moving into the delivery phase and away from the process design phase.

Mrs Daniel believed that grip and control over roster planning, temporary staffing controls and direct Executive oversight were the priority actions.

**Decision:** The Finance and Performance Committee is asked to:

- **NOTE** the analysis and assurance provided regarding the key drivers of Nursing and Support Worker variable pay expenditure;
- **ENDORSE** the Nursing/Midwifery and Support Worker Variable Pay Reduction Programme for 2026/27;
- **SUPPORT** the strengthened governance and performance framework for monitoring delivery.

**Update Report to Board:** The Committee wished to **ASSURE** the Board there was confidence in the process and oversight of the Nursing Workforce Stabalisation Programme with effective grip and control measures in place to manage the key drivers of the nursing, midwifery and Healthcare Support Worker variable pay expenditure with effective governance framework to oversee the process as part of the wider Workforce Improvement Programme.

**FPC(26)090 PROCUREMENT SCRUTINY**

Mr Thomas presented the Procurement Scrutiny report to the Committee and outlined the three procurement exercises that had been undertaken by NHS Wales Shared Service Partnership (NWSSP) on behalf of the Health Board.

Cllr Evans questioned whether the total value of the Microsoft Enterprise Agreement related to a single year with the total value stated as £23.5m. Mr Thomas advised that this was the total value for the lifetime of the contract and that approval was being sought for a Contract Change Notice (CCN) to add 400 Microsoft Windows 10 extended security licences to the existing contract.

Mr Thomas advised that he would clarify the length of the original contract and noted that the CCN had a proposed additional value of £35,352, increasing the total contract value to the £23.5m total. **HT**

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

- **APPROVE** the award of the Rubrik Portfolio contract renewal from the 01 October 2026 to the 30 September 2030 with an option to extend to 30 September 2032 at a maximum anticipated total contract value of £2,100,000.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Telephony Modernisation Subscription Renewal from 01 October 2026 to 30 September 2028 with the option to extend to 30 September 2029 with total contract value of £999,981.06 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the Contract Change Notice for the Microsoft Enterprise Agreement increasing the total contract value to £23.513,256.61 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).

**FPC(26)091 PLANNING GOALS UPDATE REPORT**

Mr Thomas presented the Planning Goals Update Report to the Committee and advised that the report oversaw the progress relating to Planning Goal 6 ('Safe, timely and high-quality care') was aligned to FPC.

There were no questions from members of the Committee.

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

**FPC(26)092 INTEGRATED PERFORMANCE ASSURANCE REPORT**

Mr Thomas presented the IPAR to the Committee and highlighted that staff sickness levels had continued to increase and that the Health Board's therapy wait breaches was the highest in Wales for the preceding 18 months.

Mr Thomas noted that there had been improvements in adult psychological therapies since March 2026 and that there had



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been strong performance on high-risk eyecare waits, with June 2026 showing the highest level of performance since November 2023.

Mr Thomas reiterated that 2 CCGs were currently at Level 4 of internal escalation for finance for the second consecutive month and had also exhibited a deterioration in their other domains.

Mr Imperato queried what were the more significant areas of concern identified through the IPAR. Mr Thomas believed that the therapies wait breaches position was a concern against the all-Wales position in addition to the concerns relating to UEC that had been discussed earlier in the meeting.

Cllr Evans believed that staff sickness was a significant issue affective both performance and finance. Mrs Gostling advised that Facilities had a high level of sickness and vacancy rates that was driving the overall staff sickness position. Mr James Severs advised that there was a plan in place to reduce sickness within Facilities with improvements exhibited within Bronglais Hospital (BGH) Facilities with management learning to be shared with other sites and counties to drive improvement.

In response to a question from Cllr Evans on infection prevention and control (IPC) showing a deteriorated position, Mrs Daniel advised that this was considered seasonal variation exacerbated by the recent warm weather and that Mr Severs and Mrs Daniel were reviewing the governance related to IPC and would provide an update to the Quality, Safety and Experience Committee (QSEC).

Mrs Marks expressed concern that a relatively small number of managers within the organisation were carrying multiple responsibilities for delivery within finance, performance and workforce domains. Mrs Gostling advised that this would be explored in greater detail at the People, Organisational Development and Culture Committee (PODCC).

Mr Imperato believed that the overall position exhibited a mixed landscape as opposed to providing a single narrative with several areas notably improving and others remaining highly fragile with gains reliant on external funding or corrective actions that were not considered sustainable.

**Decision:** The Finance and Performance Committee **DISCUSSED** the IPAR – Month 4 2026/2027 and internal Escalation report and to **RECEIVED ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

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**Update Report to Board:** The Committee wished to **ADVISE** the Board that several areas of performance were considered fragile with improvements in performance reliant on the continued receipt of external funding or on corrective actions that were not considered sustainable. The Committee expressed concern on the performance trajectories in many areas were at risk of not showing the desired level of improvement to meet or remain on target.

**FPC(26)093 NHS WALES SHARED SERVICES PARTNERSHIP PERFORMANCE REPORT Q1 2026/27**

Mr Thomas presented the NWSSP Performance Report for Q1 2026/27 to the Committee and believed that the Health Board's relationship with NWSSP was considered to be very strong with HDdUHB ahead of other health organisations in Wales on delivery.

Mr Thomas noted that the only area of performance that was not on target was for Accounts Payable for NHS Public Sector Prompt Payment (PSPP). Mr Thomas advised that an action plan had been agreed to improve PSPP compliance with additional scrutiny proposed in conjunction with SBUHB in relation to Long Term Agreements (LTAs) between the two Health Boards and with the NHS Wales Joint Commissioning Committee (JCC).

Andrew Spratt advised that the shared-services report was largely a positive one, describing it as a strong performance picture with a predominance of green indicators. He said the main area still requiring attention was inter-NHS payments, particularly involving arrangements with Swansea Bay and the joint committee framework.

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 1 2026/27 that services provided are being delivered to expected standards; and
- **NOTED** the work being developed regarding outcome measures reporting.

**FPC(26)094 MACMILLAN CANCER SUPPORT NEIGHBOURHOOD INVESTMENT PARTNERSHIP BUSINESS CASE STRATEGIC INTENT**

*Dr Bruce Bolam, Ms Rhian Evans and Dr Ardiana Gjini joined the meeting*



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Dr Ardiana Gjini presented the Strategic Intent Case for the Macmillan Cancer Support Neighbourhood Investment Partnership Business Case to the Committee and advised that the proposal has been developed in partnership with the Macmillan Cancer Support charity as the funders of the proposal do undertake a community-based investment partnership.

Dr Gjini advised that the partnership would see Macmillan provide £11m of investment over 5 years with £9m of that investment repayable over 9 years with the residual £2m being non-repayable anchor grant funding.

Dr Gjini believed that the programme was aligned to the Health Board's long-term strategy and aligned to WG policy for prevention and community resilience and supports population health metrics and develops capacity within communities. Dr Gjini advised that the strategic intent would be presented to the Board meeting on 24 September 2026 with the Full Business Case to be presented back to Executive Team and FPC ahead of Board for approval with the final contractual agreements having been confirmed and finalised.

Mrs Marks expressed support for the proposal. Mr Imperato commended the report for its clarity.

Mr Thoams noted that the funding model for the business case was novel and innovative and that engagement with WG was required before the Health Board could give its approval. Mr Thomas advised that he would discuss the funding model with the Policy Lead in WG and with the NHS Wales Director of Finance. **HT**

Dr Gjini confirmed that Public Health Wales colleagues had already been engaged on the partnership and agreed that the finance and policy engagement with WG should continue in parallel with each other.

*Dr Bruce Bolam, Ms Rhian Evans and Dr Ardiana Gjini joined the meeting*

**Decision:** The Finance and Performance Committee:

- **SUPPORTED** the strategic direction of the Macmillan Cancer Support Neighbourhood Investment Partnership.
- **NOTED** that this does not constitute approval of the final business case, funding agreement or any binding financial commitment at this stage.
- **NOTED** that further work is required on the legal, contractual and financial detail before formal approval can be considered.
- **AGREED** that a final business case will return to the next meeting of the Finance and Performance Committee for scrutiny before any onward recommendation to Board.

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**FPC(26)095 FINANCIAL PROCEDURES**

Mr Thomas presented the financial procedures that were required to be reviewed by the Committee:

- Financial Procedure 066 – Losses and Special Payments
- Financial Procedure 090 – Retention of Financial Records

Mr Thomas advised that neither procedure were new procedures and neither had changes since their previous iteration and were presented to the Committee for statutory review.

There were no questions from members of the Committee.

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

- Financial Procedure 066 – Losses and Special Payments
- Financial Procedure 090 – Retention of Financial Records

**FPC(26)096 ALL-WALES CAPITAL PROGRAMME 2026/27, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE**

Mr Thomas presented the All-Wales Capital Programme 2026/27, Capital Resource Limit (CRL) and Capital Financial Management Update to the Committee.

There were no questions from members of the Committee.

**Decision:** The Finance and Performance Committee **NOTED** the contents of this report and take assurance on the delivery of the capital programme within 2026/27.

**FPC(26)097 NHS WALES AWARDS 2026**

Mr Spratt presented the Committee with the HDdUHB Finance Team 'Making data more accessible for data-led improvement: identifying and addressing hotspots at the earliest opportunity' that had been shortlisted in the NHS Wales Information Award category at the NHS Wales Awards 2026.

There were no questions from members of the Committee.

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**Decision:** The Finance and Performance Committee is asked **NOTED** that the 'Making data more accessible for data-led improvement: identifying and addressing hotspots at the earliest opportunity' has been shortlisted in the NHS Wales Information Award category at the NHS Wales Awards 2026.

**FPC(26)098 FINANCE AND PERFORMANCE TEAM NHS WALES AWARDS 2026 FINALISTS**

Mr Spratt presented the Committee with the HDdUHB Finance Team 'Rebuilding Trust in Finance: A Cultural Change Journey with Lasting Impact for Hywel Dda Finance' that had been shortlisted in the NHS Wales Team Culture category at the NHS Wales Awards 2026.

There were no questions from members of the Committee.

**Decision:** The Finance and Performance Committee is asked **NOTED** that the 'Rebuilding Trust in Finance: A Cultural Change Journey with Lasting Impact for Hywel Dda Finance' has been shortlisted in the NHS Wales Team Culture category at the NHS Wales Awards 2026.

**FPC(26)099 JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS**

Mr Thomas presented the NHS Wales Joint Commissioning Committee Performance and Finance Sub-Committee highlight report from its meeting on 2 July 2026 to the Committee for information.

There were no questions from members of the Committee.

**Decision:** The Finance and Performance Committee **NOTED** the Joint Commissioning Committee Planning, Performance and Finance Sub-Committee 2 July 2026 Highlight Report.

**FPC(26)100 NWSSP SHARED SERVICES PARTNERSHIP COMMITTEE ASSURANCE REPORT**

Mr Thomas presented the NWSSP Committee Assurance Reports from its meetings on 14 May 2026 and 25 June 2026 to the Committee for information.

There were no questions from members of the Committee.



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**Decision:** The Finance and Performance Committee **NOTED** the NHS Wales Shared Service Partnership Assurance Reports.

**FPC(26)101 VALUE AND SUSTAINABILITY BOARD JULY 2026 OUTCOME LETTER**

Mr Thomas presented the Value and Sustainability Board July 2026 Outcome Letter sent to the Chief Executive by the NHS Wales Director of Finance following the NHS Wales Value and Sustainability Board meeting in July 2026.

There were no questions from members of the Committee.

**Decision:** The Finance and Performance Committee **NOTED** the Welsh Government Value and Sustainability Board July 2026 Outcome Letter.

**FPC(26)102 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27**

Mr Thomas presented the FPC Work Plan 2026/27 to the Committee for information.

There were no questions from members of the Committee.

**Decision:** The Finance and Performance Committee **NOTED** the Finance and Performance Committee Work Plan 2026/27.

**FPC(26)103 ANY OTHER BUSINESS**

There was no other business transacted at the meeting.

**FPC(26)104 DATE OF NEXT MEETING**

Mr Thomas advised that there would be an Extraordinary FPC meeting on 22 September 2026; 13:30 – 15:00.

The next ordinary FPC meeting will be held on 27 October 2026; 09:30 – 12:30.

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1.4 **09:30, 0 Mins**

# 1.4 - MINUTES OF EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE HELD ON 22 SEPTEMBER 2026

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

For approval

**Attachments**

1.4 2026-09-22 - Extraordinary Finance and Performance Committee Meeting - ~.pdf

# UNAPPROVED MINUTES OF THE EXTRAORDINARY FINANCE AND PERFORMANCE COMMITTEE MEETING

**DATE OF MEETING:** **1:30 PM, Tuesday 22 September 2026**

**VENUE:** **Dolau Cothi Meeting Room, Corporate Headquarters, Picton Terrace/Microsoft Teams Meeting**

**PRESENT:**
Michael Imperato (Hywel Dda UHB - Independent Board Member) (Chair) (VC)
Neil Prior (Hywel Dda UHB – Independent Member) (Vice Chair) (VC)
Rhodri Evans (Hywel Dda UHB – Independent Member) (VC)
Eleanor Marks (Hywel Dda UHB - HDUHB Vice Chair) (VC)

**IN ATTENDANCE:**
Lisa Gostling (Hywel Dda UHB – Director of Workforce & OD/Deputy CEO) (VC)
Huw Thomas (Hywel Dda UHB - Director of Finance)
Siân Jenkins (Hywel Dda UHB - Deputy Director of Finance)
James Severs (Hywel Dda UHB – Executive Director of Allied Health Professions and Health Science) (VC)
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer) (VC)
Joanne Wilson (Hywel Dda UHB – Director of Corporate Governance/Board Secretary) (VC)

**ALSO PRESENT:**
Shaun Ayres (Hywel Dda UHB – Director of Delivery) (VC)
Richard Jenkins (Hywel Dda UHB - Assistant Finance Director Commissioning, BI & Value)
Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning) (VC)
John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat)

| MINUTES REF. | ITEM | ACTION |
|---|---|---|

**FPC(26)105 WELCOME AND APOLOGIES**

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

Apologies had been received from:

- Mr Winston Weir, Independent Member
- Mr Andrew Spratt, Deputy Director of Finance

**FPC(26)106 DECLARATION OF INTERESTS**

There were no declarations of interest.

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**FPC(26)107 ROUTE-MAP TO FINANCIAL BALANCE**

Mr Huw Thomas introduced the Route Map to Financial Balance FPC and advised that the report was an outline of the gross figure of savings that the Health Board was required to aim towards to achieve financial balance the end of the 2029/30 financial year.

Mr Thomas believed that there were two elements to the equations with the report being presented to the meeting detailing the build up of pressure on the Health Board's financial outlook with the opportunities for consideration forming the second part of the discussion with the Board being required to resolve how it would address the gap between the two sides of the equation.

Mr Thomas highlighted that £60.9m was the forecasted current gross end-of-year deficit position of the Health Board with the level of non-recurrent savings identified within the current year to be added to the level of challenge taken forward into the next financial year with the anticipated level of additional demand on services and the additional prevalence of ill-health to be added to the pressure on the Health Board's financial position.

Mr Thomas noted that three income assumptions had been modelled and advised that the most pessimistic of the three scenarios, that of a 0.6% financial uplift to the funding settlement from Welsh Government being advised as the most likely of the scenarios.

Mr Thomas highlighted that the outcome of the 2026/27 deficit carried forward into 2027/28 and the additional of inflation, demand and allocation funding, resulted in a gross position and challenge of £105.2m for 2027/28 from which the Health Board required to frame its road map to achieve financial balance from.

Mr Neil Prior enquired what Mr Thomas believed were the areas that needed greatest consideration ahead of the discussion at the Board meeting on 24 September 2026. Mr Thoams believed that there were three key areas that needed consideration:

- The continued reliance on non-recurrent savings and how to address the recurrent savings challenge;
- The scale of the financial uplift from Welsh Government of 0.6% resulted in a significant challenge that would necessitate difficult choices to be made as the uplift did not keep pace with inflation or the increase in prevalence of ill-health and the demographic pressures on the Health Board's services; and
- The approach that the Health Board would want to take to its risk tolerance given the scale and pace of change that was required to be achieved



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Mr Eleanor Marks questioned who was responsible with the organisation for making the required changes and what operational leaders had committed to the delivery of the levels of change required, what confidence there was on achieving those aims and who would be held accountable.

Mr Thomas believed that the challenge was not limited to operational teams with there being a role for Planning colleagues to translate the financial figures into credible plans, for Clinical Executives to be responsible for issues such as productivity and also for the collective responsibility of the whole Board. Mr Thomas advised that named ownership of individual components of the plan would be assigned following the Board meeting on 24 September 2026.

In response to an observation from Cllr Rhodri Evans on the importance of accountability and ownership due to the scale of the challenge and the risk appetite associated with achieving the scale of change required, Mrs Joanne Wilson noted that there was an existing Risk Appetite Statement approved by the Board that would be reviewed to ensure that the Board were comfortable with the level of risk being tolerated that was associated with the choices being made.

Mr James Severs advised that the Clinical Executives had met with the Chief Operating Officer and there was an acceptance that the Health Board could not continue to operate in the manner in which it presently did and noted that individual Executive Directors were responsible for their own specific areas and additionally collectively as the Board.

Mr Thomas believed that risk appetite not only related to the formal Risk Appetite Statement and that the level of savings that the Health Board were required to make would test how hard the organisation was willing to take on the risks of changing services with any actions taken needed to link to the Risk Appetite Statement approved by the Board.

In response to a question from Mr Imperato on deficit drivers and how issues such as variable pay, delayed pathways of care (DPOC) and continuing healthcare (CHC) linked in with the financial route map, Mr Thoams believed that they were all linked with variable pay contributing to workforce costs such as agency usage and staffing growth, issues such as demands on Health Board services and complexity of care having an impact on DPOC and CHC.

**Decision:** The Finance and Performance Committee:

- **SUPPORTED** the proposed direction of travel, as the basis for developing a credible, phased route towards sustainable financial balance over the 2027-30 planning period, for



UNAPPROVED

onward ratification by the Board, recognising the Committee's role in scrutinising and supporting the Financial Road Map prior to formal Board consideration;

- **DID NOT ENDORSE** the Route Map in its entity at this stage and requested that the Route Map be progressed through the planning cycle to test and confirm its deliverability, pace, sequencing, strategic alignment, consultation and engagement requirements, risks, ownership and accountability with assurance required before specific choices contained within the Route Map could be approved;
- **DISCUSSED** the Committee's risk appetite for the scale and nature of decisions that may be required to deliver the Road Map, recognising that material recurrent improvement is likely to require choices across productivity, workforce, service configuration, pathways and demand management;
- **DISCUSSED** the Committee's appetite for the pace at which opportunities should be progressed through design, assurance, consultation and decision-making, balancing the urgency of the financial challenge with the need to maintain quality, safety, workforce sustainability and public confidence;
- **NOTED** that the next update will be brought forward as part of the wider organisational planning cycle, informing the development of the Health Board's Three-Year Plan submission in March 2027, where the opportunities will need to be prioritised and delivery plans matured through agreed owners; and
- **ACKNOWLEDGED** the material risk associated with £26.0m of conditionally recurrent funding, recognising that this funding will only be issued if the Health Board delivers a breakeven position in 2027/28 and that non-delivery would therefore materially increase the residual financial gap and the scale of corrective action required.

**FPC(26)108 DATE OF NEXT MEETING**

The next ordinary FPC meeting will be held on 27 October 2026; 09:30 – 12:30.

UNAPPROVED

1.5 **09:30, 5 Mins**

# 1.5 - REVIEW OF FINANCE AND PERFORMANCE COMMITTEE TABLE OF ACTIONS

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

For approval

**Attachments**

1.5 Table of Actions FPC 27 August 2026.pdf

**FINANCE AND PERFORMANCE COMMITTEE (FPC)/ PWYLLGOR CYLLID A PHERFFORMIAD**
**27/08/2026**
**TABLE OF ACTIONS/TABL GWEITHREDOEDD**

Key: HT-Huw Thomas; JPJ-John Jenkins; KJ-Keith Jones

| MEETING DATE | MINUTE REF | ACTION | LEAD | TIME SCALE | PROGRESS |
|---|---|---|---|---|---|
| 30/04/2026 | FPC(26)032 | Q1 2026/27 Planned Care Trajectories<br>• To present findings of NHS Wales Planned Care Optimisation Framework self-assessment to FPC. | KJ | 27/10/2026 | In progress<br>10/06/2026: NHS P&I review & assessment of the self-assessment returns submitted by each specialty is awaited. The detailed individual specialty self-assessment templates were not designed by NHS P&I as performance assurance documents. NHS P&I will review submissions from all health boards and provide each organisation with comparative feedback. This will be shared with the Committee.<br><br>Target date subject to NHS P&I confirmation<br><br>27/08/2026: Still awaiting feedback from NHS P&I. Will be circulated to Committee when received.<br><br>15/10/2026: Still awaiting NHS P&I confirmation of their anticipated date for feedback to the EA self-assessment returns previously submitted. Followed-up but no confirmation received as yet. |
| 27/08/2026 | FPC(26)088 | Financial Performance Assurance Report<br>• To add Finance Deep Dive on Delayed Pathways of Care to FPC Work Plan for FPC meeting on 27/10/2026. | JPJ | 15/09/2026 | Complete<br>Added to draft FPC agenda for 27/10/2026 for consideration at agenda setting meeting, |

| MEETING DATE | MINUTE REF | ACTION | LEAD | TIME SCALE | PROGRESS |
|---|---|---|---|---|---|
| 27/08/2026 | FPC(26)090 | Procurement Scrutiny<br>• To clarify length of Microsoft Enterprise Agreement contract. | HT | 27/10/2026 | Complete<br>Period of Five (5) years, to commence from 1st July 2026 and expire 30th June 2031. |
| 27/08/2026 | FPC(26)094 | Macmillan Cancer Support Neighbourhood Investment Partnership Business Case Strategic Intent<br>• To discuss the novel funding model fo the Macmillan Cancer Support Neighbourhood Investment Partnership Business Case with NHS Wales Director of Finance. | HT | 27/10/2026 | In progress<br>Meeting requested with Welsh Government, invitation sent on 30 September after the Board in-principle support.<br><br>Paper going to November Board will need to be approved subject to Welsh Government approval, which may occur after Board meeting. |

1.6

**09:35, 10 Mins**

# 1.6 - ASSURANCE AND RISK REPORT

***Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary), 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), Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning)***

For assurance

### Attachments

1.6 Assurance and Risk Report FPC Oct 2026.pdf

1.6 Appendix 1 - FPC Principal Risk Register - Sept 26.pdf

1.6 Appendix 2 - FPC Operational Risk Register - Oct 26.pdf




Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# Assurance and Risk Report

***Finance and Performance Committee – 27th October 2026***

# Situation

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

The Committee is asked to seek assurance from the Lead Executive Directors that principal risks are being managed effectively, and that there are processes in place to oversee operational risks to ensure these 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 December 2026.

| Principal Risks: | Operational Risks | Welsh Health Circulars |
|---|---|---|
| 1 | 24 | 2 |

# Risk Management - Overview

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

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

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

Risks are aligned to an appropriate Clinical Care Group 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 (e.g., where the risk appetite is exceeded, or there is a lack of action).

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



# Principal Risks assigned to FPC

| Hywel Dda Risk Heat Map | | | | | |
|---|---|---|---|---|---|
| | **LIKELIHOOD →** | | | | |
| **IMPACT ↓** | Rare 1 | Unlikely 2 | Possible 3 | Likely 4 | Almost Certain 5 |
| Catastrophic 5 | | | | | 1199 → |
| Major 4 | | | | | |
| Moderate 3 | | | | | |
| Minor 2 | | | | | |
| Negligible 1 | | | | | |

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

Principal risks have been aligned to the most appropriate Board level Committee.

These risks have been identified by individual Directors and associated with the achievement of the Health Board's strategic objectives. The Health Board has updated the planning objectives, principal risks and outcome measures which support the four strategic objectives as part of the Strategy Refresh.

There is 1 principal risk currently aligned to Finance and Performance Committee (out of the 12 that are on the PRR as of 17 September 2026).

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

# Principal risks aligned to FPC

The principal risk aligned to the Committee highlight that the Health Board faces challenges in:

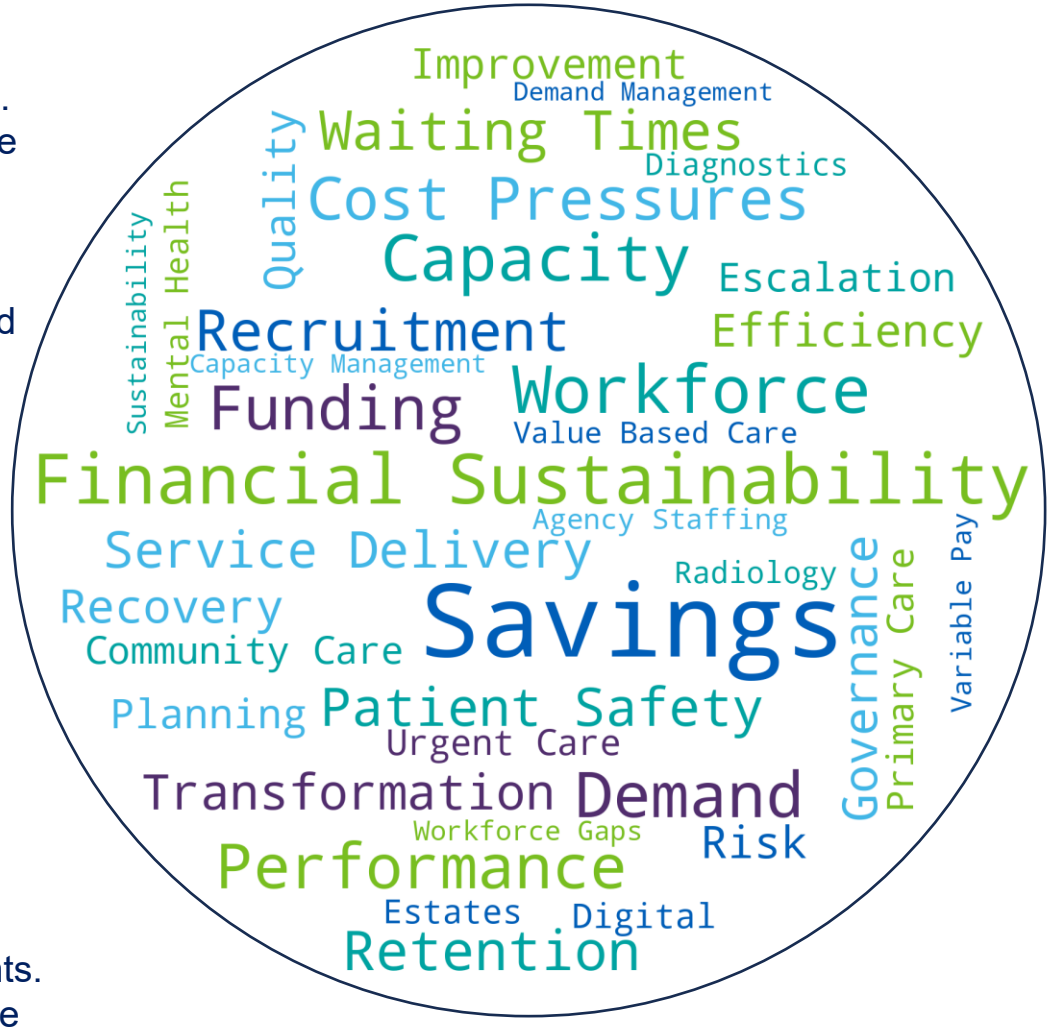
- Delivering long-term financial sustainability, achieving a balanced financial position, planned savings and transformation programmes to address the recurrent funding gap.
- Aligning workforce, capacity, demand and financial plans to support sustainable service delivery.
- Managing increasing service demand while progressing service, digital and estate transformation programmes.
- Improving urgent and emergency care performance, patient flow and community-based care models.

The potential impacts of the risk include:

- Failure to achieve financial recovery and statutory financial duties.
- Reduced organisational resilience and ability to deliver strategic objectives.
- Adverse effects on workforce morale, recruitment and retention.
- Negative impacts on patient experience and service accessibility.
- Reduced stakeholder confidence and reputational damage.

Actions noted across the risk demonstrate the need to:

- Strengthen workforce planning, recruitment, retention and staff development.
- Deliver service redesign and transformation programmes to improve sustainability and efficiency.
- Enhance operational oversight, performance management and escalation arrangements.
- Embed value-based healthcare approaches and improve resource utilisation across the organisation.



# Principal Risks assigned to FPC

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| Risk Reference & Title | Clinical Care Group / Executive Function | Lead Director | Previous Risk Score | Current Risk Score | Target Risk Score (TRS) | Expected Date to Achieve TRS |
|---|---|---|---|---|---|---|
| **1199 – Strengthening Long-Term Financial Sustainability** | Finance | Director of Finance | **25** | **25** → (Reviewed 13/10/26) | **8** | 31/03/2028 |

**Rationale for Current Risk Score (CRS)**

Operational teams have matured over the last year, yet engagement has remained challenging on planning and finance. The underlying deficit is understood and articulated, with budget-holder decisions tracked where delegated limits are exceeded. The recurrent delivery gap persists, and underlying gaps in demand vs capacity place at risk our financial sustainability. There are clear signals from Welsh Government for the current financial year that neither the revenue nor the cash implications can be fully supported; and analysis by the Institute of Fiscal Studies (March 2026) confirms this assessment for the medium term. The organisation was escalated into Targeted Intervention in October 2022 on planning and finance grounds, and escalated across the whole organisation in January 2024, and remains as such as at October 2026. The confirmed recurrent funding settlement leaves a material gap against current plans.

**Rationale for Target Risk Score (CRS)**

Three year financial balance is a statutory duty and a standing expectation of Board and Welsh Government. Integrated planning is inherently complex: demand, capacity, workforce and finance are challenging to align. Given the scale of savings required and the timeline to deliver them, the target score exceeds the Board's tolerable risk

# Operational Risks assigned to FPC

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24 operational risks on Datix have been aligned to FPC, all of which have been reviewed within the required timescales. They 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 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.

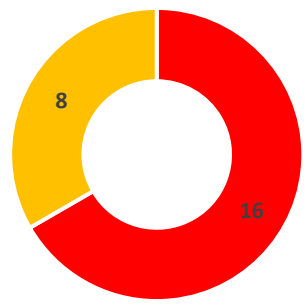
The following slide summarises the reportable operational risks aligned to FPC. The Risk Register attached at **Appendix 2,** provides full detail of reportable risks.

The following slides summarise the operational risks aligned to FPC at 8 October 2026.

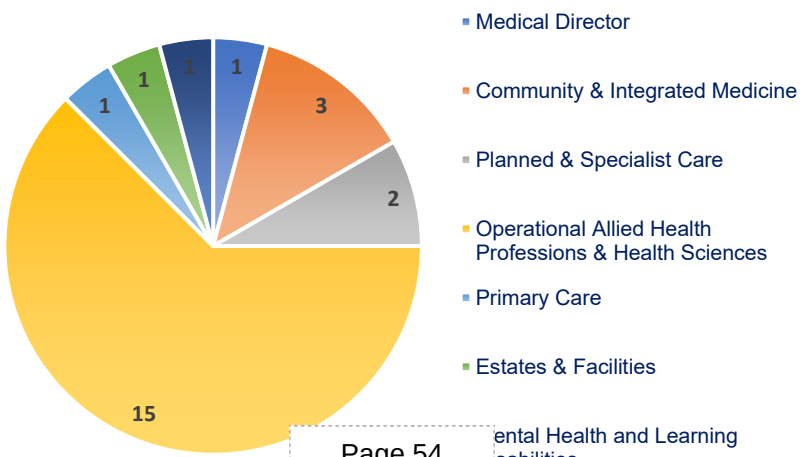
**Risks currently aligned to Estates and Facilities are being realigned to reflect the new structures and portfolio split effective from 5 October 2026, with the revised position to be reported in the next Assurance and Risk paper.*

| | |
|---|---|
| Total Number of Open Risks meeting criteria for reporting | 24 |
| New Risks since last reported to FPC | 2 |
| Closed Risks since last reported to FPC | 0 |
| Increase in Risk Score since last reported to FPC | 1 |
| Decrease in Risk Score since last reported to FPC | 4 |
| No Change in Risk Score since last reported to FPC | 17 |
| EXTREME (RED) Risks (based on 'Current Risk Score') | 16 |
| HIGH (AMBER) Risks (based on 'Current Risk Score') | 8 |

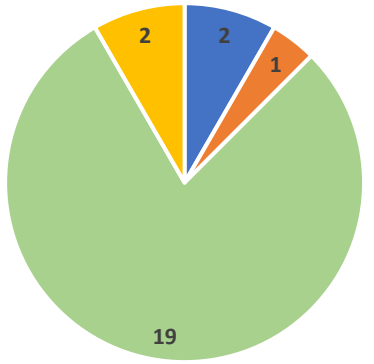
Current Level of Risk assigned to FPC




Risks split per Clinical Care Group/Executive Function




Risks by Target Risk Score Expected Date (Year)



# Operational risks aligned to FPC

The operational risks aligned to the Committee highlight that the Health Board faces challenges in:

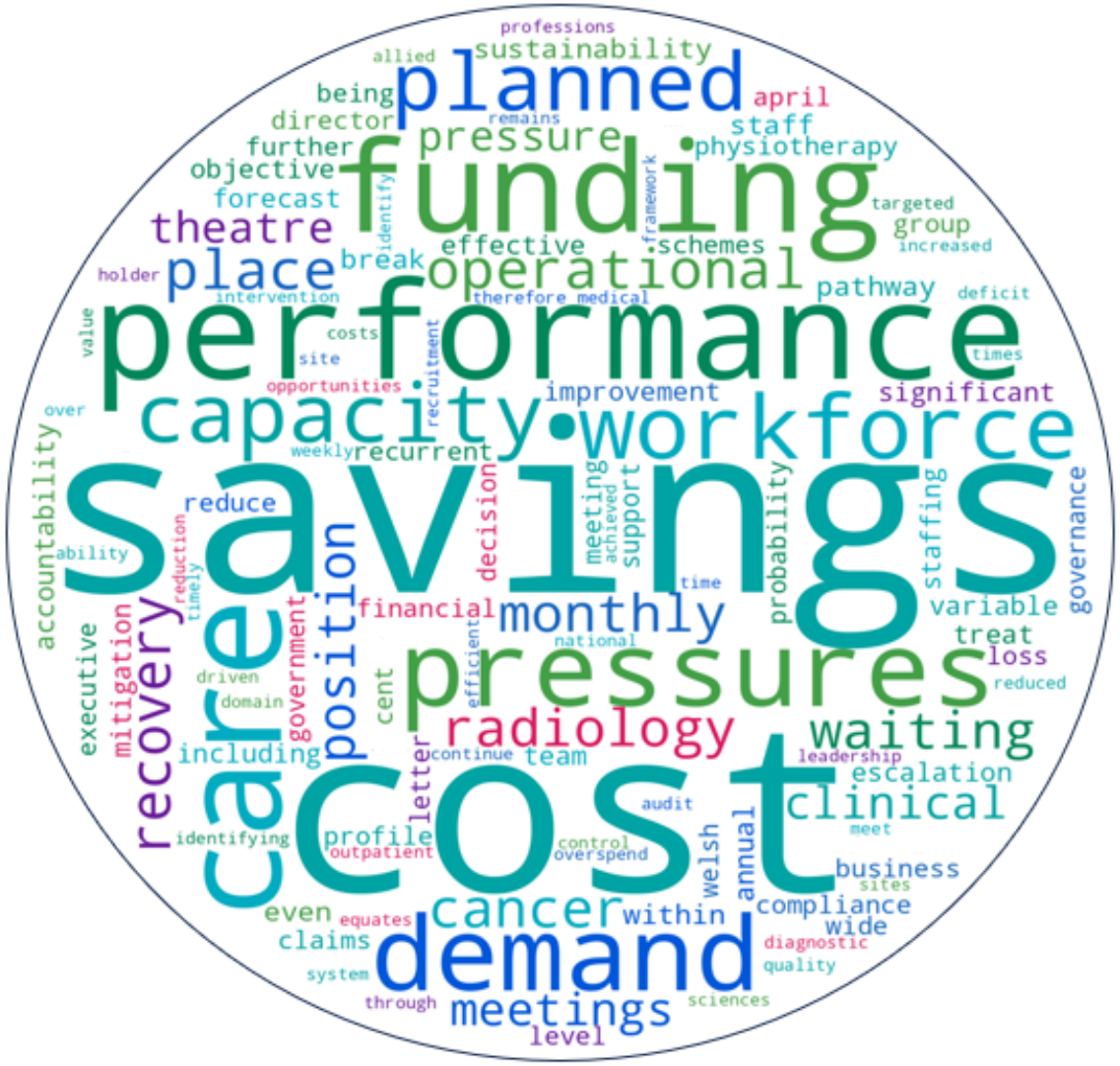
- Delivering financial sustainability and achieving savings targets.
- Managing workforce shortages and reducing reliance on agency, locum and outsourced services.
- Addressing capacity and demand pressures across services.
- Securing sustainable funding for key services and transformation programmes.

The potential impacts of the risks include:

- Financial deterioration and failure to meet savings requirements.
- Reduced service capacity, increased waiting times and performance challenges.
- Adverse impacts on patient safety, quality of care and patient outcomes.
- Workforce burnout, recruitment difficulties and reputational damage.

Common actions noted across the risks demonstrate the need to:

- Strengthen financial controls, monitoring and savings delivery.
- Improve workforce recruitment, retention and sustainability.
- Secure recurrent funding and address underlying cost pressures.
- Progress service redesign, demand management and efficiency improvements.



# New risks added since last report

| Risk Reference & 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 |
|---|---|---|---|---|---|---|
| 2408 - Risk of not achieving savings targets for 2026/27 due to significant, strategic change required across whole CCG | Community & Integrated Medicine | Chief Operating Officer | 25 | 16 | 31/03/2027 | 18/09/2026 |
| 2424 - Risk of Medication loss due to ongoing failure of the Comark fridge monitoring alerting system. | Medical | Medical Director | 20 | 4 | 31/03/2027 | 30/09/2026 |

# Risks with increased Current Risk Score (CRS)

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| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Previous Risk Score | Current Risk Score | Target Risk Score | Expected Date to Achieve Target Risk Score | Date of last risk review |
|---|---|---|---|---|---|---|---|
| 2193 - Risk to the on-going timely delivery of endoscopy procedures due to insufficient baseline capacity to meet demand growth. | Planned and Specialist Care | Chief Operating Officer | 4 | 12 | 4 | 01/04/2027 | 09/09/2026 |
| **Rationale for Current Risk Score (CRS)** | | | | | | | |
| Current core capacity insufficient to meet demand for 8-week - capacity gap of 3 lists per week (equating to 18 patients per week). Funding for the additional activity ceased in August 2026 and presents a risk to delivery from September 2026 to March 2027. | | | | | | | |

# Risks with decreased Current Risk Score (CRS) (Slide 1 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Previous Risk Score | Current Risk Score | Target Risk Score | Expected Date to Achieve Target Risk Score | Date of last risk review |
|---|---|---|---|---|---|---|---|
| 2167 - Risk of increased service fragility due to overspend absorption into service workforce budget. | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 25 | 15 | 5 | 30/06/2027 | 30/09/2026 |

**Rationale for Current Risk Score (CRS)**

The Domain of the risk is set as "Quality" based on the risk Impact i.e. sub-standard service. The Inherent Likelihood score has been set as 25 as without appropriate funding, the likelihood of service fragility leading to sub-standard care may increase. Currently, control measures are ensuring minimal impact on patients, however, further restrictions on budget would present some difficult financial challenges and further increase the likelihood of service fragility. The most recent 2 Orthotics contracts have been re-negotiated which have helped to reduce spend marginally. However, other products are continuing to increase in price. As an ongoing control measure this will be monitored regularly. An SBAR is being submitted in line with annual planning requirement to articulate options to fully mitigate cost pressure, and reduce likelihood of service fragility. This will ensure that patients will continue receive the appropriate level of service from Podiatry & Orthotics in the future. Decision required from the SBAR as to whether the forecasted financial consumables overspend of £150,000 will be approved. The current impact score is 5, as there is evidence that the most catastrophic consequences for patients (e.g amputation rate) are currently increasing. The current likelihood score is 3 due to the possibility of harm to patients. However, should annual planning proposal be unsuccessful the likelihood will increase due to service fragility.

# Risks with decreased Current Risk Score (CRS) (Slide 2 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Previous Risk Score | Current Risk Score | Target Risk Score | Expected Date to Achieve Target Risk Score | Date of last risk review |
|---|---|---|---|---|---|---|---|
| 2148 - Risk of significant impact on 2027/28 Primary Care OT budget due to withdrawal of RIF funding. | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 20 | 15 | 5 | 30/06/2027 | 30/09/2026 |
| **Rationale for Current Risk Score (CRS)** | | | | | | | |
| Some control measures in place but risk remains due to no allocated budget for staff currently funded through Regional Integration Fund (RIF). As at June 2026, it was calculated that the cost pressure on next year's Occupational Therapy Budget is approximately £700K. The probability that this will occur has reduced following a letter from Welsh Government on 25 September 2026 confirming that funding for integrated care will continue for another 5 year cycle. However, it is possible that Primary Care will not meet the criteria for this funding, therefore risk remains high currently. A separate risk is being drafted for other RIF projects. Primary Care is a higher risk project and therefore has its own risk entry. | | | | | | | |

# Risks with decreased Current Risk Score (CRS) (Slide 3 of 4)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Previous Risk Score | Current Risk Score | Target Risk Score | Expected Date to Achieve Target Risk Score | Date of last risk review |
|---|---|---|---|---|---|---|---|
| 2184 - Risk of financial and service sustainability pressures due to unfunded 3Ps Prehabilitation workforce | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 16 | 12 | 6 | 31/03/2027 | 30/09/2026 |

**Rationale for Current Risk Score (CRS)**

There is currently no identified funding for the budget shortfall from April 2026 in cost code 1962 (staff who deliver prehab to patients awaiting orthopaedic waiting list). The annual cost of these staff (who were substantively recruited into these posts) is £272K. The recurring budget for the service is £110K, therefore there is a deficit of £144K. The action plan for mitigating this risk is aimed at minimising or preventing the financial risk that will come into effect in April 2026, which is currently imminent (Likelihood score is 5) due to lack of funding. Should any indication of funding become apparent, this Likelihood score will be reviewed. Potential plans for exploring future funding options are underway (e.g. a meeting is to be scheduled with the Planned Care team to discuss alternative funding arrangements).

# Risks with decreased Current Risk Score (CRS) (Slide 3 of 3)

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Previous Risk Score | Current Risk Score | Target Risk Score | Expected Date to Achieve Target Risk Score | Date of last risk review |
|---|---|---|---|---|---|---|---|
| 2040 - Risk of decommissioning of current First Contact Physiotherapy (FCP) Primary care service due to funding uncertainty from April 2026. | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 15 | 8 | 4 | 31/03/2027 | 30/09/2026 |

| Rationale for Current Risk Score (CRS) |
|---|
| Funding for the service is currently supported by budgets under control of the Chief Operating Officer. Whilst there is still no substantive funding stream, there is not a direct cost pressure to physiotherapy services. The service is not able to replace vacant posts as workforce turnover occurs due to funding uncertainty. |

# Risks with no change in CRS (Slide 1 of 2)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Current Risk Score | Target Risk Score | Expected Date to Achieve TRS | Date of last risk review |
|---|---|---|---|---|---|---|
| 2132 - Risk of overspend due to cost pressures related to variable pay | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 25 | 15 | 31/03/2027 | 28/092026 |
| 2131 - Risk of overspend due to cost pressures related to Everlight radiology | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 25 | 15 | 31/03/2027 | 28/09/2026 |
| 2242 – Risk of budget cost pressures of £100k due to unfunded weekend physiotherapy services | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 20 | 4 | ~~31/03/2027~~ 31/03/2028 | 21/09/2026 |
| 1631 - Risk that delegation of budget manager responsibilities will not be met due to inadequate budget and increasing cost pressures | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 20 | 15 | 30/04/2027 | 29/09/2026 |
| 2107 - Budget cost pressure of £100k due to unfunded respiratory on call services. | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 20 | 4 | 31/03/2027 | 21/09/2026 |
| 2294 - Risk of reduced quality of care and patient safety for those requiring community dietetic treatment and support | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 20 | 8 | 01/02/2027 | 23/09/2026 |

# Risks with no change in CRS (Slide 2 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Current Risk Score | Target Risk Score | Expected Date to Achieve TRS | Date of last risk review |
|---|---|---|---|---|---|---|
| 975 - Risk of inability to achieve the financial target savings set for 2026/2027 due to aged estate and infrastructure | Estates and Facilities* | Director of Allied Health Professions and Health Sciences | 20 | 10 | 31/03/2027 | 15/09/2026 |
| 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 | 21/09/2026 |
| 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 | 31/03/2027 | 28/09/2026 |
| 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 | 31/03/2027 | 24/09/2026 |
| 2175 - Risk to sustainability of pelvic health physio service due to RIF funding ending in March 2027 | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 16 | 4 | 31/03/2027 | 21/09/2026 |
| 2174 - Risk to sustainability of intermediate care physio services due to potential of RIF funding ending in March 2027 | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 16 | 4 | 31/03/2027 | 21/09/2026 |

Risks aligned to Estates and Facilities are being realigned to reflect the new structures and portfolio split effective from 5 October 2026, with the revised position to be reported in the next Assurance and Risk paper.

# Risks with no change in CRS (Slide 3 of 3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Risk Reference & Title | Overseeing Clinical Care Group / Executive Function | Lead Director | Current Risk Score | Target Risk Score | Expected Date to Achieve TRS | Date of last risk review |
|---|---|---|---|---|---|---|
| 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 | ~~30/06/2026~~ 30/11/2026 | 06/08/2026 |
| 2202 - Risk to overspend and reduced performance due to the Outpatient Insourcing contract | Operational Allied Health Professions & Health Sciences | Chief Operating Officer | 12 | 6 | 31/08/2026 | 28/09/2026 |
| 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 | 31/03/2027 | 15/09/2026 |
| 2316 - Risk of being unable to identify recurrent savings required due to ad-hoc pay and non-pay | Planned & Specialist Care | Chief Operating Officer | 12 | 8 | 31/03/2028 | 24/09/2026 |
| 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 | 27/07/2026 |

# Risk themes

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 theme is currently aligned to FPC as of September 2026:

| Theme | Definition | Number of risks | Date themed Risk Register last shared |
|---|---|---|---|
| Finance | Risks associated with the possibility of financial loss and uncertainty | 106 | 19/08/2026 |

# Implementation of Welsh Health Circulars

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 Welsh Health Circular (WHC) is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of 17 September 2026, and the number completed since the previous report.

| 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** | 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** | 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. | 0 |
| **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** | 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. | 1 |

Oversight of the delivery of WHCs has been included in Clinical Care Group (CCG) 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.

# WHCs – Complete Pending Formal Approval For Closure

| Welsh Health Circular | Clinical Care Group/Executive Function | Lead Executive | UHB Implementation Date |
|---|---|---|---|
| 008-26: NHS Research and Development Finance Policy 2026<br>**Issued March 2026** | Finance | Director of Finance | Jun-26 |

# WHCs – Complete and Approved

| Welsh Health Circular | Clinical Care Group/Executive Function | Lead Executive (and CCG Director for those aligned to Chief Operating Officer) | UHB Implementation Date | Date WHC completed (i.e. exec approval received). |
|---|---|---|---|---|
| 022-26: 2026/27 NHS Wales Financial Monitoring Return Guidance<br>**Issued April 2026** | Finance | Director of Finance | Jun-26 | Jun-26 |

# Recommendations

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

**Risk Management**

- **RECEIVE ASSURANCE** that principal risks have identified controls in place which are working effectively, and 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.
- **RECEIVE ASSURANCE** that there are processes in place to oversee operational risks to ensure these are being managed effectively.

**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.



| Risk Ref | Risk (for more detail see individual risk entries) | Executive Director | Domain | Previous Risk Score | Risk Score Sep-26 | Trend | Target Risk Score (tolerable score) | Expected Date of achieving Target Risk Score | Risk on page no... |
|---|---|---|---|---|---|---|---|---|---|
| 1199 | Strengthening Long Term Financial Sustainability | Thomas, Huw - | Finance inc. claims | 5×5=25 | 5×5=25 | → | 2×4=8 | 31/03/2028 | 6 |

# RISK SCORING MATRIX

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

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

## RISK MATRIX

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

## RISK ASSESSMENT - FREQUENCY OF REVIEW

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

**Assurance Key:**

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

| Key - Assurance Required | |
|---|---|
| | Detailed review of relevant information |
| | Medium level review |
| | Cursory or narrow scope of review |

*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*

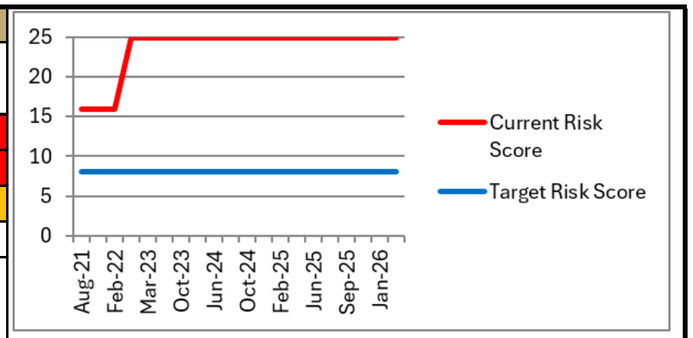
| Key - Control RAG rating | |
|---|---|
| **LOW** | Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **MEDIUM** | Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **HIGH** | Controls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

| | |
|---|---|
| **Date Risk Identified:** | Jun-21 |
| **Strategic Objective:** | 4. Positive Futures |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Thomas, Huw - | **Date of Review:** | Jun-26 |
| **Lead Committee:** | Finance and Performance Committee | **Date of Next Review:** | Jul-26 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **1199** | **Principal Risk Description:** | There is a risk that the Health Board does not deliver a credible plan for financial sustainability. This is caused by savings opportunities not being converted into deliverable schemes; agreed schemes not being delivered; change programmes being underâ€'resourced or insufficiently managed; and service changes that absorb unmet demand rather than releasing cost, compounded by the Health Board remaining in Targeted Intervention for planning and finance. This could lead to an impact/affect on organisational reputation, workforce retention and morale, patient experience, stakeholder confidence, and a drift away from delivering system value. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Finance inc. claims |
| **Inherent Risk Score (L x I):** | 5×5=25 |
| **Current Risk Score (L x I):** | 5×5=25 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Expected Date To Achieve TRS:** | 31/03/2028 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
|---|
| Operational teams have matured over the last year, yet engagement has remained challenging on planning and finance. The underlying deficit is understood and articulated, with budget-holder decisions tracked where delegated limits are exceeded. The recurrent delivery gap persists, and underlying gaps in demand vs capacity place at risk our financial sustainability. There are clear signals from Welsh Government for the current financial year that neither the revenue nor the cash implications can be fully supported; and analysis by the Institute of Fiscal Studies (March 2026) confirms this assessment for the medium term. The organisation was escalated into Targeted Intervention in October 2022 on planning and finance grounds, and escalated across the whole organisation in January 2024, and remains as such as at October 2026. The confirmed recurrent funding settlement leaves a material gap against current plans. |

| **Rationale for TARGET Risk Score:** |
|---|
| Three-year financial balance is a statutory duty and a standing expectation of Board and Welsh Government. Integrated planning is inherently complex: demand, capacity, workforce and finance are challenging to align. Given the scale of savings required and the timeline to deliver them, the target score exceeds the Board's tolerable risk. |

| Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk) | Gaps in CONTROLS | | | | |
|---|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br><br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Business intelligence comparing our spend to the rest of Wales at service, site and condition level, used to identify where resources could move.<br><br>Long term financial model in place, and a three year financial plan was presented to Board in March 2026 for the first time.<br><br>Executive led grip on specific pressures, including agency spend and urgent and emergency care.<br><br>Executive governance through Value and Sustainability, A Healthier Mid and West Wales.<br><br>Value Based Health and Care Group steering VBHC deployment and the intended shift of resource over time. | Recovery of planned care activity, alongside rising acuity and service demand, is pulling focus away from living within available financial and staffing resource.<br><br>Conversion of the Opportunities, Savings and Value for Money Frameworks into recurrent deliverable schemes is not yet consistent.<br><br>TI focus sits on in year recovery. A longer strategic horizon would help move from recovery to design.<br><br>Two TI actions remain in progress, flagged by WG as organisational challenges around clarity of plans, delivery mechanisms and monitoring, set against the balance with safety and quality. | To achieve workforce sustainability through the delivery of workforce planning, recruitment, retention, and development, and effectiveness initiatives.<br>1.Develop a Workforce Plan which sets out actions to achieve a balance between workforce demand and supply, supporting workforce stabilisation, removing the need for regular and planned variable pay and agency resource.<br>2. Delivery of a targeted Recruitment Plan which will reduce reliance on high cost agency staff through substantive recruitment (supply-side) supporting the Workforce Plan.<br>3. Delivery of a Retention Plan to support the supply-side elements of the Workforce Plan and underpin workforce stabilisation.<br>4.Delivery of a Workforce Education and Development Plan which supports the pipeline (supply-side) for staff progression. | Gostling, Lisa | ~~31/03/2026~~ 31/03/2027 | Progress to be provided at next risk review |
| | To oversee financial recovery and periodically update a three-year financial route map, through ever annual planning cycle, and interim periods between as agreed. | Thomas, Huw - | ~~31/03/2026~~ 31/03/2027 | On track as per highlight report presented to FPC in February 2026. Next update will be provided in February 2027, as a minimum. | |

| | | | |
|---|---|---|---|
| Urgent and Emergency Care (UEC) Programme - UEC / Implement the Six Goals To develop and implement a plan to by March 2027 to deliver Ministerial priorities by 2028.<br>1. Delivery and Implementation of a 24/7 Urgent Care Service, accessible via 111 Wales, to support improved access and GMS sustainability.<br><br>2. Implementation of Same Day Emergency Care services /direct access pathways.<br>3. Improving patient flow through the acute sites.<br>4. Develop a strategy for our Alternative Care Provision to support care closer to home.<br>5. Minimise delays in hospital discharge due to assessment-related issues within Pathways of Care.<br>6. Improve the effectiveness and efficiency of community services, with an emphasis on avoiding unnecessary hospital admissions and facilitating timely discharges. | Carruthers, Andrew | ~~31/03/2026~~ 31/03/2027 | Progress to be provided at next risk review |
| Mental Health and Learning Disabilities service improvement though:<br>1. Mental Health Recovery Programme Optimisation<br>2. Section 136<br>3. Redesign the End-to-End Inpatient and Community Pathway. | Carruthers, Andrew | ~~31/03/2026~~ 31/01/2027 | Progress to be provided at next risk review |
| To provide a set of plans for key clinical services to address critical sustainability risks up to the future hospital network. | Davies, Lee | ~~31/03/2026~~ 31/10/2026 | Progress to be provided at next risk review |
| Develop a Primary Care and Community Strategy which is inclusive of:<br>- Enhancement of Primary Care Services<br>- Integration of Technological Solutions<br>- Workforce Development<br>- Infrastructure and Estate Development<br>- Alignment with Community Services | Carruthers, Andrew | ~~31/03/2026~~ ~~30/09/2026~~ 31/03/2027 | Progress to be provided at next risk review |

| | | | |
|---|---|---|---|
| Progress against Business Case process for Implementation of A Healthier Mid and West Wales Strategy & Estates Rationalisation - Modernisation and rationalisation scheme year 1-4 implementation. | Davies, Lee | ~~31/03/2026~~ ~~31/08/2026~~ 28/02/2027 | Progress to be provided at next risk review |
| Implement the Digital Strategic Plan<br>A. To ensure that future planning is progressed for the following key system developments: 1. Re-procurement of the Laboratory Information Management System, 2. The Integrated Eye Care Electronic Health Record, 3. Development of a Community Information System & 4. Development of Maternity and Paediatric record systems.<br>B. To build a business case for a Patient Relationship Management System. | Thomas, Huw - | ~~31/03/2026~~ ~~30/06/2026~~ 31/12/2026 | On track. |
| Development of a revised VBHC strategy for the Health Board, recognising the Health Board's ambition to become a value managed system. | Phillips, Leighton | ~~30/06/2026~~ 30/10/2026 | On track. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | |
|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| See Our Outcomes section on the BAF Dashboard<br><br>Operational agreement to underlying deficit assessment.<br><br>Welsh Government accept and approve an | Analysts engaged and have produced a bed opportunity analysis with consistent conclusions to the internal work | 1st | | | Financial Report to every Board and FPC.<br><br>Escalation Oversight and Highlight Reports to every FPC<br><br>Annual Plan 2026/27 - Board (Mar26) | Operational governance arrangements are being updated<br><br>Internal escalation framework is being refreshed to include appropriate and timely impactful | Operational oversight and control will be consistently embedded following the review and implementation of Phase 2 of the Operational Organisations Change Process, providing clear, timely and specific escalation interventions for all Clinical Care Groups that are not delivering their targeted financial savings. | Carruthers, Andrew | 30/06/2026 | OCP changes are being prepared for update to Executive Team in May 2026. |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Integrated Medium Term Plan (IMTP).<br><br>A long-term financial plan in place, highlighting sufficient opportunities for the Health Board to achieve financial sustainability.<br><br>High level financial assessment of A Healthier Mid and West Wales in place. | Financial Reporting to Finance and Performance Committee | 2nd | | | 3 Year Financial Plan 2026-29 - FPC (Feb26 and Aug26) and Board (Sep26)<br><br>Savings Identification 2026/27 for Operational Teams - FPC (throughout 2026)<br><br>Financial Plan Update 2026/27 - F&PC (Dec25) | actions from those who enter level 4 escalation | Articulate the criteria, and response, that will be implemented should a function be escalated to level 4. | Thomas, Huw - | 30/06/2026 | Proposals drafted and being reviewed with the CEO and Executive Team for finalisation. |
| | Ways of Working to be implemented across Clinical Care Group structures (reporting to Executive Team), to oversee in-year delivery of financial performance and savings delivery | 2nd | | | | | | | | |
| | Internal escalation framework across seven domains updating on a monthly basis and overseen by Executive Team and Financial and Performance Committee | 2nd | | | | | | | | |
| | Value and Sustainability Group (reporting to Executive Team) oversees opportunities which inform medium term financial roadmap | 2nd | | | | | | | | |
| | Planning Goal (Safe, timely, high quality care) overseen by Finance and Performance Committee | 2nd | | | | | | | | |
| | WG scrutiny through Monthly Monitoring Returns and NHS Exec Financial Planning and Delivery team | 3rd | | | | | | | | |
| | Structured Assessment 2025 | 3rd | | | | | | | | |

| Risk Ref | Clinical Care Group / Executive Function | Clinical Service Group / Executive Function Service | Clinical Service Sub-Group / Executive Function Service | Executive Director | Clinical Care Group Director / Executive Function Lead | Clinical Service Group Lead / Executive Function Service Lead | Clinical Service Sub-Group Lead / Executive Function Service Lead | Date risk identified | Risk Statement | Existing Control Measures Currently in Place | Domain | Current Likelihood | Current Impact | Current Risk Score | Rationale for Current Risk Score | Additional Risk Action Required | By Whom | By When | Progress Update on Risk Actions | Lead Committee | Target Likelihood | Target Impact | Target Risk Score (tolerable score) | Rationale for Target Risk Score | Detailed Risk Decision | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2131 | Operational Allied Health Professions & Health Sciences | AHP&HS: Radiology | AHP&HS: Radiology | Carruthers, Andrew | Quarrie, Sara | Roberts-Davies, Gail | Procter, Sarah | 01-Jul-25 | There is a risk of Overspend from the cost pressures of requirement to use everlight radiology.<br><br>This is caused by Reliance on outsourcing of reporting to provide emergency 24/7 CT and MRI.<br><br>This will lead to an impact/affect on The cost pressure for Everlight is circa £1 million to provide emergency reporting out of core hours. This 3% of the radiology budget. This cost pressure has been constant over the past 2 years despite the introduction of locums to reduce outsourcing out of hours as demand for scanning is also increasing as is price per report.<br><br>Risk location, Health Board wide. | Use of locum radiologists to provide partial out of hours service<br><br>Stabilisation fund - two consultant posts are being advertised in September. | Finance inc. claims | 5 | 5 | 25 | Impact: 5 overspend of 3% of budget<br>Probability - unless demand is reduced at source then overspend will happen. Reduction of demand may result in poorer patient outcomes. | Analysis of future demand and quantification of expected overspend. Support being provided by Shaun Ayres | Procter, Sarah | **Completed** | completed | Finance and Performance Committee | 3 | 5 | 15 | Impact - risk of overspend of 3% of budget<br><br>Likelihood/probability = 3 - increases in demand and costs of outsourcing may change. | Treat | 28-Sep-26 |
| | | | | | | | | | | | | | | | | Forecast based on current demand of financial impact | Procter, Sarah | **Completed** | not included in annual plan - cost pressure identified | | | | | | | |
| | | | | | | | | | | | | | | | | Work with hospital director to try and reduce demand by clear pathways and restriction of referral rights for lower grades of staff. Meetings ongoing. | Roberts-Davies, Gail | ~~30/05/2026~~ 31/10/2026 | initial meetings have taken place<br>ToR drafted awaiting approval prior to start of formal Radiology Referral Management Group | | | | | | | |
| | | | | | | | | | | | | | | | | Undertake a cost analysis of options relating to staffing of emergency rotas. | Quarrie, Sara | 30/11/2026 | Action being taken forward and paper being written as of 26 Aug 2026 | | | | | | | |
| 2132 | Operational Allied Health Professions & Health Sciences | AHP&HS: Radiology | AHP&HS: Radiology | Carruthers, Andrew | Quarrie, Sara | Roberts-Davies, Gail | Procter, Sarah | 01-Jul-25 | There is a risk of Overspend from the cost pressures of requirement to provide imaging using variable pay<br><br>This is caused by Staffing establishment not sufficient to meet the working hours of the service 24/7<br><br>This will lead to an impact/affect on The overspend is 3% of the 29.8 million radiology budget. Reliance on call and overtime to provide radiology OOH results in poorer quality, mistakes, burnout. It also causes retention and recruitment to be difficult.<br><br>Risk location, Health Board wide. | Radiology Stabilisation plan<br>Annual Planning<br>Clinical service Plan | Finance inc. claims | 5 | 5 | 25 | Impact - The overspend is 3% of the 29.8 million radiology budget.<br><br>Probability- The overspend happens each year as it funds the radiology out of hours service on all sites which has become busier. | 2025/16 annual plan - £3.4m Stabilisation Plan implementation | Procter, Sarah | **Completed** | recruitment of staff is ongoing. Recovery of backlog is on target which will release funding for staff in 26/27 | Finance and Performance Committee | 3 | 5 | 15 | Impact - The overspend is 33% of the 29.8 million radiology budget.<br><br>Probability- The overspend happens each year as it funds the radiology out of hours service on all sites which has become busier. | Treat | 28-Sep-26 |
| | | | | | | | | | | | | | | | | Annual planning submission - £5.1m (as of April 2025) gap in demand vs capacity remains as per agreement in 2025/26 Annual Planning | Procter, Sarah | **Completed** | Annual plan funding confirmed for 2026/27 | | | | | | | |
| | | | | | | | | | | | | | | | | receive funding for annual plan and split into individual site cost codes. then risk can be closed | Procter, Sarah | **Completed** | Awaiting funding to be split into cost codes. | | | | | | | |

| Risk Ref | Clinical Care Group / Executive Function | Clinical Service Group / Executive Function Service | Clinical Service Sub-Group / Executive Function Service | Executive Director | Clinical Care Group Director / Executive Function Lead | Clinical Service Group Lead / Executive Function Service Lead | Clinical Service Sub-Group Lead / Executive Function Service Lead | Date risk identified | Risk Statement | Existing Control Measures Currently in Place | Domain | Current Likelihood | Current Impact | Current Risk Score | Rationale for Current Risk Score | Additional Risk Action Required | By Whom | By When | Progress Update on Risk Actions | Lead Committee | Target Likelihood | Target Impact | Target Risk Score (tolerable score) | Rationale for Target Risk Score | Detailed Risk Decision | Review date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | Annual plan submission 27/28 a gap of 5.1 m remains to stabilise radiology. | Procter, Sarah | 31/03/2027 | new action | | | | | | | |
| 2408 | Community & Integrated Medicine | Carmarthenshire Integrated System | Carmarthenshire Integrated System | Carruthers, Andrew | Skitt, Peter | Skitt, Peter | Skitt, Peter | 01-Jan-26 | There is a risk of of Carmarthenshire Integrated System will be unable to achieve the financial target savings for 26/27.<br><br>This is caused by being unable to identify the full savings as a result of requiring significant, strategic change required across the whole Clinical Care Groups.<br><br>This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan. Health Board remaining in Targeted Intervention (TI).<br><br>Risk location, Carmarthenshire. | Finance team work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and<br>mitigating actions.<br><br>Clinical Care Group, Financial Control Group and weekly Carmarthenshire system meeting in place which scrutinises all new and replacement posts.<br><br>Monthly Business and Performance meetings to review financial outturns and sign-off of the year-end Forecast, with the Finance Business Controller, focusing on mitigating actions and consequence to reduce spend.<br><br>Opportunities Framework, refreshed to identify alternative ways of working that may result in cost reductions/formal savings schemes identified.<br><br>Monthly financial scrutiny meetings with senior nurses in order to gain assurance over budget management and scrutinise variable pay.<br><br>Variable Pay weekly scrutiny meetings and monthly Variable Pay analysis meeting chaired by the Assistant General Manager.<br><br>Monthly review of all underspends and release as savings in order to flag what the true overspends are. | Finance inc. claims | 5 | 5 | 25 | Carmarthenshire Integrated System has been tasked with identification of Â£8.5m (of which Â£6m carried over from 25/26) savings to meet with Welsh Government planned outturn for 2026/27. As of May 2026, Â£1.3m savings have been transacted as green savings (i.e. they have been taken out of their financial position) with a further Â£500k as blue or red schemes (i.e. these are currently considerations). As of June 2026, the risk remains extreme, driven by continued use of variable pay, locum and agency use due to workforce gaps, medical recruitment and continued surge and overcrowding in some key clinical areas such as Emergency Dept (ED) and across acute inpatient areas. The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. | Implement variable pay reduction for nursing and medical. | Evans, Iona | 31/01/2027 | Nursing element should be completed by November 2026, with medical element end of January 2026. | Finance and Performance Committee | 4 | 4 | 16 | As of June 2026, Executives have put further measures in place via the Underspend Savings Conversion, however due to the pressures on the system as a result of variable pay, etc. the reality of meeting the savings is currently an extreme risk. | Treat | 18-Sep-26 |
| | | | | | | | | | | | | | | | | Review interim care bed capacity in the community with view of reduction in bed in acute sites. | Evans, Iona | 31/10/2026 | New action. | | | | | | | |
| | | | | | | | | | | | | | | | | Provide assurance within sickness absence management across all workforce. | Evans, Iona | 31/10/2026 | New action. | | | | | | | |

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| 2424 | Medical Director | Medicines Management | Medicines Management | Henwood, Mr Mark | Khandhia, Dilesh | Khandhia, Dilesh | Robson, Donna | 03-Aug-26 | There is a risk of pharmacy is/will not be alerted if the refrigerator's go out of range.<br><br>This is caused by The alerting system not advising the out of hours pharmacist on-call there is an issue with the fridges, so if there is an issue there will be a significant delay in managing the situation and reduced ability to mitigate against losses.<br><br>This will lead to an impact/affect on Considerable financial impact as a medication is likely to be discarded or have a reduced expiry if not stored correctly. The likelihood of this occurring increases with the increasing time of the excursion. Also, clinical impact as medication may not be available at the point of need.<br><br>Risk location, Bronglais General Hospital. | Comark system is intermittently working.<br><br>Department is manually checking fridge temperatures upon opening in the morning to ensure no deviations overnight and at the end of working day.<br><br>A hard wired alarm to switch will be in place within 2 weeks. Also looking to have a bank of UPS batteries for all fridges/freezer to mitigate aginst tripped fuses etc. | Finance inc. claims | 5 | 4 | 20 | From realising there is a fault with the system the unit has failed to monitor consistently. Unable to reboot for 3 consecutive days and when the system was working it has since failed but currently working.<br><br>Currently awaiting quote for update comark monitoring system. The hardwired alarm system will cost approx Â£1810 and the UPS back up will be approx Â£16,500. | Upgrade the Comark system to the newer cloud based system and install the 12 sensors required for the new system to work | Robson, Donna | 31/03/2027 | Costing to be confirmed once quote has been obtained. Quote requested on 07/08/26 for BGH site only, however we will obtain a HB wide quote as well to compare costings. | Finance and Performance Committee | 2 | 2 | 4 | The updated version that is required to replace the current unsupported outdate version is cloud based, so IT capabilities could impact. The newer vision would mitigate against hardware failure. | Treat | 30-Sep-26 |
| | | | | | | | | | | | | | | | | Hard wired system to be installed as a back up in case of system failure. | Robson, Donna | 31/10/2026 | Update at next review | | | | | | | |
| | | | | | | | | | | | | | | | | Procure back up UPS batteries for the fridges and freezers - draft and submit capital bid | Robson, Donna | 31/03/2027 | Update at next review | | | | | | | |

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| 2242 | Operational Allied Health Professions & Health Sciences | AHP&HS: Physiotherapy | AHP&HS: Physiotherapy | Carruthers, Andrew | Quarrie, Sara | Davies, John | Davies, John | 28-Nov-25 | There is a risk of of budget overspend amounting to the cost of approximately £100k<br><br>This is caused by No budget for enhanced weekend working costs for contractual 7 day service ICT front of House Withybush General Hospital. No budget for variable pay overtime costs for voluntary 7 day weekend orthopaedic service Withybush General hospital.<br><br>This will lead to an impact/affect on Inability to manage physiotherapy services within budget and ensure compliance with financial governance standards.<br>Reduction in the range of 7 day physiotherapy services to ensure service costs are within budget. Alternatively reduction in core 5 day service models to fund weekend working. This could potentially impact recovery waiting times and quality outcome measures<br><br>Risk location, Withybush General Hospital. | Monitoring of variable pay costs for weekend working<br>Monitoring of vacancy rates in core staffing<br>monitoring of bank staff/ locums within core services Monday to Friday<br>Engagement in RIF gateway review process for next steps funding stream<br>Monthly meetings with finance business partners<br>Monthly review of Qliksense system<br>Engagement in Clinical Services Plan<br>orthopaedic service review<br>engagement in annual planning process | Finance inc. claims | 5 | 4 | 20 | There is currently no new budget available to fund additional services.<br>There is currently no decision to withdraw 7 day services.<br>100k cost pressure equates to 0.83% of the budget<br><br>Justification against Risk Framework:<br>* Finance and claims - 4 Loss of 0.5â€“1.0 per cent of budget<br>* Likelihood/probability - 5, 95% + | SBAR to be presented to CCG IG to inform financial challenge (and options to mitigate further) | Davies, John | **Completed** | New action 30/03/26-SBAR completed and presented to CCG (TOCALS, w end ortho services) . No additional funding available. Question now is whether to withdraw service as it is unfunded. Options appraisal has been presented to CCG. Pending decision. | Finance and Performance Committee | 1 | 4 | 4 | Funding for service is required or decision to withdraw service therefore mitigating the likelihood of the risk. This was not decided in the 2025-26 annual planning process, so put forward to the 2026-27 annual planning process. If a decision is taken to decommission the service, custom and practice principles will apply for 12 months. The date to achieve target risk score is set with that latter point in mind. | Treat | 21-Sep-26 |
| | | | | | | | | | | | | | | | | Re draft QIA (in new format) for TOCALs cost mitigation SBAR. Review with Angela Bell and submit to corporate QIA panel. | Davies, John | 30/06/2026 30/10/2026 | QIA, EQIA completed and submitted to corporate diversity and inclusion team 11th June 2026. Further information provided to this team on the 30th June 2026. Pending further feedback. chaser emails sent | | | | | | | |

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| 2107 | Operational Allied Health Professions & Health Sciences | AHP&HS: Physiotherapy | AHP&HS: Physiotherapy | Carruthers, Andrew | Quarrie, Sara | Davies, John | Davies, John | 09-Jul-25 | There is a risk of of physiotherapy budget overspend. This is estimated to be £100,000 per year which constitutes on call availability payments , hours worked, travel claims.<br><br>This is caused by the unfunded service delivery of four Emergency respiratory on call services at all 4 DGH sites.<br><br>This will lead to an impact/affect on insufficient financial recovery or if no funding is sourced. There is likely to be adverse impact waiting times recovery in planned care MSK, paediatrics, lymphoedema and community services, if Mon- Fri core budget is utilised to fund out of hours emergency services.<br><br>Risk location, Health Board wide. | on call costs are minimised through the development of highly skilled staff second on call rotas are only implemented when workload is exceptional and this is approved by senior physiotherapy managers.<br>on call claims are scrutinised by respiratory and service leads.<br>trends in inappropriate call outs are identified and wards / individuals are educated on appropriate inclusion criteria for the service.<br>twilight shifts are in place in GGH to reduce call out rates as staff are on site in the early evening.<br>work undertaken is now only urgent respiratory work that cannot be left until the next working day. | Finance inc. claims | 5 | 4 | 20 | There is no allocated budget for 4 on call activity. Therefore, the service has a forecast overspend of 100k (equates to 0.83% of the budget).<br><br>The physiotherapy budget for core Mon-Fri services is now consistently fully spent due to successful recruitment and the use of bank staff to ensure maximum service capacity (within budget) to support service demand.<br><br>Absorbing these costs within the budget will result in further risks to unscheduled and planned care capacity<br><br>It is not clinically viable to withdraw on call services as this service maintains life. | SBAR to be presented to CCG IG to inform financial challenge (and options to mitigate further) | Griffith, Susan | Completed | 08/05/26 Cost mitigation paper re on call services submitted to CCG in April 2026. Feedback received. Post review amendments to paper required. paper complete and shared with county directors and Peter Skitt CCG | Finance and Performance Committee | 1 | 4 | 4 | There will be no financial / clinical or quality risks for the physiotherapy service if the on-call rotas are fully funded. This was not decided in the 2025-26 annual planning process, so put forward to the 2026-27 annual planning process. | Treat | 21-Sep-26 |
| | | | | | | | | | | | | | | | | Contribute to the development of National position statement on behalf of the All Wales Physio Leaders Advisory Group in relation to the delivery of on call services. | Griffith, Susan | Completed | Comments contributed to national work. Anticipated final draft by end of July 2026. | | | | | | | |
| | | | | | | | | | | | | | | | | Explore merging rotas in Carmarthenshire which may reduce costs slightly. | Griffith, Susan | 31/03/2027 | New action | | | | | | | |

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| 2294 | Operational Allied Health Professions & Health Sciences | AHP&HS: Dietetics & Nutrition | AHP&HS: Dietetics and Nutrition | Carruthers, Andrew | Quarrie, Sara | Roberts, Sarah | Eduful, Ernestina | 19-Feb-26 | There is a risk of of increased patient waits and reduced capacity to offer timely community dietetic care causing risk to patient health and safety<br><br>This is caused by Extreme fragility across the whole of community dietetic service particularly Pembrokeshire and Ceregidion with future staff leaving and decision not to approve recruitment into essential vacant dietetic posts resulting in contingency measures being in place to protect current workforce and prioritise patient safety<br><br>This will lead to an impact/affect on This will reduce community clinic capacity , reduce ability to provide dietetic oversight and treatment within community hospitals, care and nursing homes and reduce capacity to offer home visits for those unable to attend clinics and reduce reviews of patients on nutritional support in the community. increasing risk of deconditioning , frailty and poor nutritional status resulting in increased morbidity and need for hospital admissions.<br><br>Risk location, Health Board wide. | 4.0 wte junior dietitians were employed to work in the community as part of a workforce stabilisation plan June 2025, this has enabled increased capacity for clinics and dietetic in reach to nursing homes , care homes and patients homes also enabling the limited more experienced dietetic resource in community to focus on more complex caseload improving quality of care for those patients<br>service lead for community has been recruited Clinical lead in community has been recruited into<br>Revised triage and clinic process will help streamline and more equitable service across HB and increased virtual clinics.<br>contingency plans in place and prioritisation guide | Quality/Complaints/Audit | 5 | 4 | 20 | There is currently still an impact as the community dietetic service is under resourced and if members of team on leave or unwell clinics and visits have to be paused/ The likelihood is increased despite controls in place June 2026- clinical lead role in pembs vacant , Clinical lead and clinical lead in Ceredigion on secondment. No permission to recruit into upcoming vacancies and fragility in acute service which impacts on increased DBS and DBR referrals | to escalate risk and ask finance if any scope for additional 0.2wte funding to increase role to 1.0wte to improve appeal for this clinical lead post and ensure this provides adequate management and supervision across the service | Roberts, Sarah | Completed | Advert for 1.0wte clinical lead role is not out to advert closing date 12th May 2026 | Finance and Performance Committee | 2 | 4 | 8 | although there is always risk of fragility in service provision the impact would aim to be moderate and likelihood negligible if measures in place to support adequate staffing within community dietetic service along side clinical leadership to operationally oversee and ensure service development in line with HB strategic plans | | 23-Sep-26 |
| | | | | | | | | | | | | | | | | To escalate need for improved opportunities in Band 6 positions across community as currently there are 2.0wte Band 6 positions in 3 roles across the whole community dietetic service health board wide, which impacts on patients requiring more complex care and also to enable adequate supervision for junior staff | Roberts, Sarah | Completed | Awaiting decision on recruitment to band 5 vacancies - this has been delayed at exec board level potential development role for current band 6 to Band 7 in discussion to enable Band 5 role development to reduce staff turnover. no decision to recruit therefore close action | | | | | | | |

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| 975 | Estates & Facilities | Estates & Facilities | E&F: Directorate Team | Severs, James | Severs, James | Chiffi, Simon | Chiffi, Simon | 01-May-20 | There is a risk of There is a risk that the CCG is unable to deliver sustainable recurrent savings and effectively manage in-year cost pressures due to limitations in age & condition of estate & no reduction in HB space<br><br>This is caused by 1.Limited capacity to identify sustainable, realistic & recurrent savings plans.<br>2.Non-delivery of recurrent savings requirements, resulting in adverse impact on the underlying position.<br>3.Limited identification and implementation of opportunities that deliver sustainable financial benefits and support recovery and improvement trajectories without adverse safety consequen<br>4.Emerging cost pressures affecting the Directorate's in-year financial position, including those associated with the ageing estate, enhanced cleaning standards, and additional revenue pressures arising from RAAC-related issues.<br>5.External inflationary pressures impacting non-pay and pay budgets. | Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions. Monthly<br><br>Monthly establishments reviews within the service to ensure pay position is understood and actions are taking promptly, supported by Finance colleagues where appropriate. Monthly.<br><br>Care Group meetings now established where all service leads attend to ensure more scrutiny on financial positions and discuss potential savings strategies. The establishment of the care groups with greater emphasis on financial scrutiny will help to support financial stability over time. April 2026 next session.<br><br>New Facilities Managers in post focussing on budget control.<br><br>Rota reviews in Facilities teams to be implemented.<br><br>Significant focus on variable pay controls.<br><br>Additional savings schemes being | Finance inc. claims | 5 | 4 | 20 | Score driven by significant & escalating financial pressured within estates, including ongoing RAAC works, maintenance overspends due to insufficient budget and rising materials and procurement costs. Frequent dynamic failures across an aged estate continue to generate unforeseen non pay expenditure while increased statutory requirements further elevate cost pressures. Overall financial position is exacerbated by long term underinvestment, deterioration of estate backlog and repeated rejection of investment proposals to right size budget, including unresolved pay overspends and unfunded staffing approvals from 2019. Furthermore clinical and overall space requirements have | Budget holders to work closely with finance Business Control colleagues to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions | Chiffi, Simon | **Completed** | This is a key focus as part of new care group establishments. | Finance and Performance Committee | 2 | 5 | 10 | Discussed at EIGG August 2026 - SC to consider and update at next review. SC has reviewed and submitted investment proposals to right size previously agreed pay decisions and increase estate size and cost of materials. Both proposals have been rejected. Until HB Clinical space requirements are reduced there is limited scope to reduce operational budgets.<br><br>Property Rationalisation opportunities paper also presented to consider for Exec and CCG Directors. Pending firm decision | Treat | 15-Sep-26 |

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| | | | | | | | | | 6.Ongoing workforce & resource pressures within Facilities.<br>7.Escalating Health Board-wide financial pressures.<br>8.Misalignment of the Estates Operations pay budget, reflecting previously approved recruitment to GAP analysis posts (2019) that were not funded, requiring resolution through investment proposals<br><br>This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability and service deliverability and assurance around a safe estate.<br><br>Risk location, Health Board wide. | worked through to move from red to amber/green in agreement with Exec leads | | | | | grown 25% in 10 years with no revenue to cover increased space.<br><br>Overall size of the estate is unmanageable to maintain compliance and achieve savings target. Team has presented suite of estate rationalisation opportunities that have not been approved or decided upon | | | | | | | | | | | |

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| 1631 | Operational Allied Health Professions & Health Sciences | AHP&HS: Physiotherapy | AHP&HS: Physiotherapy | Carruthers, Andrew | Quarrie, Sara | Quarrie, Sara | Quarrie, Sara | 28-Mar-23 | There is a risk of that the obligations of the Delegation of budget manager responsibilities for the financial year will not be achieved<br><br>This is caused by Inadequate budget to meet organisational demands and increasing unit cost prices / SLA costs<br>M12 2025/26 position: £10.77m cost pressures 2026/27 budget break even + £4.88m saving target 2026/27<br>M1 2026/27 position: £13.1m cost pressures 2026/27 budget break even + £4.88m savings target 2026/27<br>M2 2026/27 position: £12.9m cost pressure to 2026/27 budget break even + $4.88m savings target 2026/27<br><br>This will lead to an impact/affect on Clinical Governance - Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/ independent review. Low achievement of performance/delivery requirements. Critical report.<br><br>Workforce - Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (>1 day). Low staff morale. Poor staff attendance for mandatory/key training.<br><br>Finance - Non-delivery of key objective/ Loss of >1 per cent of budget<br>Reputational<br><br>Risk location, Health Board wide. | Budget holder 1-1 meetings with finance team (monthly)<br><br>Forecast meetings monthly with CCG leadership and Finance<br><br>CCG led finance meeting with finance team and each budget holder (monthly)<br><br>CCG FCG weekly (vacancy control admin and new roles includes Finance as standing member to highlight overall budget position)<br><br>Formally clarifying and escalation of cost pressures to executives via governance routes and Executive Recovery meetings.<br><br>Annual planning 2026/27 and planned 2027/28 engagement and submissions<br><br>Accountability letter returned by HoS and Service Director identifying significant risks to break even and savings target + summarised CCG risk profile. | Finance inc. claims | 4 | 5 | 20 | See audit trail for previous months updates.<br><br>Monthly 1-1s with HOS continue, allocation of underspend to savings will limit ability to mitigate cost pressures<br><br>September 2026- 138K overspend, month 5 position, forecast EOY improved from Â£2.1 M to 1.6M, improvement driven by Pathology drugs underspend. Ongoing cost pressures remain in N&D, OT, Pathology and Radiology. Current 1.6M forecast overspend largely reflects the impact of non-recurrent savings targets, without these, the CCG would broadly be breaking even at this point in the year.<br><br>August 2026 - Forecast deterioration to Â£2.14 deficit (driven by Â£1.6m non-recurrent savings, Â£1.4m clinical haem staffing cost pressure and Â£1.8m cost pressure OoH Everlight driven by ED and Inpatient demand - discussion with clinical medical leadership and require full clinical audit to understand demand to support any decision making.<br><br>Accountability letter returned by HoS and Service Director identifying significant risks to break even and savings target + summarised CCG risk profile. | Ensure that all requests relating to additional resource expenditure or allocation by budget holders are presented to and agreed at Therapy Operational Group with management team including workforce and finance colleagues | Reed, Lance | Completed | Process established at Therapy Operational Group 18.04.23.<br><br>Introduction of Financial control total process within departments and therapy operational group following Financial Control Total letter from CEO | Finance and Performance Committee | 3 | 5 | 15 | If the CCG is able to identify and implement cost pressure mitigation schemes and savings schemes.<br>The target scoring:<br>Finance domain.<br>Impact - 5: Non-delivery of key objective (non-compliance with accountability letter) / Loss of >1 per cent of budget (M12 2025/26 forecast Â£7.6m gap equates to 8% of Â£90m budget)<br><br>Likelihood / Probability - 3: 25-75% (reduced Â£ gap to Â£0 through successful mitigation of cost pressures/savings)<br><br>Target risk score aligned to new financial year and new financial risk profile. | Treat | 29-Sep-26 |
| | | | | | | | | | | | | | | | | There is a financial risk associated with claims due to malpractice, failure to provide or poor care provision. All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated | Reed, Lance | Completed | All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated | | | | | | | |
| | | | | | | | | | | | | | | | | Risk of delivering our financial control total and required savings plans | Bradburn, Jo | Completed | Draft financial savings plan in place, predicated upon budget holders delivering cash releasing recurring efficiencies against existing budgets, primarily via workforce redesign | | | | | | | |
| | | | | | | | | | | | | | | | | Risk to be redrafted with guidance from FBP to align with new CCG structure. | Quarrie, Sara | Completed | Meeting to be scheduled to redraft new risk.<br><br>Updated risk. | | | | | | | |
| | | | | | | | | | | | | | | | | M4 saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | 04/07/2025 - New action<br><br>11.07.2025 - M4 meetings completed. | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and capacity service review Podiatry | Mulroy, Mike | Completed | 11/07/2025 - New action<br>29.09.2025 - D&C work progressing to handover stage from DS to podiatry team. | | | | | | | |

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| | | | | | | | | | | | | | | | Therefore scoring remains unchanged as:<br>Finance domain.<br>Impact - 5: Non-delivery of key objective (non-compliance with accountability letter) / Loss of >1 per cent of budget (Â£7.6m gap equates to 8% of Â£90m budget).<br>Likelihood / Probability - 4: 75-95% probability (as Â£7.6m gap in mitigation of cost pressures / savings as of April 2026) | M5 saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | 11/07 - New action<br>29/08 - Due to A/l of service director this month the focus was on Pathology savings plans and Finance saving tracker validation which was completed by Finance and DJ head of pathology<br>30/9 M5 savings meetings took place on 07.09.26 | | | | | | | |
| | | | | | | | | | | | | | | | | M6 saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | 29/08 - new action<br>29.09.2025 - M6 savings meetings continued as planned | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and Capacity review - Paed OT - New to follow-up ratio and expected d/c each week to be reviewed and work to increase to 13 new patients and 13 discharges each week. | Adams, Jon | Completed | 29/09/2025 - new action<br>29.10.2025 - HoS reporting conversation underway with Team regarding this new to follow-up ratio. Extended due date to 31.12.2025.<br>Dec 2025 - Discussions with Service lead continue and ask for alternative solutions (to be generated by Service Lead) after three months of discussions. Extedned 31.01.2026<br>Feb 2026 - We are projecting an incremental improvement at Feb month end and this will continue. They are sourcing a venue (various options on the table) for a number of workshops which will see significant improvement in breach position in the next 4 months. | | | | | | | |

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| | | | | | | | | | | | | | | | | M7 saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | 29/9 - new action<br><br>29.10.2025 - shortened meetings took place with key services due to A/L in CCG leadership team. Action complete. | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and capacity - Hands and Rhum | Adams, Jon | Completed | 29.09.2025 - new action<br>29.10 - D&C work underway not yet completed further work required. Date extended to Nov 2025.<br>28/11/25 - Action complete and D&C handed over to OT service to continue. | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and Capacity - Adult SLT and Child SLT new patient D&C analysis and tool implementation | Thomas, Alison | Completed | See audit trail for previous updates.<br><br>27.04.2026 - Performance team (DS) update... Initial scoping complete (Adults, Child excluded as ways of working do not include OPD clinics as per model). Aim to finalise and h/o plans with automated data feed and instructions by end of April 2026. Therefore date extended to end of May to give time to present to CCG IG.<br><br>June 2026 - D&C update from David Shepard - New patient demand and capacity tools signed off and handed over to services 5th June 2026. Tools completed | | | | | | | |

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| | | | | | | | | | | | | | | | | Service review - Podiatry | Mulroy, Mike | Completed | 29/09 - new action<br>28/11/2025 - Service review underway extended deadline until Jan 2026 due to new process and team working through data sets.<br>30/03/2026 - pending final drafting, being chased by CCG leadership, extension of date to align.<br>27.04.2026 - Draft received at CCG IG April 2026. Feedback given and expected return in May CCG IG. Therefore date extended.<br>29.06.2026 - Feedback from HoS rescheduled to July 2026 CCG - therefore date extended.<br>Aug 2026 - submitted to CCG IG for Sept 2026 meeting, can close. | | | | | | | |
| | | | | | | | | | | | | | | | | M7 saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | 29/10 - new action<br>28/11/2025 - meetings took place to continue to work to mitigate cost pressures and identify savings. | | | | | | | |

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| | | | | | | | | | | | | | | | | M8 (Dec 2025) saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | 29/12/2025 - meetings took place as scheduled and top cost pressures and mitigations collated and submitted to Director of Finance on 24.12.2025 as per deadline given. M8 (in Dec 25) deep dive into cost pressures and mitigations indicates end of year forecast of £295k overspent:<br>* £224k cost pressure from FCP service funding withdrawal, pending 2026/27 Annual Planning outcome (mitigation = Agreement July 2025 that this would be off set by wider operations budgets<br>* 71k cost pressures (mitigation = being developed)<br>Work underway across services to take further mitigating actions. | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and capacity - Service review Occupational Therapy | Adams, Jon | ~~31/01/2026~~ 30/10/2026 | see audit trail for historic updates.<br><br>June 2026 - Update from service, due to cost pressure mitigations schemes needing to take priority this has been delayed. Date extended accordingly.<br><br>Aug 2026 - extended due date due to competing pressures. Draft service review for acute OT services tabled at CCG Governance on 22/09/26 | | | | | | | |

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| | | | | | | | | | | | | | | | | Annual Planning - AH and HS CCG submission to workshop 21/11/2025.<br>The care group has two re-occurring risk themes across the risk profile:<br>* Right sizing budgets (aka unmitigable cost pressures circa £1 731 332)<br>* Capacity vs Demand (circa £1 200 000) | Quarrie, Sara | Completed | To meet baseline and due to the extent of the financial gap in year one (2026/27) risks that only score 25, as per the organisations risk matrix, have been prioritised. his methodology leaves significant (risks scoring 20) that will need to be tolerated by the organisation including:<br>a decision to decommission FCP Physiotherapy (as risk score 15)<br>future stabilisation funding for demand and capacity imbalance across the CCG (that will adversely affect ability to meet WG targets - circa £9m cost). | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and Capacity - Service review SLT | Slaney-Jones, Emma | Completed | 29/12/2025 - New action<br>30/03/2026 - Service review is being completed at a national level for Paeds SLT therefore action places pending national timelines for review. | | | | | | | |

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| | | | | | | | | | | | | | | | | M9 (Jan 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | M 09 (Jan 26) review of financial position and preparation for escalation slides indicates forecast EOY of 172k, identified mitigation via enacting budgetary transfer in relation to FCP. Mitigations for forecast cost pressures 26-27 identified in CCG IG meeting held 17.01.26, service leads progressing the articulation of mitigations and impact to inform decision making. | | | | | | | |
| | | | | | | | | | | | | | | | | M10 (Feb 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | Feb '26 - end of year forecast of £33k overspent (mitigation via enacting budgetary transfer in relation to FCP). Presented to Director of Finance, COO and Director of Strategy and Planning (09/02/2026 Contingent Finance Touchpoint - Allied Health and Health Sciences) 2026/27 cost pressure to break even £10.77m. Mitigation strategies "highly probable" of £4m, gap to mitigate £6.77m. 20.02.2026 Cost pressure mitigation schemes of £6.2m submitted to Director of Finance and COO for decision to progress. Further schemes being developed gap of £4.5m. | | | | | | | |
| | | | | | | | | | | | | | | | | M11 (March 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | Completed | New action 30/03/2026 - meeting took place 09/03/2026 as scheduled | | | | | | | |

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| | | | | | | | | | | | | | | | | 2026/27 Cost pressure (£10.77m) mitigation schemes to be shared with Director of Finance and Chief Operating Officer | Quarrie, Sara | Completed | Cost pressure mitigation schemes of £6.2m submitted to Director of Finance and COO for decision to progress. Further schemes being developed gap of £4.5m. | | | | | | | |
| | | | | | | | | | | | | | | | | Cost pressure mitigation scheme (£4.5m gap as of 23/02/2026) submission to Director of Finance and Chief Operating Officer | Quarrie, Sara | Completed | 20.02.2026 Cost pressure mitigation schemes of £6.2m submitted, Gap of £4.5m remains | | | | | | | |
| | | | | | | | | | | | | | | | | Paeds OT 14 week breech - clinic and workshop implementation (13 new patients 13 d/c per week D&C target) projecting an incremental improvement at Feb month end and this will continue and see significant improvement in breach position in the next 4 months. | Adams, Jon | Completed | Feb 2026 - Clinic and workshop implementation commenced.<br>June 2026 - improved trajectories noted with capacity increases improving flow. | | | | | | | |
| | | | | | | | | | | | | | | | | Demand and Capacity - Physiotherapy new patient D&C analysis and tool implementation | Davies, John | ~~30/04/2026~~ 31/10/2026 | D and C analysis completed as part of SBAR submitted to CCG in May 2026 relating to shifting demand on CMATs due to changes to community health pathway and radiology pathway changes. Detail in appendix. Additional D and C work to be undertaken with DS in relation to new CCG D and C methodology. Next meeting planned for 10/09/26. Target for C and D analysis by 15/10/26 | | | | | | | |

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| | | | | | | | | | | | | | | | | Demand and Capacity - N&D new patient D&C analysis and tool implementation | Roberts, Sarah | ~~30/04/2026~~ 30/10/2026 | See audit trail for prev updates.<br>August 2026 - Paused due to capacity needed to support urgent Radiology data issue, date extended accordingly. | | | | | | | |
| | | | | | | | | | | | | | | | | M12 (April 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings. | Quarrie, Sara | **Completed** | 30/03/2026 - new action<br>Apr 26 - Executive recovery meeting completed (16.04), reporting £11.6m breakeven deficit (Cost pressure mitigation schemes: likely £5.7m, probable £2.3m and unlikely £5.7m) + unmet savings target £4.1m (£0.8m schemes identified for £4.9m target). Accountability letter returned by HoS and Service Director identifying significant risks to break even and savings target + summarised CCG risk profile. | | | | | | | |
| | | | | | | | | | | | | | | | | M1 (May 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings | Quarrie, Sara | **Completed** | April 2026 - New action<br>May 2026 - meetings took place in May. | | | | | | | |
| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Radiology - OoH Everlight reporting TAT reduction from 1hr to 4hrs releasing £400k.<br>Initial discussion with CIC Service director. | Quarrie, Sara | **Completed** | Initial discussions with CIC Service Director held 24.04.2026. Agreement sensible cost pressure mitigation scheme. Next steps to scope risk profile for CIC and add to draft SBAR. | | | | | | | |

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| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Physiotherapy/FCP - meeting 09/04/2026 AC, JD and SQ. Next steps - confirmation of funding/commissioning arrangements communication to CCG from AC. | Quarrie, Sara | Completed | In email FCP, Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer) explains that the First Contact Practitioner service has not released secondary care capacity and remains an unfunded cost pressure to the COO budget not PT. While demand justifies the model, funding is unclear. He proposes a wholeâ€‘system MSK pathway review, aligned to national guidance, progressed through Care by Design. | | | | | | | |
| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Physiotherapy/FCP - Arrange FCP budget transfer to COO direct budget lines (with HoS (JD) remaining day to day budget management). | Quarrie, Sara | Completed | April 2026 - Requested Finance Controller (SN) request budget movement from AH and HS CCG to COO budget hierarchy.<br><br>June 2026 - Finance meeting in June 2026 confirm budget transfer complete. | | | | | | | |
| | | | | | | | | | | | | | | | | Cost pressure and Savings mitigations - SBAR submission - Agree whether to progress appraisal of options to address the Allied Health and Health Sciences Clinical Care Group's FY26/27 forecast £7.7m underlying recurrent deficit and savings gap, informing deliverability, risk, impact and de-risking of the Health Board financial plan. | Quarrie, Sara | Completed | SBAR submitted to COO office as per deadline. | | | | | | | |

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| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Physiotherapy - Reduce Variable Pay - Stop unfunded weekend Ortho / unsocial intermediate care / Tocals work releasing £100k. Initial discussion with CIC Service director. | Quarrie, Sara | Completed | Initial discussions with CIC Service Director held 24.04.2026. Agreement sensible cost pressure mitigation scheme. Next steps to scope risk profile for CIC and add to draft SBAR. | | | | | | | |
| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Physiotherapy - Reduce Variable Pay - Stop unfunded on-call acute work releasing £80k. Initial discussion with CIC Service director. | Quarrie, Sara | Completed | Initial discussions with CIC Service Director held 24.04.2026. Agreement sensible cost pressure mitigation scheme. Next steps to scope risk profile for CIC and add to draft SBAR. | | | | | | | |
| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Stop unfunded Service Gap (Heart Failure Triage test for Cardiology) releasing £85k. Initial discussion with CIC Service director. | Quarrie, Sara | Completed | Initial discussions with CIC Service Director held 24.04.2026. Agreement sensible cost pressure mitigation scheme. Next steps to scope risk profile for CIC and add to draft SBAR. | | | | | | | |
| | | | | | | | | | | | | | | | | Unlikely cost mitigation scheme - Occupational Therapy - Withdraw unfunded stroke w/e provision releasing £3k. Initial discussion with CIC Service director. | Quarrie, Sara | Completed | Initial discussions with CIC Service Director held 24.04.2026. Agreement sensible cost pressure mitigation scheme. Next steps to scope risk profile for CIC and add to draft SBAR. | | | | | | | |
| | | | | | | | | | | | | | | | | M2 (June 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings | Quarrie, Sara | Completed | June 2026 - completed finance meetings | | | | | | | |

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| | | | | | | | | | | | | | | | | M3 (July 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings | Quarrie, Sara | Completed | June 2026 - New action July 2026 - Savings meetings took place forecast has detiorated: £844,794 overspend in end of year position (£219k vacancy lag and income overperformance moved to savings from supporting budget breakevem) | | | | | | | |
| | | | | | | | | | | | | | | | | M4 (August 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings | Quarrie, Sara | Completed | Meetings took place as scheduled.<br>Forecast for end of year deteiroated due to £1.6m non recurrent savings increase from prediected vacancy lag and income over performance + £1.8m Everlight OoH overspend and £1.4m Medical Agency overspend clinical haem.<br>In month position (£90k overspent) driven by £160k move from vacancy lag and income overperformance to savings + cost pressures OoH Everlight, Medical Agency clinical Haem. | | | | | | | |
| | | | | | | | | | | | | | | | | M5 (Sept 2026) saving meetings with each HoS to identify further mitigation for cost pressures and savings | Quarrie, Sara | 30/09/2026 | Aug - new action | | | | | | | |

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| | | | | | | | | | | | | | | | | SBAR escalation - Allied Health and Health Sciences Clinical Care Group has identified £5.022m of Month 4 cost pressures that cannot be mitigated through budget virement within existing delegated limits. In line with Standing Financial Instructions, this paper seeks Chief Executive approval for those cost pressures, advised by the Executive Director of Finance. | Quarrie, Sara | **Completed** | SBAR approved at CCG IG (18.08.2026). Submitted to Delivery Review meeting scheduled 28.08.2026.<br>30/9 - SBAR tabled at finance recovery meeting 10.09.26, ensuring Executive Director of finance is aware | | | | | | | |
| | | | | | | | | | | | | | | | | Cost pressure mitigation SBAR escalation - The current orthopaedic weekend physiotherapy service operates through unfunded overtime and voluntary arrangements. While it supports patient flow, and compliance with national hip fracture standards, it presents ongoing financial, workforce, and quality risks. | Davies, John | ~~30/09/2026~~ 30/10/2026 | Aug - Paper has been shared and feedback gained from County GMs. JD to submit updated SBAR to CCG Ig Sept 2026.<br>30/9 SBAR not tabled at Sept CCG, due to Service Director absence reschedule for Oct | | | | | | | |
| | | | | | | | | | | | | | | | | Cost pressure mitigation SBAR escalation - The physiotherapy respiratory on-call service provides essential out-of-hours support for high-risk acute patients across all hospital sites, but has no recurrent funding. Reliance on vacancy lag creates a forecast £81.5k-£95k cost pressure for 2026/27, reducing core physiotherapy capacity and increasing patient safety, workforce, performance. | Davies, John | ~~30/09/2026~~ 31/10/2026 | Aug - Paper has been shared and feedback gained from County GMs. JD to submit updated SBAR to CCG Ig Sept 2026.<br>30/9 - SAVR not tabled at Sept CCG due to Service Director absence, reschedule for Oct | | | | | | | |

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| | | | | | | | | | | | | | | | | Cost pressure SBAR -The TOCALS therapy element at Glangwili General Hospital supports admission avoidance, patient flow and early discharge. However, current delivery includes unfunded elements, including a vacant Band 6 physiotherapy post and voluntary weekend cover. A sustainable delivery model is required to align service provision with available funding and manage associated patient flow risks | Davies, John | 30/10/2026 | CCG IG discussion and support for discussion with CIC CCG re funding or accept risk as funding terminated. | | | | | | | |
| | | | | | | | | | | | | | | | | Cost pressure mitigation - Everlight OoH cost pressure discussion with Clinical Leadership | Quarrie, Sara | **Completed** | Meeting took place: Thank you for the meeting today.<br>Summary: Following discussion on out-of-hours (OoH) imaging, MRI activity was reviewed and found to be largely driven by ED and emergency spinal cases. Auditing against Health Board guidelines could reduce inappropriate scans, although potential savings (£30k) were not considered a priority. Greater value is likely achievable through reducing OoH CT demand via pathway redesign and specialty-led review (including clinical audit of demand to validate the risk) | | | | | | | |

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| 971 | Mental Health and Learning Disabilities | Mental Health and Learning Disabilities | MHLD | Carruthers, Andrew | Carroll, Mrs Liz | Carroll, Mrs Liz | Carroll, Mrs Liz | 01-May-20 | There is a risk of the MH&LD Directorate failing to remain within their allocated budget over the medium term.<br><br>This is caused by the inability to either:<br>Identify and deliver robust and realistic recurrent savings plans.<br><br>Manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement.<br><br>Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved.<br><br>This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability.<br><br>Risk location, Health Board wide. | Finance Business Partners work closely with budget holders to support informed decision making and ensure that there is sufficient focus on the financial implications of operational pressures and mitigating actions.<br><br>There are regular financial reviews where this risk is considered, including a monthly financial review of the Directorate's in-month performance, a monthly update of our full year annual forecast and an annual update of our following year financial plan.<br><br>Risk Register is a standing agenda item at BP&PAG on a bi-monthly basis. End of month meeting with Directorate Finance Business Partner, KPI meetings and individual Head of Service meetings are also forums for monitoring the position and informing and managing the forecast.<br><br>Mechanism in place to draw down funding to service cost codes inline with original bids.<br><br>Weekly key performance meetings in place for areas working outside of | Finance inc. claims | 4 | 4 | 16 | As at July 2025, the Clinical Care Group are Â£342,000 overspent. This position is driven by use of private beds, medical staffing and CHC costs. The Clinical Care Group continue to identify further non recurrent/recurrent saving opportunities.<br><br>There have been different approaches adopted by finance colleagues to the forecasting for the commissioning full year spend. This has resulted in the end of year forecast now being predicated at Â£1.6m overspend. | Leon Popham to review impact of CHC uplift reserve on position and determine treatment and risk level on an ongoing basis.<br><br>To provide an update for Executive Team to clarify the budget setting process and allocation for FY 2024/25. | Popham, Leon<br><br>Carroll, Mrs Liz | **Completed**<br><br>**Completed** | Review undertaken as part of ongoing budget processes. While action unresolved, this will be picked up as part of the new action noted for the risk in September 2023.<br><br>CHC overspend neutralised for 2024/25 allocation through £1.9M uplift relating to 2022/23 and operational driver funding remaining pressure.<br><br>Directorate have undertaken to identify £2.6M of non-recurrent savings for 2024/25 for underspend in pay position, with a view of identifying recurrent saving 2025/26. | Finance and Performance Committee | 1 | 3 | 3 | Working towards a position where 6.5% savings are identified and to remain within budget. | Treat | 24-Sep-26 |

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| | | | | | | | | | | allocated budgets in collaboration with Senior Finance Business Partner.<br><br>MHLD is in Escalation for Finance due to the lack of a 6.5% recurrent savings plan. Directorate are meeting weekly to progress plans.<br><br>Directorate also attend Health Boards Integrated Quality Financial Performance Delivery Group (IQFPDG). | | | | | | Following Executive Director led recovery workshops on the 26th of July and the 9th of August the Directorate were tasked to consider the impact on services should variable pay be eliminated. The ask also involved service reconfiguration on this basis. | Carroll, Mrs Liz | ~~29/03/2024~~ ~~30/09/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ ~~31/03/2026~~ ~~31/06/2026~~ 30/09/2026 | CCG continues to work with Corporate services to strengthen Nurse Bank capacity/eliminate spend. Update on inpatient recruitment is being collated for each ward. Further options being explored through international recruitment for Medical staff. Additional funding of £2.4m has been allocated with an associated recruitment plan. Additional establishment in place and majority of posts now appointed to. Additional fixed term posts to deliver S136 suite in progress. Fixed term nature given uncertainty regarding final location of S136 suite. | | | | | | | |
| | | | | | | | | | | | | | | | | Work to identify recurrent savings for 25-26 underway. First phase to be transacted by end of February 2025. | Carroll, Mrs Liz | **Completed** | Completed | | | | | | | |

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| 2174 | Operational Allied Health Professions & Health Sciences | AHP&HS: Physiotherapy | AHP&HS: Physiotherapy | Carruthers, Andrew | Quarrie, Sara | Davies, John | Griffith, Susan | 10-Sep-25 | There is a risk of that Intermediate Care (IC) physiotherapy services are not sustainable due to RIF funding ending in March 2027. Any reduction on service provision will lead to poorer outcomes for patients and is likely to result in opportunities for avoidable admissions to be missed.<br><br>This is caused by £885K of IC workforce is currently funded by RIF and the funding is due to end in March 2027. There is significant uncertainty around future funding opportunities. Physiotherapy services do not have sufficient budget or capacity to absorb the cost.<br><br>This will lead to an impact/affect on poorer outcomes for patients who are either admitted to hospital or who have longer length of stay, resulting in | Funding is currently in place until March 2027.<br>The physiotherapy service is engaged in 'future funding workshop process'<br>The physiotherapy service is engaged in integrated forums. Current RIF funded services appear to be valued and outcome reports to WAG show positive impacts. | Safety - Patient, Staff or Public | 4 | 4 | 16 | Whilst services are currently funded until March 2027, there is currently no sustainability or exit strategy. Recognising the lead in time for annual planning processes, the risk impact has been scored as 4. This is to ensure that the risk is visible to the organisation in sufficient time to inform decision making. | Set up Physiotherapy workstream/ forum with key stakeholders to review the evidence for current service model and agree metrics to inform business case development for RIF 'future funding' process. | Davies, John | **Completed** | Data collated in Physio service / finance MS team to support SBAR development | Finance and Performance Committee | 1 | 4 | 4 | The future funding process is in its early stages. There is not an imminent risk to decommissioning of RIF funded services. | Treat | 21-Sep-26 |

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| | | | | | | | | | deconditioning.<br>Adverse impact on flow through acute and community system.<br>Delays in unscheduled care.<br>Increased avoidable admissions to hospital.<br>Poorer quality discharge with increased risk of re admission.<br>Withdrawal of entire community falls service and entire pelvic health service in Ceredigion.<br>Withdrawal of entire Intermediate Care Service and A&E service in Pembrokeshire.<br>Entire withdrawal of Front of House services in both acute sites as well as further impact on stroke services in Carmarthenshire. Reduction of activity in Carmarthenshire community hospitals by at least 50%<br><br>Risk location, Health Board wide. | | | | | | | | develop SBAR and submit to CCG, that outlines exit strategy if comisioning for RIF funded services does not continue from April 2027 | John Davies, | Completed | Initial draft of paper to be submitted to CCG IG forum for May 2026 | | | | | | | |

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| 2175 | Operational Allied Health Professions & Health Sciences | AHP&HS: Physiotherapy | AHP&HS: Physiotherapy | Carruthers, Andrew | Quarrie, Sara | Davies, John | Griffith, Susan | 10-Sep-25 | There is a risk of that the pelvic health service in Ceredigion will not be sustainable when RIF funding ends in March 2027.<br><br>This is caused by Feedback from Regional Partnership Board has been that the project does not meet eligibility criteria for future funding from March 2027<br><br>This will lead to an impact/affect on poor outcomes for patients with pelvic health conditions with increased risk of developing chronic conditions.<br>It could also lead to increased avoidable referral into secondary care consultant led services.<br><br>Risk location, Ceredigion. | Funding is currently in place until March 2027.<br>A pelvic health service is currently being delivered for patients in Ceredigion. | Safety - Patient, Staff or Public | 4 | 4 | 16 | Whilst services are currently funded until March 2027, there is currently no sustainability or exist strategy. Recognising the lead in time for annual planning and implementation processes, the risk likelihood has been scored as 4. This is to ensure that the risk is visible to the organisation in sufficient time to evaluation and decision making regarding future funding options. The impact is scored at 4 as decommissioning would lead to in equitable care for patients and poorer outcomes. | Development of SBAR / business case to inform discussions as part of annual planning and 'RIF future funding' process | Griffith, Susan | ~~30/11/2025~~ 30/10/2026 | 29/09/25- SBAR in development 30/10/25-SBAR in progress for presentation. Sue has highlighted upcoming RIF meetings to ensure AHP representation. 18/11/25 SBAR in development. 29/12/25-RIF future funding meetings continue. 30/03/26-SBAR in progress. No other updates. Requirement for paper flagged in physio PPP governance meeting 7/05/26. Deadline extended due to other service pressures/ priorities. 01/07/26. Update on timeline for draft SBAR requested AP/SG. 21/9/26 first draft of paper to be circulated to Pelvic health SDM By end of Sept | Finance and Performance Committee | 4 | 1 | 4 | A key action is the development of a business case to be considered through annual planning processes. If this is successful then the target score could be realised. It is difficult at this stage to gauge the likelihood of success in this process. | Treat | 21-Sep-26 |

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| 1892 | Operational Allied Health Professions & Health Sciences | AHP&HS: Radiology | AHP&HS: Radiology | Carruthers, Andrew | Quarrie, Sara | Roberts-Davies, Gail | Roberts-Davies, Gail | 26-Jul-24 | There is a risk of that Radiology will not achieve projected savings targets.<br><br>This is caused by unidentified savings plans to reduce expenditure in the directorate.<br><br>This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan.<br><br>Risk location, Health Board wide. | 1. Monthly meetings with Head of Radiology, Site Leads and Finance Business Partner to oversee progress on saving plan workstreams<br>2. Introduction of 5/5 locum consultants to undertake reporting and emergency duty sessions to reduce outsourcing, via a graded approach of most costly elements of outsourcing, including out of hrs rotas to cover busiest times.<br>3. Scrutiny of individual budgets by finance and Head of Radiology to capture any erroneous spend<br>4. All vacancy proposed by sites to be approved by Head of Radiology prior to finance Trac sign off or application for FCG approval as appropriate.<br>5. Other cost avoidance measures, e.g. increased additional reporting sessions for HB consultants utilised in place of outsourcing at higher cost to maintain and improve quality and performance. | Finance inc. claims | 4 | 4 | 16 | Recurrent and non-recurrent savings were identified, however these did not achieve the 5% expected. The budget position at M12 24-25 for Radiology was Â£92k underspent (provisional figure)with savings of Â£669k achieved.<br><br>As of 09/04/2025 Radiology investment in workforce has been agreed and is currently subject to case scrutiny by the Executive Team.<br><br>The Allied Health Professions and Health Sciences CCG has an opening savings position of Â£3.744m to be achieved in 25-26, of this Â£873k is the opening savings target for Radiology. | To review historic charges for Powys patients attending Hywel Dda with a view to arranging an SLA and understand LTA arrangements.<br><br>To scope the feasibility of and any potential savings from changing the current on-call arrangements for Radiographers to a shift system across the four main sites. | Roberts-Davies, Gail<br><br>Roberts-Davies, Gail | ~~01/01/2025~~ ~~31/03/2025~~ 31/03/2026 ~~31.5.26~~ 31/03/2027<br><br>**Completed** | Update from VBHC team as of 11/02/2025:<br>We're currently working with Chris James from Data Development to move this piece of work forward. Still ongoing. As of August 2026 work is progressing in this space and service is due to meet with RJ (assistant Finance Director) in early Sept 2026 to discuss next steps<br><br>This is progressing but is very complex so will take longer to deliver. In line with the annual plan, the first step will be to increase the numbers of MRI and CT Radiographers and reporting Radiologists via investment to extend the working day and week to increase capacity and reduce variable pay and improve VFM. Shift systems in these areas is not possible at this time due to the low numbers of existing staff.<br><br>This action is to be closed as the workforce investment opportunity work supersedes this action which was not able to be progressed due to low staffing numbers. Shift system feasibility is described as part of the 2024/25 annual plan which has been set over a 3 year context | Finance and Performance Committee | 3 | 4 | 12 | Likelihood reduce therefore reduce in score | Treat | 28-Sep-26 |

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| | | | | | | | | | | | | | | | | Recruit a fourth locum Radiologist to enact the proposed level of savings from reduction in outsourcing | Roberts-Davies, Gail | **Completed** | Action complete | | | | | | | |
| | | | | | | | | | | | | | | | | Explore opportunities for income from dental practices referring for OPT examinations | Roberts-Davies, Gail | ~~01/01/2025~~ ~~31/03/2025~~ ~~31/03/2026~~ ~~30/06/2026~~ ~~30/09/2026~~ 30/10/2026 | Discussed at TI meeting August 2024 and responded to the collective submission for permission from WG on 21/1/2024. Awaiting feedback following this.<br>Feb 2025 update- GRD has received queries from SN- due to discuss on 26/02/2025.<br><br>This will be taken forward to the 25/26 financial year and progressed via the new CCG structure. | | | | | | | |
| | | | | | | | | | | | | | | | | Review charges which constitute the historic SLA with SBUHB for Medical Physics Services to ascertain potential opportunities. | Roberts-Davies, Gail | **Completed** | The review ascertained that historically Radiology have been charged for Medical Physics Support to Theatre and Community Dental Services. This has been since separated out and costs past on to the respective services. | | | | | | | |
| | | | | | | | | | | | | | | | | To review cardiac catheter consumables and ascertain if less expensive alternatives can be purchased. | Roberts-Davies, Gail | **Completed** | Action complete | | | | | | | |
| | | | | | | | | | | | | | | | | Provide mitigating actions for the projected EOY overspend at Month 3 of £39.5K | Roberts-Davies, Gail | **Completed** | Mitigating Action was provided to the Monthly Radiology Escalation Meeting | | | | | | | |

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| | | | | | | | | | | | | | | | | To formulate savings scheme plans for the 25/26 financial year | Roberts-Davies, Gail | Completed | Savings plan have been reviewed in September 2025 | | | | | | | |
| 1906 | Community & Integrated Medicine | Pembrokeshire Integrated System | Withybush General Hospital: WGH | Carruthers, Andrew | Skitt, Peter | Svetz, Jess | Matthews, Joseph | 16-Aug-24 | There is a risk of that the Directorate will overspend against its delegated budget and declared savings plans.<br><br>This is caused by Delivery of savings and adherence to delegated budgets is constrained by maintaining fragile services and lack of a clear roadmap to shift care left. OCP2 changes may further impact financial grip and accountability. Short-term cost actions risk driving inefficiencies and higher downstream costs, affecting sustainability.<br><br>This will lead to an impact/affect on remaining within Statutory Financial Duty in year and the inability to de-escalate from Welsh Government's Target Intervention status.<br><br>Risk location, Pembrokeshire, Withybush General Hospital. | Finance Business Controllers work closely with budget holders to support informed decision-making, ensuring clear visibility of financial implications arising from operational pressures and proposed mitigations. Robust governance is in place through monthly finance meetings to review outturn, agree and sign off year-end forecasts, and scrutinise delivery with the Deputy Head of Business Control, with a clear focus on mitigating actions and consequence management to reduce spend.<br><br>Monthly financial scrutiny meetings with senior nursing leaders provide additional assurance on budget management, with particular focus on variable pay controls. A weekly control group reviews all vacancies and new cost pressures to ensure appropriate challenge, prioritisation, and affordability.<br><br>The Finance Business Partner Opportunities Framework has been refreshed to identify alternative models of working that support cost reduction and enable the development of formal savings schemes. This is complemented by engagement in value-based projects aimed at reducing low-value activity and improving productivity.<br><br>Targeted controls are in place to reduce premium costs, including defined exit strategies for variable pay, implementation and monitoring of rate card compliance, and strengthened oversight of agency and bank usage. In addition, a pipeline of cost improvement has been established, including eight cost-saving PIDs currently in development/delivery to support financial recovery and sustainability. | Finance inc. claims | 4 | 4 | 16 | The operational pressures, fragility of the medical workforce in medicine and emergency department and the complexity management of patients is creating cost pressures due to reliance on agency, bank and security. CHC is an ongoing cost pressure. Continuing to run current services on the site is making it unrealistic to delivery the savings needed without major service configuration and workforce redesign. | 5% reduction in costs of revenue within annual plan. | Andrews, Bethan | Completed | We have achieved non recurrent savings due to vacancies, however, this is not a sustainable position. | Finance and Performance Committee | 3 | 4 | 12 | The system requires time to realise and deliver the savings due to strategic, high-level decisions to be made. Whilst the system is required to realise savings must balance this with patient safety and quality of services and other requirements of TI. | Treat | 21-Sep-26 |
| | | | | | | | | | | | | | | | | reduction of in patient beds by 25 since pre RAAC. Puffin ward now closed | Andrews, Bethan | Completed | completed | | | | | | | |
| | | | | | | | | | | | | | | | | Recruitment of newly qualified nurses and international nurses. | Thomas, Carol | Completed | ongoing<br>Recruitment continues were required. | | | | | | | |
| | | | | | | | | | | | | | | | | Recruitment of medical staffing to reduce reliance on locums. | Andrews, Bethan | Completed | recruitment continues as required to reduce reliance.<br>Recruitment continues but due to the fragility of workforce and no prospective cover for ED doctors, we rely on agency. | | | | | | | |
| | | | | | | | | | | | | | | | | Review of compendium of variation to identify additional savings | Svetz, Jess | Completed | Meeting to be arranged | | | | | | | |
| | | | | | | | | | | | | | | | | Develop a 90 day plan for cost savings | Svetz, Jess | Completed | Developing a draft to share with my senior team | | | | | | | |
| | | | | | | | | | | | | | | | | Development of PIDs and QIAs for identified areas of opportunities | Svetz, Jess | Completed | Identified a number of cost saving opportunities with agreed SROs and working through the PIDs and QIAs. | | | | | | | |

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| | | | | | | | | | | | | | | | | Review scheme of delegation and all cost centre to ensure alignment at the appropriate level | Svetz, Jess | Completed | Reviewed and now moving towards implementation | | | | | | | |
| | | | | | | | | | | | | | | | | Pipeline Cost saving schemes are being worked through to move from red to amber/green | Svetz, Jess | Completed | PIDs developed and meetings taking place with each PID owner | | | | | | | |
| | | | | | | | | | | | | | | | | Ongoing risks being added to the register to evidence fragility of services and have actions to mitigate the safety and financial impact | Svetz, Jess | Completed | Added Respiratory pathway, Emergency Medicine, ED Consultant and Medicine Consultant risk | | | | | | | |
| | | | | | | | | | | | | | | | | Workshop to be held to explore further opportunities which will be organised by Peter Skitt and Andrew Lewis | Skitt, Peter | ~~30/09/2026~~ 31/10/2026 | Following our weekly financial escalation meeting, it was a proposed a workshop is organised to explore what services we would need to de-commission and work through invest to save business cases | | | | | | | |
| | | | | | | | | | | | | | | | | Self assessment framework of grip and control to be completed with improvement plan | Riggs, Joanne | Completed | Completed the first version of the self assessment. Submit to CCG FCG 28th July for sign off. Improvement plan 11th August | | | | | | | |
| | | | | | | | | | | | | | | | | Variable pay spend conversion to substantive funding business case | Svetz, Jess | ~~31/08/2026~~ ~~30/09/26~~ 31/10/26 | Successfully agreed an additional 1 WTE ED Consultant. Working with Medical Directorate on Tier 1, Tier 2 and Medical Consultant Business case. Work still progressing. Still waiting for the substantive funding business case | | | | | | | |

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| 2167 | Operational Allied Health Professions & Health Sciences | AHP&HS: Podiatry & Surgical Appliances | AHP&HS: Podiatry and Surgical Appliances | Carruthers, Andrew | Quarrie, Sara | Evans-Bundy, Katie | Evans-Bundy, Katie | 02-Jul-22 | There is a risk of of service fragility and substandard patient care within the Podiatry & Orthotics services.<br><br>This is caused by unavoidable increase in consumables which has resulted in overspend to non-pay budget. Approximately £150,000, based on end of year financial forecast. This overspend was identified in 2023, and has continued to increase. This is primarily due to a 33% increase for contract Orthotic products unit price as a result of inflationary pressures. Increase of 20% with particular companies due to Iran war.<br><br>This will lead to an impact/affect on patient care and safety<br>staff burnout due to inability to recruit<br>reduction to service delivery<br>reputational damage to the health board which will cause future recruitment challenge<br>uncertainty to delivery of key objectives for the service<br>increased complaints, litigation and patient safety incidents (with associated risk of administrative burden)<br>decrease of flow of patients through the health care system<br>increasing waiting times<br>withdrawal or reduction of support to SDEC, MIU and other non-core pathways<br>more stress on other services<br><br>inability to safeguard people with disabilities<br>Withdrawal or reduction of support to SDEC, MIU and other non-core pathways<br><br>Risk location, Health Board wide. | Shared Services benchmarking has shown that even with these increases NHS Wales is still receiving best price when compared to what NHS England and Scotland are paying.<br><br>Orthotics contracts currently being renegotiated could potentially result in reduction of spend.<br><br>Patients are continuously triaged and robust measures taken to assess whether patients are meeting strict eligibility criteria to receive products and interventions. Patients are signposted to purchase products commercially if they are available.<br><br>Effective triaging reduces spend by employing strict eligibility criteria.<br><br>Effective financial management in service has resulted in consistent overspend from year to year, with a focus on cost-effective solutions for patients. | Quality/Complaints/Audit | 3 | 5 | 15 | The Domain of the risk is set as "Quality" based on the risk Impact i.e. sub-standard service. The Inherent Likelihood score has been set as 25 as without appropriate funding, the likelihood of service fragility leading to sub-standard care may increase.<br><br>Currently, control measures are ensuring minimal impact on patients, however, further restrictions on budget would present some difficult financial challenges and further increase the likelihood of service fragility. The most recent 2 Orthotics contracts have been re-negotiated which have helped to reduce spend marginally. However, other products are continuing to increase in price. As an ongoing control measure this will be monitored regularly.<br><br>An SBAR is being submitted in line with annual planning requirement to articulate options to fully mitigate cost pressure, and reduce likelihood of service fragility. This will ensure that patients will continue receive the appropriate level of service from Podiatry & Orthotics in the future. Decision required from the SBAR as to whether the forecasted financial consumables overspend of | Ensure submission to 2026/27 Annual Planning cycle for uplift of Orthotics budget by £200k. | Mulroy, Mike | Completed | Awaiting outcome of previous action.<br>17.02.26 update- Annual planning template to request funding was submitted by CCG directors 12.01.26, in line with organisational process | Finance and Performance Committee | 1 | 5 | 5 | An increase in Podiatry & Orthotics budget to offset the overspend and allow a buffer for further cost increases and reflect the annual costs of the service would reduce the likelihood of noted risks that would be caused by further overspend.<br><br>There is always the possibility of future cost increases, however in the case of this risk, the jump in cost was unprecedented and may require some steer on how best to deal with the financial challenges this poses to the service and the impact this is having on patient care.<br><br>TRS date has been further extended to June `27 to account for annual planning process.<br><br>Should the annual planning proposal be successful the likelihood will become negligible i.e. target likelihood score of 1 as patients are unlikely to receive a substandard service as a result of this risk and the risk will be mitigated. | Treat | 17-Sep-26 |
| | | | | | | | | | | | | | | | | Risk to be escalated via CCG to Executive risk meeting for steer on financial challenges | Mulroy, Mike | Completed | SBAR updated and resubmitted on 27/11/25 by request to CCG meeting 17/12/25. To confirm whether with CCG Director whether this has been escalated to IQFPD. 25/3/26 - SBAR presented in CCG 3Ps on 17/3/26. Await decision. 17/02/26.Updating SBAR in line with annual planning requirement to articulate options to fully mitigate cost pressure from 01.04.26. Due to be submitted to CCG 17th Feb, to align with HB timeline submission to EDF by 21.02.26. decision needed by by mid-March/next risk review date | | | | | | | |

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| | | | | | | | | | | | | | | | Â£150,000 will be approved.<br><br>The current impact score is 5, as there is evidence that the most catastrophic consequences for patients (e.g amputation rate) are currently increasing. The current likelihood score is 3 due to the possibility of harm to patients. However, should annual planning proposal be unsuccessful the likelihood will increase due to service fragility. | SBAR submitted to exec for Annual planning submission- deferred to 2027 for review | Mulroy, Mike | **Completed** | Decision needed to continue with service or restrict new products. Submitted to CCG IG - decision that options are not viable. Will escalate as per SFI guidance issued June 2026 for CEO approval of overspend in 2026/27. | | | | | | | |
| | | | | | | | | | | | | | | | | Funding - Escalate SBAR on 2026/27 overspend for CEO decision (£130,000.00 required). | Quarrie, Sara | ~~31/08/2026~~ 30/10/2026 | Risk forms part of annual planning process. | | | | | | | |
| | | | | | | | | | | | | | | | | Contract management - Eureka contract negotiations underway in July 2026 (may increase cost pressure) | Evans-Bundy, Katie | ~~31/07/2026~~ 30/10/2026 | Awaiting update on new contract prices | | | | | | | |
| | | | | | | | | | | | | | | | | HB review of product formulary | Mulroy, Mike | **Completed** | Orthotics review team to further update catalogues and product formulary | | | | | | | |

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| 2148 | Operational Allied Health Professions & Health Sciences | AHP&HS: Occupational Therapy | AHP&HS: Occupational Therapy | Carruthers, Andrew | Quarrie, Sara | Adams, Jon | Adams, Jon | 15-Aug-25 | There is a risk of to the Primary Care OT budget for 2027/28 which will have a significant affect on the service's delivery model and ongoing sustainability of the service.<br><br>This is caused by mainstreaming of Regional Integration Fund (RIF) from March 2027 (withdrawal of funding has been confirmed).<br><br>This will lead to an impact/affect on significant cost pressures within the Occupational Therapy Budget from March 2027.<br><br>This will inevitably have a large impact on service delivery if we need to pause or stop some services that don't meet WG criteria.<br><br>The PCOT roles will likely need to be absorbed into core funding to address emerging RIF cost pressures. The risk is that this transition will impact our ability to deliver the service in its current form as there will be increased pressure to maintain core Health Board delivery, resulting in a potential loss of capacity to work proactively and preventatively in the ICN.â€‹<br><br>Risk location, Pembrokeshire. | Regular (monthly) meetings with finance partners to review budgets.<br><br>Meetings with RIF project team to review project outcomes<br><br>Reviewing any vacant posts funded through RIF to consider options<br><br>Exit strategies reviewed and presented to CCG in September | Finance inc. claims | 3 | 5 | 15 | Some control measures in place but risk remains due to no allocated budget for staff currently funded through RIF.<br><br>As at June 2026, it was calculated that the cost pressure on next year's Occupational Therapy Budget is approx. Â£700K.<br><br>Risk framework justification:<br>* Impact = Loss of >1 per cent of budget<br>* Probability = 3 (75-95)%<br><br>The probability that this will occur has reduced following a letter from WG on 25/09/26 confirming that funding for integrated care will continue for another 5 year cycle. However, it is possible that Primary Care will not meet the criteria for this funding, therefore risk remains high currently.<br><br>A separate risk is being drafted for other RIF projects. Primary Care is a higher risk project and therefore has its own risk entry. | Head of Occupational Therapy attend regular RIF Finance Review meetings | Adams, Jon | **Completed** | Ongoing (closed as meetings now attended) | Finance and Performance Committee | 2 | 5 | 10 | Permanent funding will have been identified for the majority / all staff .<br><br>By way of mitigation , we will consider the opportunity to bring Community services closer to Primary care, however, constraints on our budget will restrict recruitment to Core Service for a number of years, which will have continued impact on other areas of service provision and lessen impact. | | 06-Oct-26 |
| | | | | | | | | | | | | | | | | Service Leads attend RIF workshops discussing future funding - Dates available 10th, 15th September Pembrokeshire Meeting | Adams, Jon | **Completed** | Meetings arranged with RIF team. Meetings attended. | | | | | | | | |
| | | | | | | | | | | | | | | | | Meet with system leaders in Pembrokeshire to discuss the RIF funding issues and impact on wider Pembs system and ICN. | Davies, Sharon | ~~31/07/2026~~ 31/10/26 30/11/26 | Meeting held April 2026 and further meeting with Primary Care / Cluster leads to be established. Due to colleagues availability this has been extended.<br><br>Once meeting has been held, new actions to be added to risk. | | | | | | | | |
| | | | | | | | | | | | | | | | | RIF SBAR was presented to CCG on 22/09/26 outlining risk to the occupational therapy service and mitigation plan for OCP process to be instigated later in the year if no funding identifed. | Adams, Jon | **Completed** | SBAR presented and discussed in CCG Governance on 22/09/26 | | | | | | | | |
| | | | | | | | | | | | | | | | | SBAR specific to Primary Care OT RIF funding to be drafted outlining options appraisal for absorption of staff into core funding | Davies, Sharon | 31/12/2026 | New action | | | | | | | | |

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| 2193 | Planned & Specialist Care | Cancer & Scheduled Care | Scheduled Care: Endoscopy | Carruthers, Andrew | Goode, Paula | Humphrey, Lisa | Edwards, Sara | 16-Oct-25 | There is a risk of the on-going timely delivery of endoscopy procedures<br><br>This is caused by a lack of adequate baseline capacity to meet projected demand growth<br><br>This will lead to an impact/affect on the on-going delivery of ministerial targets (USC, 8-week diagnostic and RTT, surveillance) plus the planned delivery of the surveillance recovery plan.<br><br>Risk location, Health Board wide. | The service is currently meeting the USC and 8-week diagnostic target through the use of additional activity. This is due to a 5% growth in elective demand and 30% growth in inpatient/emergency demand - which requires increased service capacity of a further 3 procedure lists/week from April 2026/27.<br>Funding for this ceases in August 2026 and presents a risk to delivery September 2026-March 2027. | Safety - Patient, Staff or Public | 4 | 3 | 12 | Current core capacity insufficient to meet demand for 8-week - capacity gap of 3 lists per week (equating to 18 patients per week). Funding for the additional activity currently ceases in August 2026 and presents a risk to delivery September 2026-March 2027. | The service is currently working in collaboration with the Urology team on the development of two proposals to expand endoscopy service capacity. | Edwards, Sara | 31/08/2026 | Awaiting annual planning decision. | Finance and Performance Committee | 2 | 2 | 4 | This is an upcoming risk from April 2026/27 (based on projected D&C modelling) - aim is to maintain delivery of USC/8-week ministerial targets (as current).<br><br>Target risk score updated - annual plan funding not allocated in FY 26/27 to support mitigation plan. | | 09-Sep-26 |

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| 1951 | Community & Integrated Medicine | Carmarthenshire Integrated System | Carmarthenshire County | Carruthers, Andrew | Skitt, Peter | Skitt, Peter | Jenkins, Angharad | 31-Mar-24 | There is a risk of overspend against the Specialist Palliative Care budget.<br><br>This is caused by the potential withdrawal of funding from Ty Bryn Gwyn Trustees for permanent posts. Historically a decision was made that staff would be appointed 'at risk', given permanent contracts with these permanent posts being funded by Ty Bryn Gwyn Trustees (year on year funding).<br><br>This will lead to an impact/affect on the stability of the budget within specialist palliative care. It will also impact on recruitment into the team as the service will need to balance the books and this will have a negative effect upon service delivery.<br><br>Risk location, Carmarthenshire. | Regular meetings are held with the Trustees to discuss what their priorities are and to inform them of the Health Board's position.<br><br>Recent recruitment has converted permanent posts into fixed term in order to minimise the impact on the budget. | Finance inc. claims | 3 | 4 | 12 | The risk remains high because the decision-making remains with the Trustees - the Health Board has no control over this and therefore there is no assurance that funding will be secured in the future (year on year funding). As staff leave we are recruiting into temporary positions rather than permanent to reduce the risk.<br><br>The posts are: 1 x 0.9 WTE Specialty Doctor now substantive and 1.7 Clinical Nurse Band 7 Specialist Palliative Care, 0.8 Band 6 Bereavement Councillor(Secondment) and admin support. The admin support isn't being utilised as we secured core funding. We are currently reviewing the current WTE with finance business partners to confirm the current position. Situation is still ongoing, SDM and HoN to review finances, therefore no change to score. | To submit the business case and an SBAR outlining our work with the Trustees for Executive Team approval. | Jenkins, Angharad | **Completed** | Closed completed. | Finance and Performance Committee | 1 | 4 | 4 | Business case cycle now in process with the trustees to review and agree funding streams and priorities on an annual basis.<br><br>Expected date to achieve TRS extended to 31/03/2026 to allow report from finance business partner.<br><br>Based on slow progress target risk score has been moved to end of Q1 FY26/27.<br>Target risk score to change to end of Sept pending further discussions.<br><br>06/08/26 - Risk needs to be reviewed in-line with new risk 2397 with a view to closing as the risk is potentially duplicating. | Treat | 08-Oct-26 |
| | | | | | | | | | | | | | | | | Awaiting full report from finance business partner regarding current status of posts (including fixed term/secondments) so that recommendations can be made to the HoN and System GM. | Jenkins, Angharad | **Completed** | Review of action undertaken, agreed in risk meeting to extend timeline to the end of the financial year.<br>Awaiting data from finance so SDM and HoN can undertake review.<br>Data provided and review completed - ok to close. | | | | | | | |
| | | | | | | | | | | | | | | | | Meeting to consider whether fragile posts can be funded via core, and any potentially within the medical budget to look at additionality within the team. Results of meeting to be fed back to System GM and Consultant lead for SPC. | Jenkins, Angharad | **Completed** | This is being address via the SPC Fragility Risk ref 2397 | | | | | | | |
| | | | | | | | | | | | | | | | | To have further discussions regarding the draft SBAR re whether there is any potential to bring any of these permanent posts into core funding. | Jenkins, Angharad | 30/11/2026 | SBAR written and sent. | | | | | | | |

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| 2202 | Operational Allied Health Professions & Health Sciences | AHP&HS: Radiology | AHP&HS: Radiology | Carruthers, Andrew | Quarrie, Sara | Roberts-Davies, Gail | Procter, Sarah | 01-Oct-25 | There is a risk of That the introduction of insourcing will mean that performance trajectories towards zero breaches will be impacted and that this will cause an overspend.<br><br>This is caused by The increase in referrals for diagnostic referrals from the increase in outpatient appointments<br><br>This will lead to an impact/affect on This may cause a financial overspend and mean that trajectories for planned care breaches will not be met.<br><br>Risk location, Health Board wide. | Monitoring of performance<br>there is some funding available but it does not meet the cost of outsourcing the examination and report. | Finance inc. claims | 3 | 4 | 12 | Impact 4- Uncertain delivery of key objective/Loss of 0.5â€“1.0 per cent of budget<br>Uncertain delivery of key objective/service due to lack of staff.<br>Low achievement of performance/delivery requirements<br><br>Likelihood 3- Probability (25-75%*) | Deputy COO discussing with WG that the tariff doesn't meet the cost of outsourcing examinations. | Jones, Keith - | **Completed** | assurance by deputy COO that if funding doesn't meet tariff cost then the actual cost will be paid | Finance and Performance Committee | 2 | 3 | 6 | Impact 3 -An event which impacts on a small number of patients.<br>Loss of 0.25â€“0.5 per cent of budget.<br>Likelihood 2 - Probability 5-25% | Treat | 28-Sep-26 |
| | | | | | | | | | | | | | | | | Issues with tracking insourcing OP requests due to new RIS subsystem | Procter, Sarah | **Completed** | Able to track again | | | | | | | |
| | | | | | | | | | | | | | | | | Capacity and demand to establish increase in waiting list due to OPD insourcing. | Procter, Sarah | 30/04/2026 31/10/2026 | awaiting final patients who are still progressing through the service.<br>patients still in system. | | | | | | | |

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| 2184 | Operational Allied Health Professions & Health Sciences | AHP&HS: Occupational Therapy | AHP&HS: Occupational Therapy | Carruthers, Andrew | Quarrie, Sara | Adams, Jon | Adams, Jon | 03-Apr-25 | There is a risk of There is a risk of a recurring £142k budget deficit from April 2026 due to cessation of Welsh Government funding and no identified replacement funding for substantive 3Ps workforce posts.<br><br>This is caused by The temporary Welsh Government funding used to establish substantive workforce posts within the 3Ps Prehabilitation and Optimisation Service has come to an end, with no confirmed replacement funding identified. The annual staffing cost is £258,462 against a recurring budget allocation of £116,759, resulting in a recurring annual funding gap of approximately £142,000.<br><br>This will lead to an impact/affect on Failure to secure recurrent funding may result in an ongoing budget deficit, impacting the Health Board's ability to achieve financial recovery objectives and maintain a balanced budget. Whilst the substantive staff within the service are not currently at risk, the continued financial pressure may reduce organisational flexibility to invest in workforce growth, manage vacancies, deliver savings targets and sustain service development. In the longer term, this could adversely affect service capacity, patient access, waiting time performance and the timely delivery of prehabilitation support to patients awaiting orthopaedic intervention.<br><br>Risk location, Health Board wide. | Monthly budget monitoring and financial performance reviews with Finance Business Partners, including forecast outturn reporting, identification of cost pressures and horizon planning for future financial years.<br><br>Ongoing exploration of recurrent and non-recurrent funding opportunities to address the funding gap, including engagement with Planned Care colleagues and incorporation of funding requests into relevant annual planning and recovery processes.<br><br>Regular review of workforce establishment, expenditure and service activity to inform financial planning and support the development of sustainable funding solutions. | Finance inc. claims | 3 | 4 | 12 | There is currently no identified funding for the budget shortfall from April 2026 in cost code 1962 (staff who deliver prehab to patients awaiting orthopaedic waiting list). The annual cost of these staff (who were substantively recruited into these posts) is Â£272K. The recurring budget for the service is Â£110K, therefore there is a deficit of Â£144K.<br><br>The action plan for mitigating this risk is aimed at minimising or preventing the financial risk that will come into effect in April 2026, which is currently imminent (Likelihood score is 5) due to lack of funding. Should any indication of funding become apparent, this Likelihood score will be reviewed.<br><br>Potential plans for exploring future funding options are underway (e.g. a meeting is to be scheduled with the Planned Care team to discuss alternative funding arrangements). | Develop an action plan with finance business partners to explore funding options and monitor service budget. 30/09/26 Confirmation of Tranche 2 funding approx £180K working with colleagues to clarify detail and allocation for 3Ps service. to be closed and new action added. | Adams, Jon | Completed | New action - action to be updated further as we approach next round of annual planning. | Finance and Performance Committee | 2 | 3 | 6 | Should permanent funding be agreed to cover the current establishment under this budget code, the financial risk is mitigated as all of the impacts associated with these cost pressures will be addressed and averted (Likelihood = 1). | Treat | 30-Sep-26 |
| | | | | | | | | | | | | | | | | Meeting with planned care colleagues to discuss future funding arrangements. MP to raise with QSIG group 28/04/26. JA to follow up with MP on 12/05/26. 12/08/26 Update from MP - funding request included in planned care recovery plan | Adams, Jon | Completed | Meeting to be scheduled. MP to raise with QSIG group 28/04/26. JA to follow up with MP on 12/05/26. Meeting scheduled 03/09/26. Meeting with MP & LH & JA on 03/09/26 awaiting update from Tranche 2 funding application. Tranche 1 funding received by HB nut not included funding for 3Ps. 21/09/26 Tranche 2 funding received approx £180K awating confirmation from finance on allocations for 3Ps service. | | | | | | | |
| | | | | | | | | | | | | | | | | Confirmation of Tranche 2 funding approx £180K. Working with colleagues to clarify detail and allocation for 3Ps service and escalate any shortfall. | Adams, Jon | 31/12/2026 | meeting with finance on 30/09/26. Finance going to speak with planned care colleagues. | | | | | | | |

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| 1869 | Primary Care | Primary Care | PC,CS,LTC: Dental | Carruthers, Andrew | Jones, Keith - | Bond, Rhian | Mickiewicz, Marie | 20-May-24 | There is a risk of of General Dental Services not achieving the Dental Patient Revenue Income Charge target set by Welsh Government.<br><br>This is caused by Multiple contributing factors including<br><br>Dental Contract Reform impacting the throughput of patients resulting in reducing income.<br><br>Reduced access to NHS dental services across the Health Board area<br><br>The current economic climate contributing to an increase in patients who are exempt from charges.<br><br>This will lead to an impact/affect on our ability to invest in dental services and cause capacity and cost pressures in other services such as GPs, Pharmacy and A&E. If the risk is not addressed this could lead to a permanent reduction in investment in NHS dental contracts.<br><br>Lack of investment will significantly reduce the pace of improvement to NHS General Dental Services<br><br>Risk location, Health Board wide. | Procurement to replace lost contracts NHS Business Services Authority monitoring of income trends and patient exemption data.<br>The Health Board will endeavour to replace handed back contracts within 9 months of the contracts being handed back.<br>Ongoing monitoring of the impact of newly awarded contracts on patient revenue charges.<br>Welsh Government increase to patient charges from April 2024. | Finance inc. claims | 3 | 4 | 12 | The allocated Dental budget is Â£20M, with Â£17M collected from WG directly and the other Â£3M expected to be collected from patient charge revenue. If we do not meet this target, the Health Board would need to consider reducing allocated funding however this in turn will reduce further patient charge revenue<br><br>In 2024/25, the Health Board collected Â£1.8M in patient charge revenue, leaving a gap of Â£1.2M.<br><br>Data suggests that the situation will not improve during 2025/26 - the projected shortfall is estimated at Â£1.5 million (6.5% of the overall dental allocation).<br><br>The replacement contracts procured are unlikely to generate enough income to close the gap.<br><br>Please see risk 1823 for impact on patient care.<br><br>Previously, the debt has only been offset by terminated contracts, however this cannot continue indefinitely and those contracts must be replaced to increase levels of access. | The Health Board will work with the NHSBSA to monitor evidence of a growing patient exempt evidence base. Currently, we are running at an increase of 3% growth in exempt patients compared to pre COVID. | Owens, Mary | Completed | New action | Finance and Performance Committee | 2 | 4 | 8 | It will take time for the new contract to embed and therefore it may be at least 12 months before reportable and comparable data is available in order to inform further changes in risk score.<br><br>It is expected that the throughput of patients will decrease based on the metrics for the 2026/27 contract amendments and therefore income from patient charge-related income will drop to a new normal.<br><br>Target score to be revisited at the end of the financial year, when we may know more about Welsh Government's decisions around contract reform. | Treat | 15-Sep-26 |
| | | | | | | | | | | | | | | | | Decision from Finance to progress the Dental Investment Plan and improve access to services | Spratt, Andrew | Completed | Dental Investment plan has been approved | | | | | | | |
| | | | | | | | | | | | | | | | | Consider procurement / direct delivery of additional GDS services. Paper to be submitted to Execs. | Mickiewicz, Marie | ~~31/07/2026~~ 30/09/26 -30/11/26 | Decision expected 16/09/26 | | | | | | | |

| Risk Ref | Clinical Care Group / Executive Function | Clinical Service Group / Executive Function Service | Clinical Service Sub-Group / Executive Function Service | Executive Director | Clinical Care Group Director / Executive Function Lead | Clinical Service Group Lead / Executive Function Service Lead | Clinical Service Sub-Group Lead / Executive Function Service Lead | Date risk Identified | Risk Statement | Existing Control Measures Currently in Place | Domain | Current Likelihood | Current Impact | Current Risk Score | Rationale for Current Risk Score | Additional Risk Action Required | By Whom | By When | Progress Update on Risk Actions | Lead Committee | Target Likelihood | Target Impact | Target Risk Score (tolerable score) | Rationale for Target Risk Score | Detailed Risk Decision | Review date |
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| 2316 | Planned & Specialist Care | Children, Women & Family Health | Children, Women and Family Health | Carruthers, Andrew | Goode, Paula | Davies, Nick | Davies, Nick | 27-Mar-26 | There is a risk of that<br><br>1. the Children, Women and Family Health Clinical Service Group will be unable to identify the level of recurrent savings in-year required (£3.7m) which includes under delivery of savings in 25/26.<br><br>2. further risk of CSG being overspent due to ad-hoc variable pay (current run rate £2.2m in this financial year with).<br><br>This is caused by 1. fragile services requiring workforce planning and wider Health Board engagement to enact service change within the financial year.<br><br>2. fragile services and workforce pressures driving spend on ad-hoc variable pay.<br><br>This will lead to an impact/affect on a worsening of the overall financial position of the CSG.<br><br>Risk location, Health Board wide. | 1. Finance Business Partner assigned to the Clinical Service Group, with meetings in place with Clinical Service Group management, and ad hoc meetings as and when required<br><br>2. Weekly review of nursing and medical staff rotas<br><br>3. Regular job planning reviews<br><br>4. Weekly Operational team meetings<br><br>5. Monthly Clinical Service Group Business meetings<br><br>6. Continual onboarding of substantive locum staff in order to reduce reliance on premium locum staff and spend<br><br>6. Reduction in the O&G and Paediatric spend and working with Medical Sustainability project<br><br>7. Scrutiny of budget/Savings schemes via TI escalation meetings<br><br>8. Re-assessment of streamlining and education commissioning for Nursing and Midwifery services<br><br>9. Workstream future-proof Withybush Creche ' | Finance inc. claims | 3 | 4 | 12 | Sept 26- additional opportunities continue to be explored, including r/v non-pay budgets, medication and equipment costs. There is concern that budgets are not yet sufficiently aligned with actual service activity; further Finance review is therefore needed to establish the underlying position. Releasing further underspends is likely to create unseen additional financial, operational, performance or quality risks | Continue to progress CIP schemes identified with CW&FH | Davies, Nick | ~~30/09/2026~~ 31.03.2027 | Sept 26 - all CIP schemes and cost drivers tracked at CCG level and reviewed monthly by executive teams | Finance and Performance Committee | 2 | 4 | 8 | If all schemes are achieved then the risk will reduce. If partial schemes achieved it will improve the financial position however the full savings target will not be met for 26/27. | Treat | 24-Sep-26 |
| | | | | | | | | | | | | | | | | Work to resolve the Medical HR issues across the CSG | Davies, Nick | ~~30/09/2026~~ 31.03.2027 | Sept 2026 All cases tracked and monitored monthly. CCG tracker created and associated cost pressures identified. Workforce processes revisited with workforce partners. All other procedures and sickness monitoring continued. | | | | | | | |
| | | | | | | | | | | | | | | | | Review of WGH Creches sustainability | Davies, Nick | ~~31/03/2027~~ 31.12.2026 | Sept 2026. Creche temp closed as supported by Executive Team until 31.10.26. Staff temp redeployed with workforce guidance applied. OCP procedures now being initiated with a view to full termination of creche services and redevelopment of staff. | | | | | | | |
| | | | | | | | | | | | | | | | | Review Midwifery staffing in line with corporate nursing position | Llewellyn, Cerian | ~~30/09/2026~~ 31.12.2026 | Additional temp staffing requirements (10wte, 7 months B6) identified and subject to internal approvals (Sept 2026) BR+ cycle now under way. | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2040 | Operational Allied Health Professions & Health Sciences | AHP&HS: Physiotherapy | AHP&HS: Physiotherapy | Carruthers, Andrew | Quarrie, Sara | Davies, John | Evans, Nick | 24-Mar-25 | There is a risk of of cessation of funding for the FCP service. This has been rolled out across a number of years using Cluster finding. The GP Clusters have now stated their intent to service notice on the contracts that are in date, and to not sign up to those that have rolled out of contract. This will effect 9.4 clinical staff (Band 7 and Band 8a) plus 0.5 Band 8a Service Lead that is funded on income from a small management fee.<br><br>This is caused by the fact that cluster funding should only be used for short periods to prove the worth of an initiative. In this case, FCP has been proven to be a more cost effective and timely way of managing musculoskeletal conditions in the community, releasing capacity through moving some of the MSK caseload to the Physiotherapists, allowing GP's to complete other tasks, and reducing onwards referrals into secondary care (investigations and interventions)<br><br>This will lead to an impact/affect on an increased staffing of >£675,000 added to the Physiotherapy budget without any funding to cover this.<br><br>Risk location, Health Board wide. | FCP service now sitting directly with DCOO. Physiotherapy continues with operational management. This is a cost pressure for the Op's directorate and has no solution. | Finance inc. claims | 2 | 4 | 8 | Funding for the service is currently supported by budgets under control of the Chief Operating Officer. Whilst there is still no substantive funding stream, there is not a direct cost pressure to physio services. The service is not able to replace vacant posts as workforce turnover occurs due to funding uncertainty. | 12/06/25 - Development of CCG Business Case within 25-26 financial year for mainstream funding of FCP service | Evans, Nick | Completed | 12/06/25-New Action<br>11/09/25-Plans currently under development ready for Annual planning Workshop<br>24/10/25-Inital plans supplied and under review as part of annual planning process | Finance and Performance Committee | 2 | 2 | 4 | Whilst the risk to the Physiotherapy service has been mitigated, this is now a risk sitting with the DCOO and without a mainstream funding solution. | Treat | 30-Sep-26 |
| | | | | | | | | | | | | | | | | Await outcome of Annual planning (2026/27) process | Evans, Nick | Completed | New action. Annual Plan funding requests submitted. Pending outcome.<br>30/03/26-No update.<br>01/05/26-Funding extended until March 2027. Pending decision on permanent funding in next round of annual planning. Close this action and create new 2027/28 Annual Planning cycle. | | | | | | | |
| | | | | | | | | | | | | | | | | Funding - FCP budget move to Chief Operating Officer budget centre to reduce pressures on Physiotherapy Budget lines. | Quarrie, Sara | Completed | Budget virement confirmed 11.05.2026 in savings meeting with finance (SN) | | | | | | | |
| | | | | | | | | | | | | | | | | Funding - Engage in HB system work to resolve FCP service risks | Evans, Nick | 31/03/2027 | 29.06.2026 - New action<br>10/08/26 - FCP now sits with DCOO. Still escalating that this service requires mainstream funding. | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1646 | Operational Allied Health Professions & Health Sciences | AHP&HS: Pathology | AHP&HS: Pathology | Carruthers, Andrew | Quarrie, Sara | Jones*, Dylan | Jones*, Dylan | 24-Jan-23 | There is a risk of of overspending against funding allocated for external tests. There is also a risk to the health board if funding for COVID/respiratory testing is not supported by Welsh Government funding.<br><br>This is caused by increased workload sent for testing and changes in test repertoire resulting in higher costs.<br><br>This will lead to an impact/affect on financial overspend.<br><br>Risk location, Health Board wide. | 1. Regular SLA meetings to review spend<br>2. Reviewed external testing sites<br>3. Clinical Scientist test vetting<br>4. Demand management in place to prevent sending duplicate samples. | Finance inc. claims | 4 | 2 | 8 | This remains a significant financial risk for Pathology as the increase in high cost tests (genetic/ genomic tests) and general workload growth has resulted in considerable overspend. Currently we have no firm process in place to scrutinise and agree what new tests are introduced and/or if there are changes in protocol that creates variations to test frequency and volumes. A Value Based Healthcare (VBHC) steering group is in the process of being established to review new tests and changes in protocols that may have an impact to Pathology. The group will also look at key tests that the service has identified as opportunities to either reduce unwarranted testing or may have benefits to other areas.<br><br>The service is also working closely with Swansea Bay University Health Board (SBU) as part of the Regional Pathology Programme at opportunities to repatriate tests to the region so they can be performed at reduced cost. | Regional collaboration providing opportunities to repatriate tests. | Peters, Lee | Completed | On going and linked to the ARCH Regional Solution. discussions ongoing.<br>05/06/2024 - update, exploring opportunities with SBU in laboratory medicine workstream. ongoing<br>31/05/25 - teicoplanin being reviewed to bring in house as a regional test. this is now being discussed in SBU CIG with both HD and SBU representatives | Finance and Performance Committee | 4 | 2 | 8 | The risk has been mitigated a far as it can within the means of the Pathology service. There are no further actions possible at this time. Monthly SLA reviews are no in place and the service is now challenging areas where there is potential overspend.<br><br>It has been proposed that this risk remains open, but with a tolerated score of 8. | Tolerate | 27-Jul-26 |
| | | | | | | | | | | | | | | | | Review main SLAs to look at repatriating service | Peters, Lee | Completed | FIT, MPO and PR3 testing being considered for repatriation<br>5.4.24 - linked to ARCH regional solution<br>31/1/25 - these tests are now being discussed in CIG meetings by HD and SBU representatives. | | | | | | | | |
| | | | | | | | | | | | | | | | | Standardising clinical haematology processes, reducing send away tests | Peters, Lee | Completed | Continually reviewing opportunities to standardise processes. Looking at subspecialising the service in the future.<br>30/1/24 - reviewed send away tests. haemoglobinopathy being reviewed to bring house<br>5.4.24 - new managed service now in place | | | | | | | | |
| | | | | | | | | | | | | | | | | Establish VBHC Steering Group to review demand optimisation opportunities within Pathology. | Jones*, Dylan | Completed | Steering group established and workstreams identified to progress demand optimisation work.<br>5.4.24 - ongoing. | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | Review Public Health Wales SLA CMR data. To look at test costs and volumes. | Williams, Mike | Completed | SLAs being scrutinised to check they deliver value for HB etc. Several tests have been challenged. | | | | | | | |

2

**09:45, 0 Mins**

# 2 - ANNUAL PLAN 2026/27 AND ESCALATION UPDATE

2.1

**09:45, 15 Mins**

# 2.1 - ANNUAL PLAN 2026/27 AND ESCALATION PRIORITIES

***Lee Davies (Hywel Dda UHB - Executive Director of Strategy and Planning), Shaun Ayres (Hywel Dda UHB - Director of Delivery)***

For approval

### Attachments

2.1 Escalation Update - October 2026 .pdf

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

# Escalation oversight and highlight report

## October 2026

Nineteen criteria: finance, urgent and emergency care, planned care, and diagnostics and therapies

Committee meeting: Tuesday 27 October 2026

**Lead executive:** Mr Lee Davies, Executive Director of Strategy and Planning

**Report author:** Mr Shaun Ayres, Director of Delivery

Finance at month 6 (September); performance to September 2026 unless stated

### The nineteen criteria this committee holds

| 1 to 4 | 16 to 19 | 12, 15, 25 to 29 | 30 to 33 |
|---|---|---|---|
| **Finance and savings** | **Urgent and emergency care** | **Planned care** | **Diagnostics and therapies** |

# Introduction

We are two weeks from the Escalation Board with Welsh Government on 9 November. The September urgent care test was not met, and the forecast deficit relies on (£20.2m) of further actions that do not yet have confirmed plans.

The criteria come from our February 2026 escalation framework and remain in force until Welsh Government confirms the outcome of the first assessment under the new national framework in November. This committee holds the finance criteria and the access criteria for urgent and emergency care, planned care, diagnostics and therapies.

In September the Board asked that each update show the effect of recovery actions on access, recurring spend and service sustainability, and the response when a milestone is missed. This update reports on that basis.

Nine of our fourteen access measures were worse in July to September than in April to June. Five improved: time to clinical assessment, overdue follow-ups, high-risk eye care, endoscopy and, on average, ambulance handovers. In planned care, diagnostic waits are below the recovery trajectories we report weekly to NHS Wales Performance and Improvement, and waits of more than two years are just above theirs.

Our internal escalation scoring, published on 13 October on September data, has four ratings at level 4, the highest level, against two a month earlier. Workforce has joined finance: Community and Integrated Medicine is now at level 4 for both.

**Since the committee met in August**

| | |
|---|---|
| **16 September** | Accountability review with Welsh Government |
| **24 September** | Route map to financial balance and the Annual Plan update taken to the Board |
| **28 September** | Call Before Convey live: crews speak to a senior clinician before taking a frail or older patient to hospital |
| **29 September** | NHS Wales Accountability and Support Framework launched; our first assessment under it is in November |
| **1 October** | Reset support from NHS Wales Performance and Improvement began, on flow, financial recovery and quality |
| **October** | Month 6 forecast deficit revised to £37.5m, wholly from a lower Welsh Risk Pool charge |

# The position at September

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The forecast has improved through the Welsh Risk Pool, but spending has not yet fallen, and urgent care did not meet its September test. Planned care recovery is close to its trajectories, with most of the extra activity still to come.

## Finance and workforce

### Forecast deficit

**£37.5m**

for the year, after a (£3.5m) Welsh Risk Pool reduction; plan £41.0m

### Further actions needed

**(£20.2m)**

from October to hold the forecast; plans not yet confirmed

### Savings to identify

**£10.0m**

£32.8m of £42.8m identified, of which £7.8m recurrent

### Underlying deficit

**£62.1m**

carried into next year, against £40.8m in the plan

### Temporary staffing

**£61.4m**

a year at current spend; ministerial expectation £44.5m

## Access

### Ambulance handovers

**Circa 875**

over 45 minutes in September, provisional; the test is 789

### Twelve-hour waits

**10 in 100**

patients in September, against 7 in 100; 1,649 people

### Pathway of care delays

**222**

patients waiting to leave hospital; ceiling 174

### Waits over two years

**862**

in September, against a recovery trajectory of 851

### Diagnostic waits

**7,593**

over eight weeks at 13 October, 554 below the recovery trajectory

# Criteria: finance and urgent care

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Six of these eight criteria are at Alert and none meets the threshold for de-escalation. Savings identification and time to clinical assessment are improving; twelve-hour waits and pathway of care delays are moving away.

| Criterion | Rating | Direction | Position | Next evidence |
|---|---|---|---|---|
| **Finance and savings \| lead: Executive Director of Finance** | | | | |
| **1 Financial governance and control** | **Advise** | No clear change | Governance strengthened since August; the two care groups at internal level 4 have not yet reduced spending | Plans for the (£20.2m) with owners, dates and recurrent values, by 9 November |
| **2 Understanding and reducing the deficit** | **Alert** | Improving | £32.8m of £42.8m savings identified, £7.8m recurrent; underlying deficit £62.1m | Recurrent conversion plans with named owners |
| **3 Target control total** | **Alert** | Slightly better, from the Welsh Risk Pool | £37.5m forecast against Welsh Government's control total of £22.1m | Month 7 forecast; cash support confirmed by December |
| **4 Financial improvement trajectory** | **Alert** | Slightly better | £29.9m deficit to September, £9.4m more than planned; £1.3m a month needed from October | October and November monthly deficits |
| **Urgent and emergency care \| lead: Chief Operating Officer** | | | | |
| **16 Ambulance handovers over 45 minutes** | **Alert** | Better than April to June; rising since July | About 875 in September against 789, provisional; 833 in August | October, reported to the Escalation Board on 9 November |
| **17 Twelve-hour waits in emergency departments** | **Alert** | Worsening | 10 in 100 in September against 7; 15 in 100 at Glangwili and Withybush | October, reported to the Escalation Board on 9 November |
| **18 Time to clinical assessment** | **Advise** | Improving | 66 minutes in September against 60; Withybush 54 | Three months in a row at 60 minutes or less |
| **19 Pathway of care delays** | **Alert** | Worsening | 222 in September against a ceiling of 174 and a plan of 195 | Effect of the reset support on discharge |

**Alert** the evidence does not yet support the required outcome **Advise** progress, with material caveats **Assure** the evidence supports the required position

Internal escalation, October scoring (September data): finance is at level 4 in Community and Integrated Medicine and Planned and Specialist Care, and at level 3 in Mental Health and Learning Disabilities, Operational Allied Health and Health Sciences, Estates and Facilities, and the long term agreements. Performance is at level 3 in all five clinical care groups rated.

# Criteria: planned care and diagnostics

Six of these eleven criteria are at Alert. Since they were last rated, criteria 12, 26, 28, 30 and 33 have moved from Advise to Alert and criterion 25 from Assure to Advise. Endoscopy continues to meet its criterion.

| Criterion | Rating | Direction | Position | Next evidence |
|---|---|---|---|---|
| **Planned care \| lead: Chief Operating Officer** | | | | |
| **12 Key performance measures** | **Alert** | Worsening | Nine of fourteen measures worse than April to June | A sustained improving trend |
| **15 High-risk (R1) eye care** | **Advise** | Improving | 47 in 100 in August against 65 and a plan of 66 | Monthly progress towards 65 in 100 |
| **25 Outpatients waiting under 52 weeks** | **Advise** | Worsening | 625 waiting over a year; 100 in 100 in March | Back to 100 in 100 |
| **26 Waiting under 26 weeks** | **Alert** | Worsening | 63 in 100 against 75; 69 in March | The trend turning as recovery activity runs |
| **27 Waiting under 104 weeks** | **Advise** | Worsening | 862 waiting over two years, against a recovery trajectory of 851 | October against the trajectory of about 630 |
| **28 Waiting under 36 weeks** | **Alert** | Worsening | 74 in 100 against 80; 77 in March | The trend turning as recovery activity runs |
| **29 Overdue follow-up appointments** | **Advise** | Improving | 13,725, the lowest recorded, against a goal of 11,368 | 11,368 by March 2027 |
| **Diagnostics and therapies \| lead: Chief Operating Officer** | | | | |
| **30 Diagnostic tests within 8 weeks** | **Alert** | Worsening | 60 in 100 against 85; 7,593 waiting longer at 13 October, below trajectory | Waits after December, when most extra activity ends |
| **31 Endoscopy within 8 weeks** | **Assure** | Improving | 96 in 100; 85 or above for seven months in a row | Welsh Government to confirm de-escalation |
| **32 Ultrasound and MRI within 8 weeks** | **Alert** | Worsening | 51 in 100 for each, against 85 | A recovery trajectory for each test |
| **33 Therapies within 14 weeks** | **Alert** | Worsening | 68 in 100 against 90; 4,153 waiting longer | A trajectory that reverses the decline |

**Alert** the evidence does not yet support the required outcome **Advise** progress, with material caveats **Assure** the evidence supports the required position

Direction compares July to September with April to June. Cancer (criterion 21) remains de-escalated: 62 in 100 patients started treatment within 62 days in August, against 63.

# The tests for November

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Government expects clear evidence of impact at the Escalation Board on 9 November. The savings, recurrent and September urgent care requirements are not met, and waits of more than two years are just above their recovery trajectory.

| What Welsh Government requires | By when | Where we are | Status |
|---|---|---|---|
| Close the savings gap with full confidence that it will be delivered | End of September | £32.8m of £42.8m identified; £10.0m still to find | Not met |
| Convert one-off savings into savings that recur | End of September | £7.8m of the £32.8m is recurrent | Not met |
| Agree a route map to financial balance | End of September | Taken to the Board on 24 September as the basis for the 2027/28 to 2029/30 plan | Complete |
| Deliver a deficit no worse than £41.0m, and look for improvement | March 2027 | £37.5m forecast, improved wholly by the Welsh Risk Pool; relies on (£20.2m) of unconfirmed actions | At risk |
| A deliverable financial plan: quantified actions, named executive owners, timescales and the recurrent effect of each | 9 November | In preparation | On Track |
| No more than 789 ambulance handovers over 45 minutes, and no more than 7 in 100 patients over 12 hours, in each month | September and October | September not met: about 875 handovers over 45 minutes (provisional) and 10 in 100 over 12 hours; October to follow | Not met |
| Clear evidence of impact | 9 November | To be presented at the Escalation Board | Due |
| Eliminate waits of more than two years | March 2027 | 862 in September, against a trajectory of 851; the trajectory needs about 630 by the end of October | At risk |
| No patient waiting more than eight weeks for a diagnostic test | March 2027 | 7,593 at 13 October, below trajectory; the trajectory falls to about 3,700 in January, then rises to about 6,900 by March as extra activity ends | Not on course |

The first assessment under the new national framework follows in November and will draw on the same evidence.

# The new accountability framework

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

From November, Welsh Government assesses us against the NHS Wales Accountability and Support Framework. Our nineteen criteria sit in two of its four pillars, and status will normally be set for a whole pillar.

| Quality | Workforce | **Finance and planning** | **Delivery and performance** |
|---|---|---|---|

Leadership (well-led) foundation

| Pillar | What it looks for before level 4 can end | Our criteria | Where our evidence stands |
|---|---|---|---|
| **Finance and planning** | Serious risks to delivery stabilised or reducing; an effective route map to financial balance; controls that address the causes of the underlying deficit; credible financial governance | 1 to 4 here; 5 to 9 at the Strategy and Planning Committee | Route map agreed as the basis for planning; the forecast relies on (£20.2m) of unconfirmed actions; underlying deficit £62.1m |
| **Delivery and performance** | A sustained improving trend in access, outcomes and productivity; operational risks managed; a recovery plan delivering measurable impact; outside support that has built our own capability | 12, 15 to 19 and 25 to 33 | Planned care recovery close to trajectory; urgent care, ultrasound, MRI and therapy waits moving away; cancer de-escalated |

### What it means for this committee

Planned care (level 3) and urgent and emergency care (level 4) are likely to be judged together. The pillar's national measures include handovers over 45 minutes, patients spending 12 hours or more in emergency care, waits over 104 weeks, diagnostic waits over eight weeks and cancer treated within 62 days. Welsh Government decides status after a joint review with Audit Wales, Healthcare Inspectorate Wales and NHS Wales Performance and Improvement, known as the tripartite. Our current levels and criteria continue until then.

### Reset support, October and November

NHS Wales Performance and Improvement is working alongside our executives on urgent care flow and discharge, financial recovery and three quality priorities. The support is designed to strengthen our existing plans rather than add new ones, and accountability for delivery stays with us. A light-touch review in December will assess the capability it leaves behind.

# Internal escalation at September

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Four ratings are now at level 4, our highest internal escalation level, against two a month earlier. Finance and performance, the two domains that match this committee's criteria, carry more than half of the 25 ratings at level 3 or 4.

| Function | Quality and safety | Governance | Workforce | Finance | Strategy, planning and fragile services | Population health | Performance |
|---|---|---|---|---|---|---|---|
| **Clinical care groups** | | | | | | | |
| Community and Integrated Medicine | 3 | 2 | 4 | 4 | 3 | 2 | 3 |
| Chief Operating Officer Management | 1 | 1 | 3 | 2 | 1 | 1 | n/a |
| Mental Health and Learning Disabilities | 3 | 2 | 2 | 3 | 3 | 1 | 3 |
| Planned and Specialist Care | 2 | 2 | 3 | 4 | 3 | 2 | 3 |
| Primary Care | 1 | 1 | 2 | 1 | 2 | 2 | 3 |
| Operational Allied Health and Health Sciences | 3 | 1 | 2 | 3 | 3 | 1 | 3 |
| **Executive functions** | | | | | | | |
| Estates and Facilities | 2 | 1 | 2 | 3 | 1 | 2 | 3 |
| Executive Director of Finance | 1 | 2 | 2 | 1 | 1 | 2 | n/a |
| Medical | 1 | 1 | 2 | 1 | 1 | 2 | n/a |
| Pharmacy and Medicines Management | 1 | 1 | 3 | 2 | 1 | 2 | n/a |
| Executive Director of Nursing, Quality and Patient Experience | 1 | 2 | 2 | 1 | 1 | 2 | 3 |
| Executive Director of Public Health | 1 | 1 | 4 | 1 | 1 | 1 | 2 |
| Executive Director of Strategy and Planning | 1 | 1 | 2 | 1 | 1 | 2 | n/a |
| Long term agreements | n/a | n/a | n/a | 3 | n/a | n/a | n/a |
| Executive Director of Workforce and Organisational Development | 1 | 1 | 1 | 1 | 1 | 1 | n/a |
| Governance and Communication | 1 | 1 | 2 | 1 | 1 | 1 | n/a |

## Levels

- 1 Reasonable assurance
- 2 Limited assurance
- 3 No assurance or insufficient engagement
- 4 No assurance and insufficient actions or engagement
- 4 New at level 4 this month
- Domain matching this committee's criteria

## How it lines up with this report

**Finance, criteria 1 to 4.** Community and Integrated Medicine and Planned and Specialist Care are in a fourth month at level 4. The month 6 finance report records no material impact to date.

**Performance, access criteria.** All five clinical care groups rated are at level 3, in line with nine of our fifteen access criteria at Alert.

**Workforce, temporary staffing.** Community and Integrated Medicine and Public Health are now at level 4. Fourteen of the fifteen functions rated are at level 2 or worse.

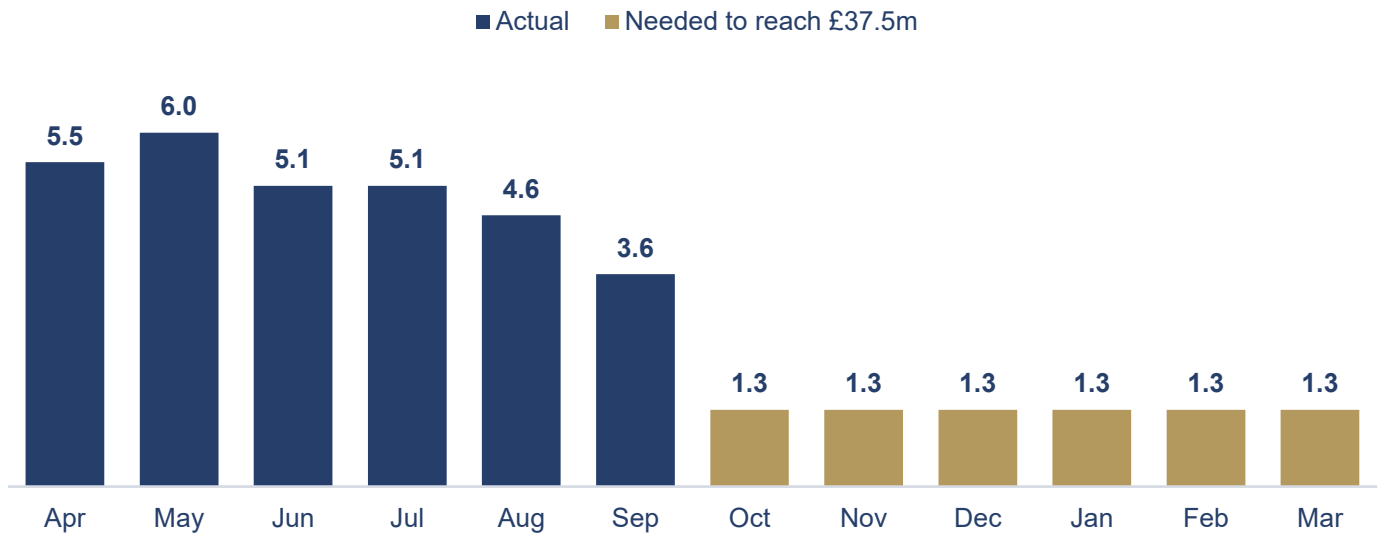
**Where the ratings sit.** Of the 25 ratings at level 3 or 4, nineteen sit in the clinical care groups, five of them in Community and Integrated Medicine.

# Criteria 3 and 4: the monthly deficit

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The forecast deficit has improved to £37.5m, but the whole of the (£3.5m) improvement is our share of a lower Welsh Risk Pool charge. To reach it, the next six months must average £1.3m, against £5.0m so far.

**Monthly deficit, £m: actual to September, and what the forecast needs from October**




The Welsh Risk Pool meets clinical negligence claims across NHS Wales, and each health board pays a share. September includes a one-off (£1.8m) adjustment for April to September; without it, the September deficit was £5.4m.

**£29.9m** deficit from April to September, £9.4m more than planned

**£1.3m** average monthly deficit needed from October to reach £37.5m, against £5.0m so far

**£57.7m** forecast before (£20.2m) of further actions that do not yet have confirmed plans

**£22.1m** Welsh Government's target control total for the year

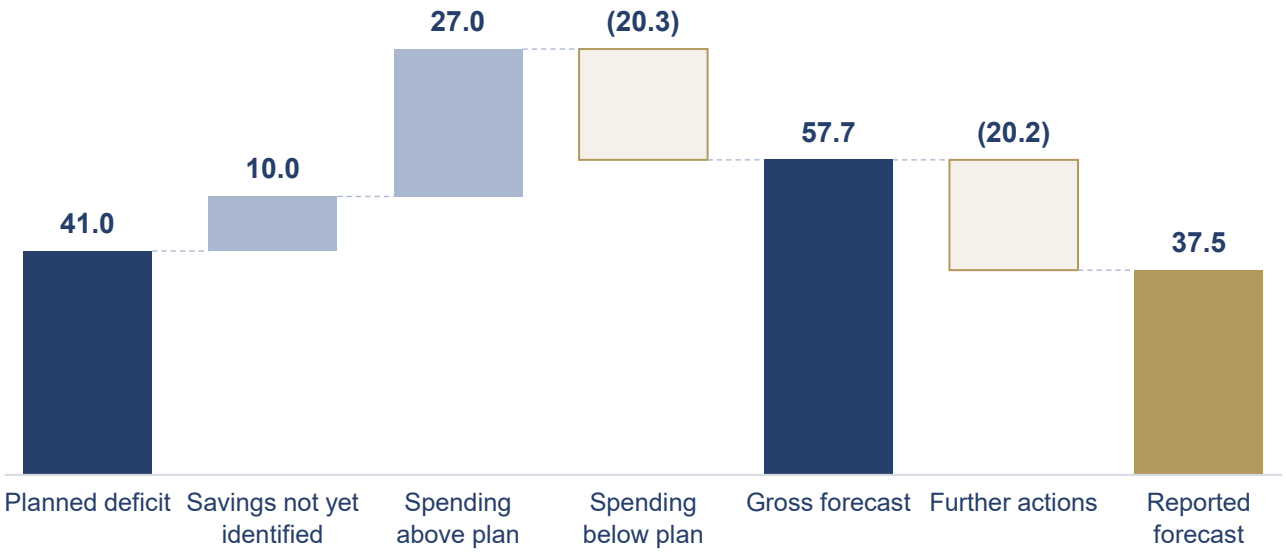
**Alert** **Rating: no change.** The October and November deficits need to move towards £1.3m a month for the forecast to hold. On the forecast we also need strategic cash support from Welsh Government by the end of February; if it is not confirmed by December, we will apply our cash management strategy.

# Criterion 1: financial control

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The forecast holds at £37.5m only if (£20.2m) of further actions deliver from October. Plans for them are not yet confirmed, and the two care groups at our highest internal escalation level have not yet reduced their spending.

**From the planned deficit to the reported forecast, £m**




| Spending above plan, total 27.0 | £m |
|---|---|
| Medical locum and agency cover | 7.2 |
| Continuing healthcare and out-of-area placements | 5.9 |
| Outsourced theatre and other activity | 3.6 |
| Radiology outsourcing and double running | 2.8 |
| Prescribing prices | 2.6 |
| Estates, supplies, Swansea Bay agreement, banding | 4.9 |

| Spending below plan, total (20.3) | £m |
|---|---|
| Primary care, including dental contracts | (7.6) |
| Administrative vacancies | (3.7) |
| Welsh Risk Pool | (3.5) |
| Clinical vacancies and fill rates | (2.9) |
| Income above plan | (2.6) |

Welsh Government has confirmed it will recover unspent dental allocation, which the forecast counts as a (£5.1m) underspend. The finance report also records £8.7m of net risk.

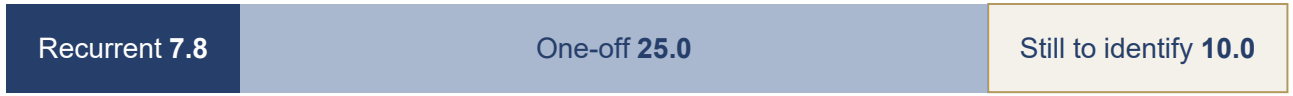
**Advise**

**Rating: no change.** Governance is stronger: the Performance and Recovery Group, chaired by the Chief Executive, meets fortnightly and reports through this update. Community and Integrated Medicine (£14.9m above plan) and Planned and Specialist Care (£7.1m) remain at internal level 4 for finance. What would move the rating: confirmed plans for the (£20.2m) by 9 November.

# Criterion 2: savings and the deficit

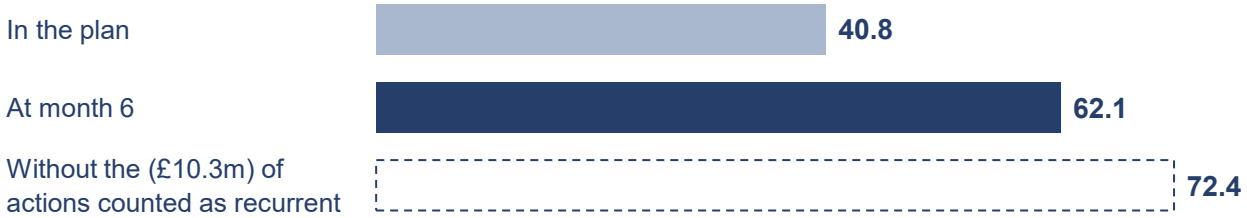
We have identified £32.8m of the £42.8m savings target, £2.3m more than at month 5. Only £7.8m recurs into next year, so the deficit we carry forward is £62.1m, against £40.8m in the plan.

**The £42.8m savings target at month 6, £m**




£32.8m identified, of which £7.8m is recurrent; £10.0m still to identify

**The deficit carried into next year (underlying deficit), £m**




The underlying deficit is the deficit left once one-off savings and gains fall away. The £62.1m already counts (£10.3m) of the further actions as recurrent.

| Savings, £m | Target | Identified | Recurrent | Still to find |
|---|---|---|---|---|
| Community and Integrated Medicine | 12.5 | 9.1 | 1.4 | 3.4 |
| Planned and Specialist Care | 5.9 | 2.8 | 1.0 | 3.1 |
| Mental Health and Learning Disabilities | 6.4 | 3.1 | 0.1 | 3.3 |
| Operational Allied Health and Health Sciences | 4.9 | 1.7 | 0.0 | 3.2 |
| Other operational and primary care | 1.0 | 0.7 | 0.0 | 0.3 |
| Corporate and health board wide | 12.1 | 15.4 | 5.3 | (3.3) |
| **Total** | **42.8** | **32.8** | **7.8** | **10.0** |

The four clinical care groups hold £13.0m of savings still to find. Corporate and health board wide budgets over-deliver by (£3.3m), mostly one-off.

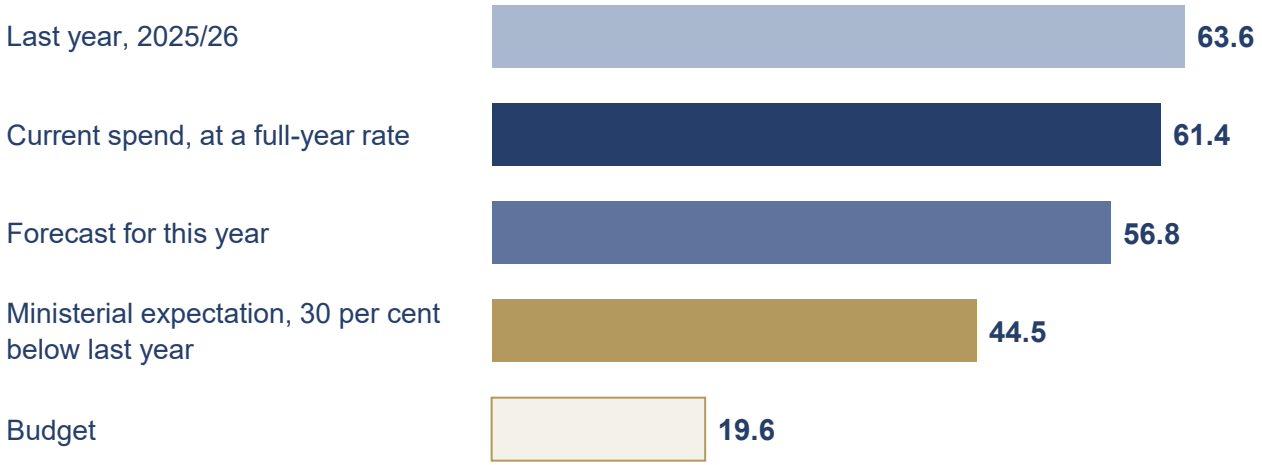
**Alert** **Rating: no change.** Recurrent plans rated green, on a full-year basis, have risen from £1.7m in April to £8.9m, but most of the recurrent opportunity is still at the earliest stages, leaving a full-year gap of £33.9m. What would move the rating: recurrent conversion, with named owners, dates and full-year values, reported from month 7.

# Temporary staffing and the workforce

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Temporary staffing is running at £61.4m a year, against a budget of £19.6m and a ministerial expectation of £44.5m. The forecast expects it to fall to £56.8m as new permanent staff start.

**Temporary staffing (bank, agency, overtime, additional hours and locum cover), £m a year**




Current spend is April to September doubled. Meeting the expectation would take a further (£12.3m) off the forecast, or (£16.9m) off current spend.

**Where the pressure sits**

Medical and dental pay is £7.2m above plan, mainly locum and agency cover for vacancies and sickness in Community and Integrated Medicine, women and children's services at Bronglais, pathology and mental health. The reduction previously assumed in Planned and Specialist Care is no longer expected.

**What the cover does**

On wards, temporary staff more than cover the 271 nursing and healthcare support worker vacancies, so wards run 53 whole time equivalents above funded staffing. All other staff groups, excluding doctors, run 597 below funded staffing after all cover.

**What is changing**

Ten workforce workstreams work from one reconciled baseline of staffing, rosters and finance, and the medical temporary staffing programmes are now one. The (£10.0m) of pay actions in the forecast sit in permanent staff pay from November.

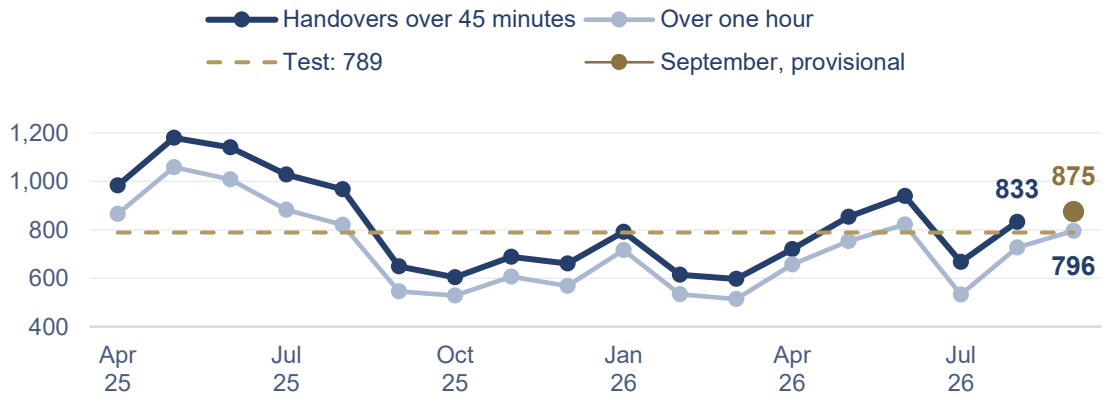
**Level 4**

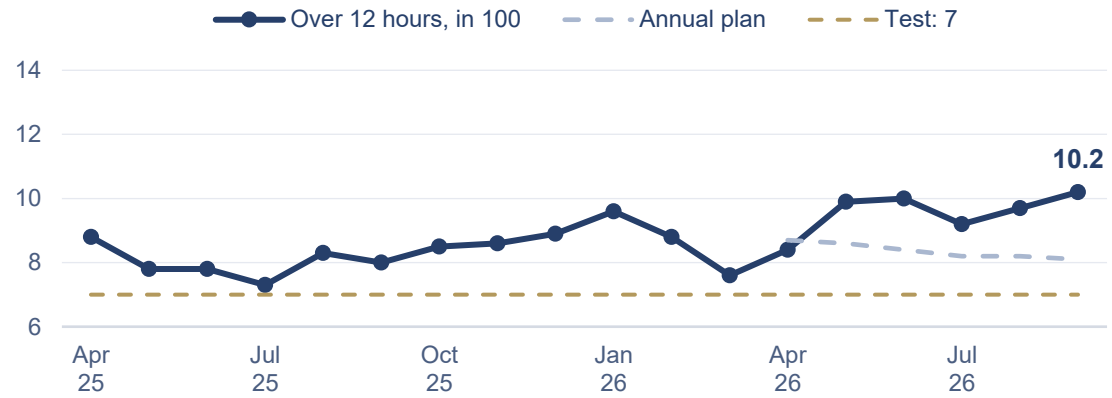
**Internal escalation:** Community and Integrated Medicine, already at level 4 for finance, is now at level 4 for workforce, as is Public Health. Chief Operating Officer management, Planned and Specialist Care and Pharmacy are at level 3. Fourteen of the fifteen functions rated for workforce are at level 2 (limited assurance) or worse, so each temporary staffing reduction needs testing against the cover it provides.

# Urgent care: the September test

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September did not meet either test. Provisional figures put handovers over 45 minutes at about 875, against 789, and about 10 in 100 patients spent more than 12 hours in our emergency departments, against 7.




| September | Bronglais | Glangwili | Prince Philip | Withybush | Health board |
|---|---|---|---|---|---|
| **Handovers over one hour** | 166 | 350 | 29 | 250 | 796 |
| **Plan for September** | 164 | 266 | 17 | 83 | 530 |
| **Patients over 12 hours, in 100** | 10 | 15 | 0 | 15 | 10 |

The September figure for handovers over 45 minutes is provisional, subject to final ratification. Year to date, Bronglais and Glangwili are within their handover plans; Withybush has averaged 226 handovers over an hour a month since April, against a plan of about 85, and accounts for more than the whole of the gap to plan.

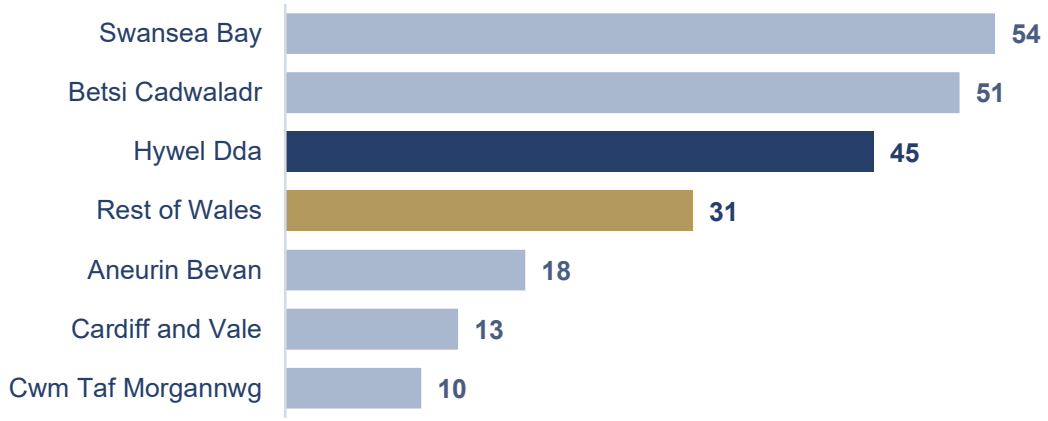
**Alert** **Rating: no change for criteria 16 and 17.** October is the second test month and is reported to the Escalation Board on 9 November.

# Ambulance handovers across Wales

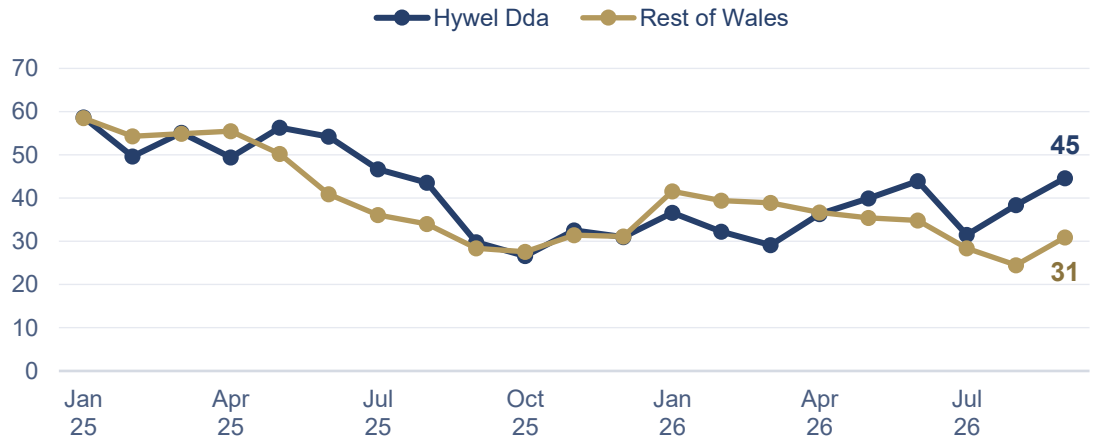
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Provisional figures put September at about 875 handovers over 45 minutes, against the test of 789. About 45 in 100 ambulance arrivals at our hospitals waited that long, against about 31 in 100 in the rest of Wales.

**Ambulance arrivals waiting more than 45 minutes, in 100, September**




**Waiting more than 45 minutes, in 100: Hywel Dda and the rest of Wales**




**September against our own tracker**

The all-Wales figures count 238 of our handovers over four hours and 804 over one hour, within 2 and 8 of our own figures of 236 and 796. On the 45-minute measure they have run between 12 and 40 above our tracker in each of the last 20 months, so their 902 for September points to about 860 to 890 on our basis.

**What the comparison shows**

From September 2025 to April 2026 we were level with the rest of Wales or better. We moved above it from May, as we did in the summer of 2025, but this year the gap widened in August and September rather than closing. About 12 in 100 of our arrivals waited more than four hours, against 8 in 100 elsewhere.

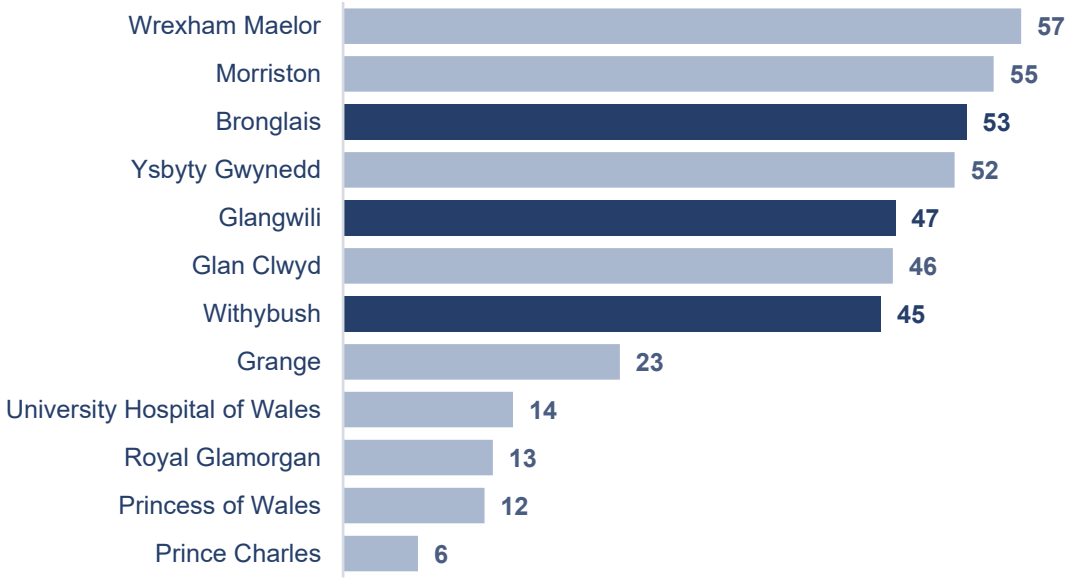
Provisional figures, subject to final ratification. Powys has no emergency department and is not shown.

# Ambulance handovers by hospital

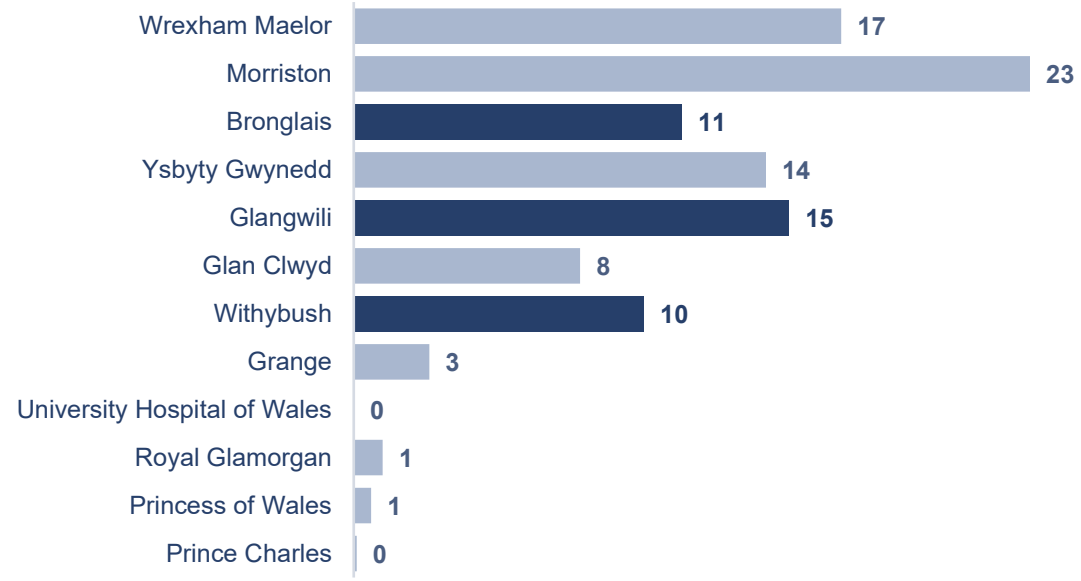
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

In September, Bronglais, Glangwili and Withybush each had about 45 in 100 ambulance arrivals or more waiting over 45 minutes. Seven of the twelve major emergency departments in Wales were at that level, and five were well below it.

**Arrivals waiting more than 45 minutes, in 100**




**Arrivals waiting more than four hours, in 100**




Prince Philip, which is not a major department, had 19 in 100 arrivals waiting more than 45 minutes. Withybush had the lowest share of our three major departments in March, at about 14 in 100, and in September was level with Glangwili. Glangwili had the most very long waits of our hospitals: 15 in 100 arrivals waited more than four hours.

Major emergency departments in Wales, ordered by the share waiting more than 45 minutes. Provisional figures, subject to final ratification.

# Urgent care: what changes and when

Two of the plan's main urgent care changes now start in the winter rather than before it. Time to clinical assessment is the one urgent care measure moving the right way, and Withybush met the 60-minute standard in September.

| Change in the annual plan | Planned | Now | What it should change |
|---|---|---|---|
| Seven-day clinical streaming, directing patients to the right service before they reach hospital | June 2026 | Go-live on 30 November | Handovers and twelve-hour waits at every site |
| Same day emergency care at Withybush, assessing and treating patients without an overnight stay | Seven days a week from October 2026 | Five days from December; seven days from February 2027 | Twelve-hour waits and handovers at Withybush, the site furthest from its plan |

## Under way now

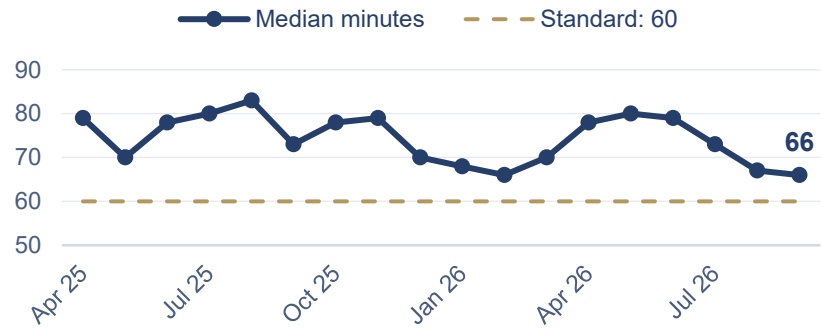
- Call Before Convey, from 28 September: ambulance crews speak to a senior clinician before taking a frail or older patient to hospital.
- Reset support on flow: a daily operating model, discharge planned from the first ward round of the day seven days a week, and clear accountability from ward to executive.
- The handover programme continues, with ambulance service managers on the daily patient flow call.
- Improvement plans coming out of the Senior Leadership Forum on the 14 October.

The later start of the clinical streaming investment is counted as a saving this year, so the financial and urgent care positions move in opposite directions while it is delayed.

## Criterion 18: time to clinical assessment

**66 min**

median wait from arrival to assessment by a senior clinician in September, against 60 and the plan's 71

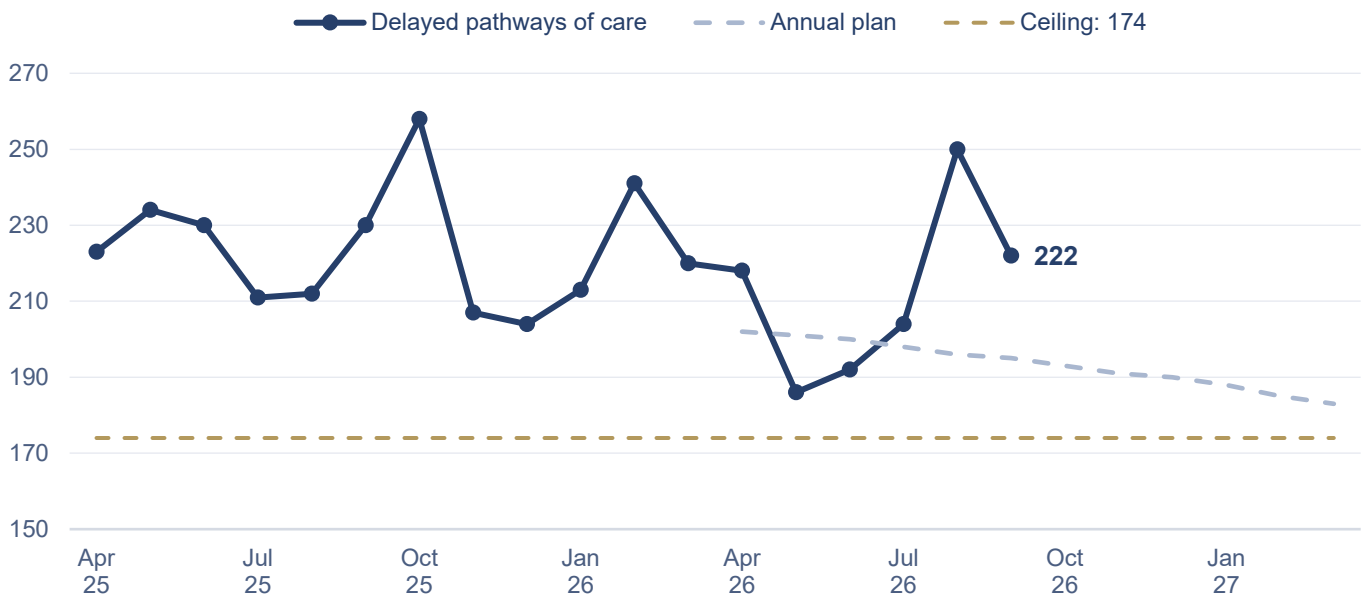



September by site: Withybush 54, Bronglais 67, Glangwili 77 minutes.

**Advise** **Criterion 18: improving.** Three months in a row at 60 minutes or less would meet the criterion, and Withybush is there now. The plan's two changes now need to start on their new dates.

# Criterion 19: pathway of care delays

222 patients were waiting in hospital for onward care at the end of September, down from 250 in August but above the plan of 195. We have not been at or below the ceiling of 174 in 43 months of reporting.




May 2026 was recorded during ward closures and is treated as incomplete. A pathway of care delay is a patient well enough to leave hospital who is waiting for an assessment, a care package or a placement.

| County | June | September |
|---|---|---|
| **Carmarthenshire** | 93 | 142 |
| **Pembrokeshire** | 62 | 55 |
| **Ceredigion** | 33 | 23 |

**Carmarthenshire now holds almost two in three delays.**

**What is in place**

- Call Before Convey for frail and older people
- Reset support on discharge, seven days a week
- An agreement with local authority partners, an electronic patient flow system and long-stay reviews
- More social work and reablement capacity
- Additional considerations associated with the improvement plan post senior leadership away day

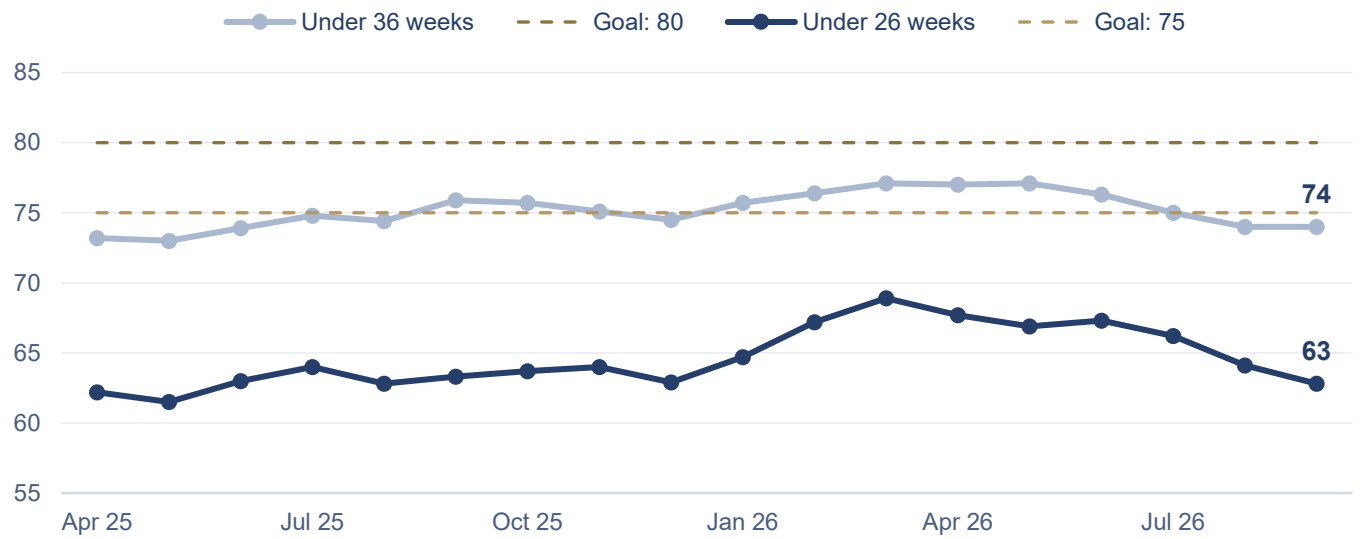
**Alert** **Worsening:** the plan expects 193 in October and 183 by March. Continuing healthcare packages and out-of-area mental health placements are £5.9m above plan, so the routes out of hospital carry a financial cost as well as freeing beds.

# Planned care: waits and recovery

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Waits of more than two years were just above their recovery trajectory in September. The share of patients waiting less than 26 and 36 weeks has fallen since the spring as the list grows; overdue follow-ups are at their lowest recorded level.

**Patients on the waiting list who have waited less than 26 and 36 weeks, in 100**




**862** waiting more than two years in September, against a recovery trajectory of 851; zero by the end of March

**13,725** overdue follow-up appointments, the lowest recorded, against a goal of 11,368 by March

**47 in 100** high-risk eye care patients within tolerance in August, against 65; 34 a year earlier

**625** patients waiting more than a year for a first outpatient appointment

The recovery return expects the waiting list to grow from about 78,400 to 85,100 by March while extra activity goes to the longest waits, so the share waiting less than 26 and 36 weeks is likely to keep falling this year.

**Alert**

**Advise**

**Alert:** criteria 12, 26 and 28. Nine of fourteen measures are worse than in April to June, and fewer patients wait under 26 weeks (63 in 100, against 75) and 36 weeks (74 in 100, against 80). Extra activity goes to the longest waits while the list grows towards 85,100, so these are unlikely to turn before March. Internally, Planned and Specialist Care is at level 3 for performance and level 4 for finance, and recovery relies on outsourced activity already £3.6m above plan.

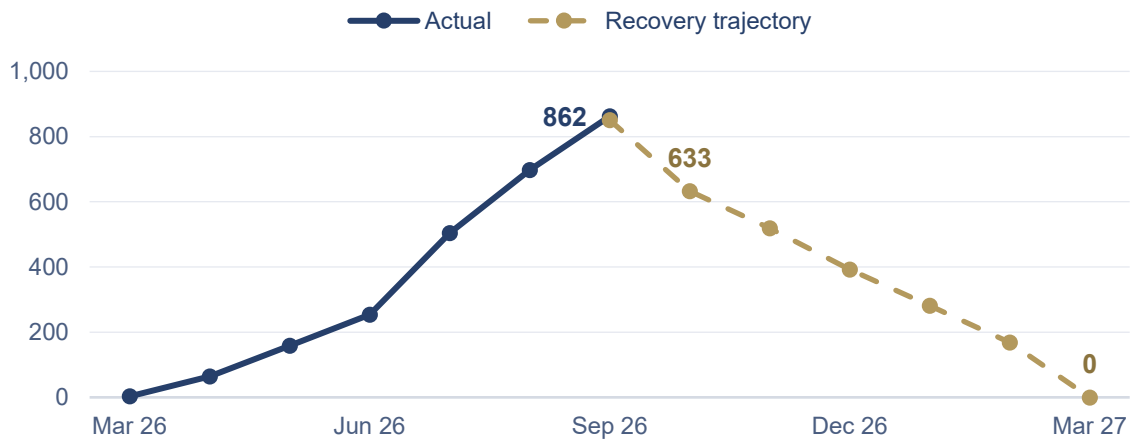
**Advise:** criteria 15, 25, 27 and 29. What would move them: each month on the recovery trajectory, and the 26 and 36 week trend turning.

# Planned care recovery: progress to 13 October

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The weekly recovery return shows diagnostic waits below trajectory and waits of more than two years just above it. Most extra activity starts from mid-October, so October and November will show whether the trajectories hold.

### Patients waiting more than two years at the end of each month




Actual: monthly reporting. Trajectory: weekly recovery return, last week of each month.

### Patients waiting more than eight weeks for a test, 13 October

| Test | Actual | Trajectory | Extra activity since September |
|---|---|---|---|
| Ultrasound | 3,583 | 3,655 | None until 26 October, then 240 scans a week |
| MRI | 2,165 | 2,370 | 1,079, against 862 planned |
| Echocardiography | 1,128 | 1,195 | 400, against 516 planned |
| Cardiac CT | 445 | 447 | None until mid-October |
| CT (non-cardiac) | 34 | 136 | 1,408, against 1,407 planned |
| Endoscopy | 0 | 0 | 115, against 108 planned |
| **All tests** | **7,593** | **8,147** | |

### What the trajectories depend on

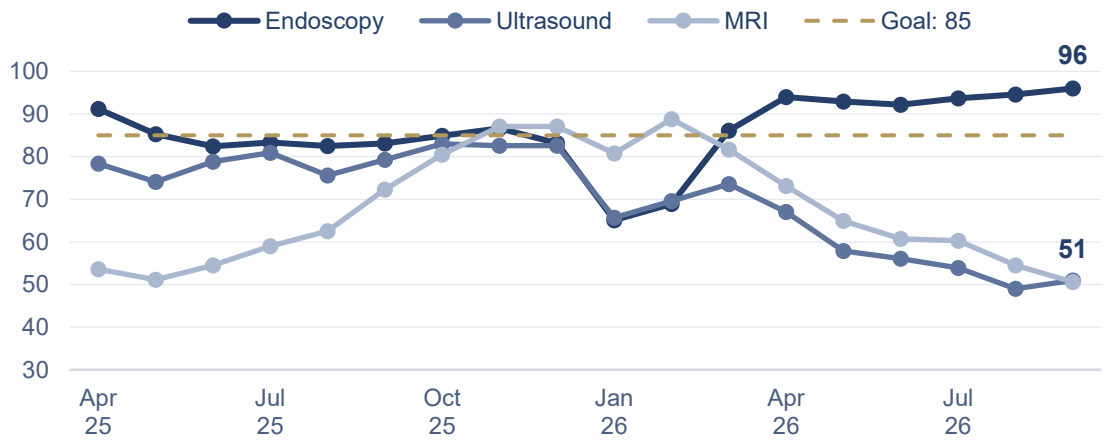
- About 2,500 extra operations and procedures are planned in orthopaedics, ophthalmology, ENT, urology and dermatology. Almost all start from mid-October, and nearly two thirds fall before the end of December.
- Ophthalmology accounts for 1,150, outsourced between October and Christmas. Outsourcing on that scale needs approval to share patient details with the provider, which is still with our information governance team; 42 cataract operations have been outsourced since the end of September.
- Orthopaedics has reduced its planned extra activity from 1,102 to 888 cases in this return, and 55 operations cancelled during the scabies outbreak at Prince Philip Hospital still have to be recovered.
- The two-year trajectory also relies on clinical validation from early November, confirming with each patient's clinical team that treatment is still needed.

# Diagnostics and therapies

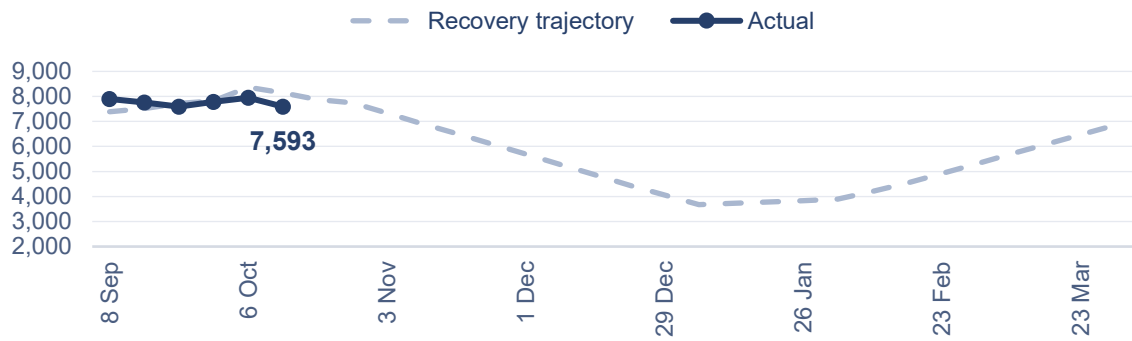
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Endoscopy has met its criterion for seven months in a row. Diagnostic waits are below the recovery trajectory, but ultrasound, MRI and therapy waits are further from their criteria than in the spring, and most extra diagnostic activity ends in December.

**Patients waiting less than eight weeks, in 100**




**Patients waiting over eight weeks for a diagnostic test, weekly**




**31 Endoscopy** — Assure

**96 in 100**

within eight weeks; 85 or above for seven months in a row

**32 Ultrasound and MRI** — Alert

**51 in 100**

within eight weeks for each, against 85

**30 All diagnostic tests** — Alert

**7,593**

over eight weeks at 13 October, below trajectory; about 3,700 in January, then 6,900 by March

**33 Therapies** — Alert

**68 in 100**

within 14 weeks, against 90; 4,153 waiting longer

Radiology outsourcing and double running are £2.8m above plan, matched by a (£2.8m) underspend on radiology vacancies: we buy in capacity because the posts are not filled. The current recovery plans do project an improvement in the coming months, but, these are non-recurrent in nature. Therefore, this is liable to be a real issue in the 27/28 Annual Plan.

# Risks and dependencies

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

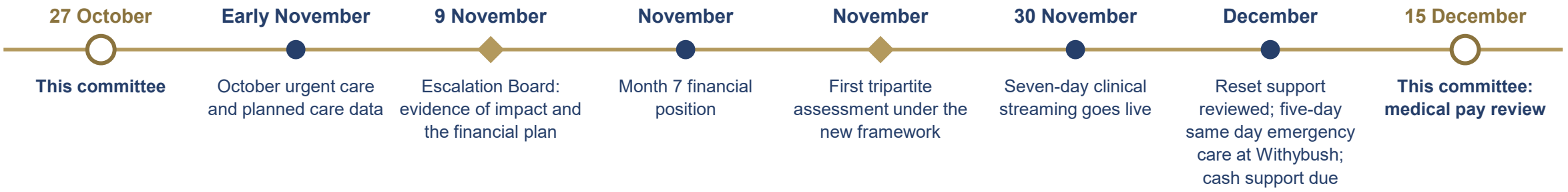
The main risks cut across the finance and performance criteria, because the same teams, rotas and budgets carry both. We manage each one through the recovery arrangements rather than alongside them.

| | Risk | Criteria | How we are managing it |
|---|---|---|---|
| 1 | **The further actions**<br>The forecast relies on (£20.2m) of actions from October without confirmed plans. Risks 2326 (this year's plan) and 1199 (financial sustainability) both score 25 out of 25. | 1, 3, 4 | Each action tested by the Performance and Recovery Group for an owner, a date and a recurrent value before 9 November; any gap raised with Welsh Government early |
| 2 | **Temporary staffing and the front door**<br>Reducing temporary staffing touches the same medical and nursing rotas that the urgent care tests depend on at Withybush and Glangwili. | 1, 4, 16, 17 | Reductions tested rota by rota against the risk the cover manages; medical pay review to this committee in December |
| 3 | **Urgent care changes start in winter**<br>Seven-day clinical streaming starts on 30 November and seven-day same day emergency care at Withybush in February 2027, after the test months. | 16 to 19 | Reset support on flow and discharge through October and November; Call Before Convey live; a daily operating model for flow |
| 4 | **Planned care recovery**<br>Most extra activity starts from mid-October, and almost half relies on ophthalmology outsourcing that awaits approval. Diagnostic waits rise again from January as extra activity ends. | 26 to 28, 30 to 33 | Weekly recovery returns to NHS Wales Performance and Improvement; the 2027/28 plan starts from what each service can deliver without one-off activity |
| 5 | **Cash**<br>On the forecast, we need strategic cash support from Welsh Government by the end of February 2027. | 3, 4 | Cash position reported to Welsh Government each month; cash management strategy applied if support is not confirmed by December |
| 6 | **Capacity to deliver**<br>The same leaders carry in-year recovery, the reset support, the Escalation Board and the 2027/28 plan. | All | One order of priority set through the Performance and Recovery Group; reset support aligned to existing plans rather than added to them. Also aligned to Audit and Risk Committee. |

# What the committee will see next

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Escalation Board and the first assessment under the new framework both fall before this committee meets again on 15 December. Each step gives the committee new evidence.




## What we will bring to the December meeting

| Finance and savings | Temporary staffing | Urgent care | Planned care and diagnostics | The new framework |
|---|---|---|---|---|
| Months 7 and 8; confirmed plans behind the (£20.2m); progress on recurrent conversion; cash support | The medical pay review, and each proposed reduction set against the rota and the risk its cover manages. This will be linked across the performance recovery group and improvement plans. | The October result and the Escalation Board outcome; the effect of the reset support on flow and discharge | October waits of more than two years against the trajectory of about 630; extra activity delivered; Welsh Government's response on endoscopy | The outcome of the November assessment and what it means for this committee's criteria |

# Recommendations

The committee is asked to:

| | | |
|---|---|---|
| 1 | **APPROVE** | these ratings: twelve criteria at Alert, six at Advise and one at Assure. Only endoscopy (criterion 31) meets the threshold for de-escalation. |
| 2 | **NOTE** | that September did not meet either urgent care test, with provisional figures putting handovers over 45 minutes at about 875 against 789; that the improvement in the forecast deficit to £37.5m comes wholly from the (£3.5m) Welsh Risk Pool reduction; and that most of the extra planned care activity is still to come. |
| 3 | **SCRUTINISE** | the plans behind the (£20.2m) of further actions before they go to the Escalation Board on 9 November: each with an executive owner, a date, a recurrent value and its effect on staffing and access. |
| 4 | **SUPPORT AND REQUEST** | that the December meeting receives the confirmed financial actions, the medical pay review, the October/November urgent care and planned care actions and results, and the outcome of the November assessment. |
| 5 | **SEEK ASSURANCE** | on the step change in internal escalation: four ratings at level 4 in the October scoring, against two last month. Community and Integrated Medicine is now at level 4 for workforce as well as finance, and Public Health for workforce. The level 4 action plans, and their effect on spending, should come to the December meeting. |

*Welsh Government sets escalation levels through the tripartite process. These ratings are the committee's evidence into it.*

3

**10:00, 0 Mins**

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

3.1 **10:00, 20 Mins**

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# 3.1 - HOSPITAL FLOW PROCESSES

***Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Mark Henwood (Hywel Dda UHB - Executive Medical Director), Nadine Gould (Hywel Dda UHB - Deputy Director of Nursing, Quality & Patient Experience)***

**Split into the UEC Three Pillars Programme:**

- **Pillar 1:** Pre-Hospital and Community (Executive Sponsor: James Severs)
- **Pillar 2:** Front Door and First 72 Hours (Executive Sponsor: Mark Henwood)
- **Pillar 3:** Ward-Based Flow and Discharge (Executive Sponsor: Sharon Daniel)

> For assurance

## Attachments

3.1 Hospital Flow Processes - UEC 3 Pillars October 2026.pdf




Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# UEC 3 Pillars Programme

## 27th October 2026

# Pillar 1: Update

| Report Date: | RAG Status | Project Lead: Bianca Oakley | Project Manager: Olivia Barnes |
|---|---|---|---|
| October 2026 | | Summary: Five active workstreams are progressing across service implementation, peer review, extended out-of-hours delivery and digital community falls. Immediate attention is required on workforce approvals and implementation readiness for the seven-day Clinical Streaming Hub. | |

| Project | RAG Status | Due date | Owner | Key Actions |
|---|---|---|---|---|
| **Call Before Convey** | | 29/09/26 | Bianca Oakley | • Project Go-Live date as per planned on the 28th September<br>• Review weekly activity data with WAST following go-live, identify learning and continue monitoring. Gather ED leads feedback to inform the formal evaluation. |
| **7-day CSH Implementation** | | 01/12/26 | Bianca Oakley | • Expedite recruitment and financial approvals; complete Pembrokeshire Community Nursing OCP; finalise regional and local SOPs; confirm go-live readiness and contingency. |
| **CSH Peer Review** | | 31/12/26 | Bianca Oakley | • Complete peer reviews through November, produce the final assessment report and recommendations and agree improvement plans. |
| **Extended OOH Service** | | 30/01/27 | Rhian Bond | • Complete recruitment and mobilisation, agree the operating model and workforce plans, and evaluate activity and impact to inform next-stage delivery. |
| **Enhanced Community Care** | | 31/12/26 | Sonia Hay | • Begin discussions on development or consolidation of the services reported on within the National dashboard. |
| **ISTUMBLE Digital Community Falls** | | 31/12/26 | Ellen Lewis | • Finalise governance and measures; confirm Phase 1 care homes; complete digital workflow review; prepare communications, training, safe implementation and early-use monitoring. |

# Pillar 2: Update

| Report Date: | RAG Status | Project Lead: John Evans / Eiry Edmunds | Project Manager: Olivia Barnes / Ellen Lewis |
|---|---|---|---|
| October 2026 | | Summary: Five workstreams are progressing though actions and developing plans following two Pillar 2 meetings. | |

| Project | RAG Status | Due date | Owner | Key Actions |
|---|---|---|---|---|
| **72 Hour Vision Document** | | 30.11.26 | Scott O'Rourk | Identify a programme plan from the First 72-Hours Vision Document incorporating CLD, D2RA allocation.<br>• Complete a on-call senior decision maker at the front door review.<br>• Undertake a gap analysis to identify resource requirements.<br>• Progress reaccommodation's following review and assessment of data. |
| **Ambulance Handover 45** | | 31.10.26 | Louise Cullum | • Progress and finalise the escalation policy.<br>• Continue monitoring and reviewing Call Before Convey implementation to identify learning opportunities<br>• Review NHSP&I report actions and confirm which remain applicable. |
| **WGH 7 Day SDEC Implementation** | | 12.3.27 | Jessica Svetz | • Complete OCP consultation process.<br>• Develop 7-Day SDEC SOP<br>• Commence recruitment once OCP requirements are addressed. |
| **Frailty** | | 28.1.27 | Angela Puffet /Marilize du Preez | Complete mapping against the 14 NHS P&I frailty standards.<br>• Agree identified gaps across acute sites.<br>• Rewrite the Frailty Plan.<br>• Develop clear actions, timescales and named ownership for delivery |
| **Escalation Policy** | | 31.12.26 | Sonia Hay | •Remove non-applicable content and adapt the document to reflect local roles, structures and processes.<br>•Complete review of terminology and align wording with NHS Wales Planning & Improvement definitions and local terminology.<br>•Review and update all Action Cards allocated to medical, nursing, operational and site management teams.<br>•Obtain approval on the Determining Escalation Levels document from: Paediatrics, Mental Health, WAST & AHP's.<br>•Incorporate feedback and amendments received from reviewers into the final document. |

# Pillar 3: Update

| Report Date: | Current RAG | Project Lead: Marilize du Preez | Project Manager: Ellen Lewis |
|---|---|---|---|
| October 2026 | | Summary: | |

| Project | RAG | Due date | Owner | Key Actions |
|---|---|---|---|---|
| **Optimal Hospital Flow** | | Ongoing | MDP | Visible on-site support to improve optimal flow elements. Ward managers event report to be finalised and areas identified for the next engagement sessions with the Pembrokeshire and Ceredigion systems. |
| **Discharge Leaflet** | | Nov 26 | MDP | Revise the draft patient discharge leaflet and circulate with clinical deputies for review. |
| **Red2Green** | | TBC | MDP/ Digital | Engage with Digital Services and system suppliers to review identified MIYA functionality issues affecting Red2Green compliance and data quality. Agree and implement a solution to address functionality constraints and improve data capture, visibility and reporting. |
| **Management of Clinically Optimised Patients SOP** | | Nov-26 | MDP | Identify a pilot area for the Management of Clinically Optimised Patients SOP. |
| **Pathway of Care Delays (PoCD) Trusted Assessor** | | Dec 26 | MDP | Complete and submit the PoCD Deep Dive. Support NHS P&I to complete the TA audit. |
| **Discharge to Recover Assess (D2RA)** | | Dec-26 | MDP | Focus on improving measure one compliance (D2RA pathway allocated within a day of admission)- linked to pillar 2. |
| **Preventing deconditioning** | | Nov-26 | MDP | Identification of phase 3 roll out areas, incorporating the community and care homes.<br>Review of the DEWI evaluation report. |
| **Strengths Based Collaborative Communication** | | Nov 2026 | MDP | Meeting scheduled with stakeholders to consider future funding and agree areas for further programme delivery between health and local authorities. |
| **Discharge Lounge** | | Nov 2026 | MDP | Optimal utilisation of the discharge lounge by predicting tomorrow's discharges today. Draft Discharge Lounge principles document developed. |
| **Board Rounds & Afternoon Huddles** | | Nov 2026 | MDP | Board round audit and ward specific improvement plans to support "by who, by when" approach at board rounds. AHP leadership meeting and ongoing engagement. Draft Board Rounds & Afternoon Huddles SOP developed. |
| **Carmarthenshire 15 bed pilot** | | Dec 2026 | Jonathan Edwards | Complete procurement and provider selection. Finalise operational model and governance arrangements. Establish pilot measures and reporting framework. Mobilise beds, nursing support and transport arrangements. Launch pilot and monitor impact on discharge flow and acute bed capacity. |
| **Pre-Clinically Optimised Carmarthenshire Social Worker Referrals** | | TBC | Jo Jones | Pilot agreed with Carmarthenshire Local Authority to enable earlier Social Worker referrals, prior to clinical optimised patients. |
| **Carmarthenshire Housing Delays** | | TBC | Jo Jones | Multi-agency discussion scheduled to identify potential solutions to housing-related delays impacting discharge. |

# Pillar 3: Risk Register

| Project | Risk Title | Risk Statement | Severity | Likelihood | Risk Score | Mitigation Plan | Mitigated Severity | Mitigated Likelihood | Mitigated Risk Score |
|---|---|---|---|---|---|---|---|---|---|
| Optimal Flow | Optimal Flow Implementation | There is a risk that the deadline for implementing the Optimal Hospital Flow Framework (OHFF) may not be achievable due to limited resource availability, particularly clinical / site staff. These constraints could lead to delays in overall implementation progress. | 3 | 2 | 6 | A series of Reset Weeks and Sprints have been delivered to reinforce the principles of Optimal Flow. The appointment of an Executive Sponsor for Pillar 3 has strengthened governance and accelerated delivery of key actions. Site-specific Optimal Flow plans are monitored monthly through the programme, supported by performance data, with related improvement work across established groups aligned to the Optimal Hospital Flow Framework. Refreshed Optimal Flow and discharge guidance for staff developed to support ongoing implementation. Renewed focus on Board round process and effectiveness. | 2 | 2 | 4 |
| Optimal Flow | DEWI Tool | There is a risk that the benefits of the DEWI Tool will not be fully realised as it is currently a paper-based tool, resulting in inconsistent completion, limited oversight of compliance, and an inability to routinely capture and analyse data to demonstrate impact on deconditioning prevention and patient outcomes. | 3 | 4 | 12 | Development of a digital solution is being explored to enable real-time data capture, reporting, compliance monitoring, and integration into routine patient care processes. In the interim, regular audits and ward-level compliance monitoring are being undertaken. | 3 | 3 | 9 |
| Clinically Optimised Patient SOP | Delay in identifying and securing a pilot ward for the Clinically Optimised Patient SOP | There is a risk that implementation of the Clinically Optimised Patient SOP will be delayed due to difficulties engaging operational teams and securing a suitable pilot ward. This may result in missed opportunities to test and refine the process, reduced pace of improvement in patient flow, and delays in achieving benefits associated with the timely management of clinically optimised patients. | 3 | 4 | 12 | Identify a smaller-scale pilot area if a full ward pilot cannot be agreed. | 3 | 2 | 6 |
| Optimal Flow | CLD | There is a risk that Criteria Led Discharge (CLD) will not be implemented consistently across inpatient areas due to a lack of clinical engagement, ownership, and buy-in from key stakeholders. This may delay adoption of the model and limit opportunities to improve patient flow, reduce discharge delays, and release capacity within the hospital. | 4 | 4 | 16 | Actioning within Pillar 2 as part of the 72 hour standards document. Engage clinical leaders, consultants, nursing teams, and therapy staff early in the design and implementation process. Develop and implement a comprehensive Criteria Led Discharge training package to improve awareness, understanding, and confidence in the CLD process. | 4 | 2 | 8 |
| Optimal Flow | Red2Green | There is a risk that limitations in MIYA system functionality impact the accuracy, completeness and consistency of Red2Green (R2G) data, resulting in reduced compliance, unreliable reporting, and an inability to effectively identify, monitor and escalate delays in patient flow and discharge processes. | 3 | 4 | 12 | Engage with Digital Services and system suppliers to review identified MIYA functionality issues affecting Red2Green compliance and data quality. Agree and implement a solution to address functionality constraints and improve data capture, visibility and reporting. | 2 | 2 | 4 |
| Optimal Flow | Discharges Before Midday measure | The Discharges Before Midday measure currently includes patients transferred to the Discharge Lounge before midday rather than those who have physically been discharge from the hospital. As this metric is reported to NHS Planning & Improvement (NHS P&I) as a key Optimal Hospital Flow Framework measure, there is a risk that discharge performance is inaccurate and not reliable of reported outcomes. | 4 | 4 | 16 | The issue has been escalated to Digital Services and the Deputy Chief Operating Officer (Deputy COO) for review and action. Work is underway to validate the reporting methodology, clarify the definition of the Discharges Before Midday measure, and identify any system or reporting changes required to ensure data submitted to NHS P&I accurately reflects patients who have physically left hospital before midday. | 2 | 2 | 4 |
| Optimal Flow | Absence of Clinically Optimised Worklist Functionality in MIYA | The clinically optimised patient worklist functionality previously available within Frontier is not currently available within MIYA. As this functionality supports the identification and management of clinically optimised patients, discharge communication, and the coordination of complex discharges, its absence may reduce visibility of patients ready for discharge, delay discharge planning activities, and contribute to increased length of stay, increased pathways of care delays (PoCD), and reduced patient flow across hospital sites. | 4 | 4 | 16 | Issue escalated to Digital Services on multiple occasions. Continue engagement through Digital governance and programme reporting structures to secure a solution and implementation timeline. Explore interim reporting mechanisms and manual workarounds to support identification and tracking of clinically optimised patients pending system enhancement. Monitor impact through discharge and patient flow groups. | 3 | 2 | 6 |
| Carmarthenshire Interim Bed Pilot | Mobilisation Timeline | There is a risk that the planned mobilisation of commissioned care home beds by 1 December 2026, or as soon as possible thereafter, may not be achieved due to procurement timescales, operational capacity constraints, contractual requirements and other unforeseen factors. This could delay implementation of the scheme and reduce the anticipated impact on patient flow, discharge performance and system capacity during winter pressures. | 4 | 3 | 12 | Procurement team contacted to highlight the urgency of the requirement. Request made for a dedicated procurement lead to support progression. Carmarthenshire System Operational Triumvirate engaged and briefed on mobilisation requirements. Regular progress reviews established to identify and escalate barriers promptly. Mobilisation plan to be developed with key milestones, responsibilities and dependencies. | 4 | 2 | 8 |
| PoCD | Achievement of PoCD Target | There is a risk that the Pathway of Care Delay target (PoCD) target will not be achieved, as only 13% of delayed pathways are attributable solely to Health Board factors. The majority of delays are either jointly owned with partner organisations or are the responsibility of Local Authorities, limiting the Health Board's direct ability to deliver the target independently. | 4 | 4 | 16 | Memorandum of Understanding (MoU) hospital discharge in place. Agree and monitor delivery of the regional action plan; maintain regular partnership meetings; strengthen system-wide accountability and collaborative working; utilise strengths-based approaches to problem solving and escalation across partner organisations. | 4 | 2 | 8 |

# UEC Trajectories and Actuals 2026/27

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| | 45-minute handover (breaches; % within) | 4-hour ED/MIU (% within; modelled) | 12-hour waits (count; %) | Pathways of Care Delays (count) |
|---|---|---|---|---|
| **Target** | **Q4: >90% in 15 mins; 100% within 45 mins** | **95%** | **7% or fewer** | **174 or fewer** |
| **May 2026 (baseline)** | 879 (59.5%)<br>Actual: 60% | 72.4%<br>Actual:63% | 1,443 (8.6%)<br>Actual: 11% | 201<br>Actual: 186 |
| **June 2026** | 846 (59.3%)<br>Actual: 55% | 72.5%<br>Actual: 64% | 1,325 (8.4%)<br>Actual: 11% | 200<br>Actual: 192 |
| **July 2026** | 786 (64.1%) *Stretch 65.9%*<br>Actual: 68% | 72.5%<br>Actual: 64% | 1,374 (8.2%)<br>Actual: 10% | 198<br>Actual: 204 |
| **August 2026** | 691 (68.6%) *Stretch 75.4%*<br>Actual: 61% | 72.6%<br>Actual: 63% | 1,364 (8.2%)<br>Actual: 11% | 196<br>Actual: 250 |
| **September 2026** | 582 (73.0%) *Stretch 77.5%*<br>Actual: 55% | 72.6%<br>Actual: 63% | 1,249 (8.1%)<br>Actual: 11% | 195<br>Actual: 222 |
| **October 2026** | 599 (74.0%) *Stretch 78.2%* | 73.4% | 1,293 (8.0%) | 193 |
| **November 2026** | 645 (69.7%) *Stretch 79.8%* | 73.8% | 1,197 (8.3%) | 191 |
| **December 2026** | 644 (69.2%) *Stretch 79.7%* | 74.7% | 1,212 (8.6%) | 190 |
| **January 2027** | 656 (69.6%) *Stretch 79.7%* | 75.1% | 1,356 (9.4%) | 188 |
| **February 2027** | 538 (71.7%) *Stretch 79.9%* | 75.4% | 1,116 (8.2%) | 185 |
| **March 2027** | 585 (71.8%) *Stretch 80%* | 75.5 | 1,106 (6.9%) | 183 |

# Recommendations

- **NOTE the progress made across the Three Pillars Programme and the range of improvement activity currently being progressed across urgent and emergency care, hospital flow and discharge.**
- **NOTE the key delivery risks and dependencies, particularly workforce and financial approvals for the seven-day Clinical Streaming Hub, completion of the Pembrokeshire Community Nursing organisational change process, and confirmation of implementation readiness and contingency arrangements.**
- **TAKE ASSURANCE that outstanding workforce, recruitment, financial and digital dependencies are being addressed through the appropriate executive and governance routes, with any unresolved matters that may impact delivery escalated promptly.**
- **TAKE ASSURANCE that workstreams with identified delivery pressures have clear recovery actions, accountable owners, achievable timescales and defined escalation routes, with exceptions reported through the established governance arrangements.**
- **NOTE that current performance remains below the stated year-end targets for ambulance handovers, four-hour performance and Pathways of Care Delays, notwithstanding the improvement anticipated through the programme trajectories.**



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3.2

**10:20, 20 Mins**

# 3.2 - PATHWAY OF CARE DELAYS

***Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Sharon Daniel (Hywel Dda UHB - Executive Director of Nursing, Quality & Patient Experience)***

For assurance

### Attachments

3.2 PoCD Deep Dive October 2026.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 27 October 2026 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Urgent and Emergency Care: Pathway of Care Delays (PoCD) Deep Dive |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Andrew Carruthers, Chief Operating Officer, Sharon Daniel, Executive Director of Nursing, Quality and Patient Experience |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Peter Skitt, Community and Integrated Medicine Clinical Care Group Director |

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

## DRODDIAD SCAA SBAR REPORT

### Sefyllfa / Situation

The Urgent and Emergency Care Pillar 3 is responsible for the oversight and improvement of Pathway of Care Delays (PoCD) across the Health Board, as part of its wider remit for ward-based flow and discharge. It aims to reduce avoidable delays and prolonged hospital stays by embedding a Home First approach, strengthening discharge planning from admission, improving multidisciplinary working and supporting patients to recover in the most appropriate setting. The Executive Director of Nursing, Quality and Patient Experience has been appointed as the Pillar 3 Executive Sponsor, providing clear executive leadership, accountability and oversight for delivery.

The Health Board is required to submit monthly Pathway of Care Delay (PoCD) census data to Welsh Government, in accordance with revised guidance issued in April 2025.

### Cefndir / Background

A Pathway of Care Delay is experienced by an adult inpatient occupying a bed in an NHS hospital, who is ready to move on to the next stage of care but is prevented from doing so by one or more reasons. The definition for recording a PoCD is any patient still in an NHS hospital bed 48 hours after being declared clinically optimised (including mental health beds).

A patient is considered “Clinically Optimised” if a clinical decision has been made by the registered professional(s) that the patient is ready for transfer or discharge from an inpatient hospital bed (NHS Wales Data Dictionary) in an acute or community setting. The registered professional must be part of the multi-disciplinary team (MDT) and have discharge/ transfer

rights. The term “Clinically Optimised” applies to all adults occupying an NHS hospital bed, who are “clinically optimised” ready to return home or move on to the “next stage of care”. The “next stage of care” refers to all destinations outside of NHS hospitals.
A patient is considered clinically optimised when both the following criteria have been met:

1. Acute medical needs have been addressed – their medical condition is stable, and no further hospital-based care is required.

2. No longer requires specialist hospital-based MDT interventions. Any ongoing care can be provided outside a hospital setting (including rehabilitation needs).

To ensure a clear understanding of the term “clinically optimised”, a Clinically Optimised Definition Paper has been developed for staff, to standardise how clinically optimised status is defined, recorded, escalated and monitored.

**Health Board and Local Authorities Regional Validation Process**
The reported PoCD data reflects the regional position on the third Wednesday of each month (a one day “snapshot”). To support the regional West Wales monthly submission of PoCD census data to Welsh Government, a formal validation process has been established between the Health Board and local authority partners.

The monthly validation process supports accurate and consistent reporting of PoCD. A master list of clinically optimised patients is extracted from the digital patient flow system on the third Monday of each month and circulated to county teams by the Regional Validation Chair. Each county then validates the information with its Local Authority, Long-Term Care and Allied Health Professional teams before Census Day.

A regional validation meeting is held on Census Day, the third Wednesday of each calendar month, with health and Local Authority representatives from each county. Each individual PoCD patient is discussed and the delay reason agreed against the list of 63 national delay codes. Each county is responsible for entering their validated data onto the national PoCD database, confirming completion and returning the coded master list. Named deputies are required to maintain continuity during staff absence, reducing the risk of gaps or delays in reporting. The Chair reviews submissions against the master cohort, confirms compliance with the national definition and resolves any outstanding queries before final submission.

A similar process is established within Mental Health and Learning Disabilities services.

**Regional PoCD reporting and targets**
Within the national reporting structure, the Health Board, Carmarthenshire, Ceredigion and Pembrokeshire Local Authorities are collectively referred to as the West Wales Region. PoCD delays for any residence of a region, regardless of which health board bed in Wales they are in, will be captured in the regionally reported dataset. This accounts for discrepancies sometimes seen between Health Board reported PoCD data (patients within HDdUHB hospitals, regardless of where they normally reside) and regional PoCD (West Wales residents in any hospital across Wales).

In 2025/26, three national PoCD targets were set against a baseline position from March 2025:

- Number of total PoCD delays (target 15% reduction)
- Number of days delayed (target 20% reduction)
- Number of assessment delays (target 20% reduction)

In the absence of any agreed national targets for 2026/27, health boards have set their own; however, each region's performance is still being tracked against the original targets (baseline March 2026). In additional to the national targets, the Health Board is also being monitored against:

- % of Emergency Admissions with a length of stay >21 days
- Average length of stay pre and post clinically optimised
- % Patient delayed 100+ days

## POCD Target Trajectories Vs Actual – HDUHB

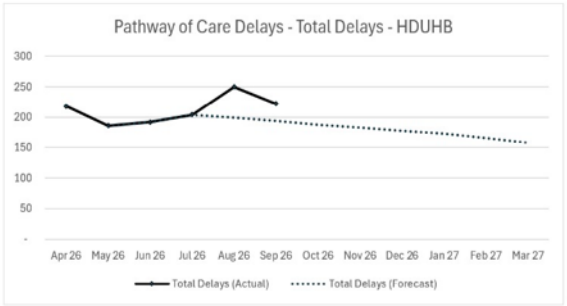
**Outcome measure:** Pathway of Care Delays (including a reduction in total delays, days delayed and assessment delays)

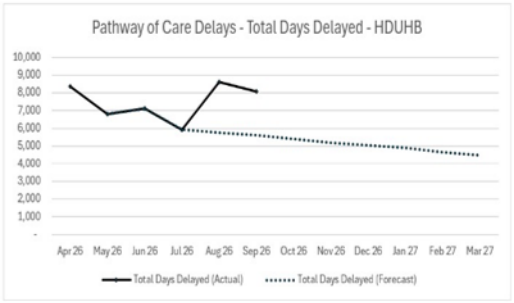
**People Delayed**

| | April'26 | May 26 [Baseline] | June 26 | July 26 | Aug 26 | Sept 26 | Oct 26 | Nov 26 | Dec 26 | Jan 27 | Feb 27 | March 27 | Health Board Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | |
| HDUHB | 218 | 201 / 188 | 200 / 192 | 198 / 204 | 196 / 250 | 195 / 222 | 193 / | 191 / | 190 / | 188 / | 185 / | 183 / | < 174 |

**Total Days Delayed**

| | April 26 | May 26 [Baseline] | June 26 | July 26 | Aug 26 | Sept 26 | Oct 26 | Nov 26 | Dec 26 | Jan 27 | Feb 27 | March 27 | Health Board Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | Forecast / Actual | |
| HDUHB | 8,344 | 6,813 | 7,112 | 5,919 | 8,588 | 8063 | | | | | | | - |




**Please note:** Trajectory chart updates may be delayed by up to two months.

## Asesiad / Assessment

**Current performance**

Despite an ongoing challenging position in the number of PoCD across the region, an analysis of the data demonstrates sustained improvement across a number of core indicators:

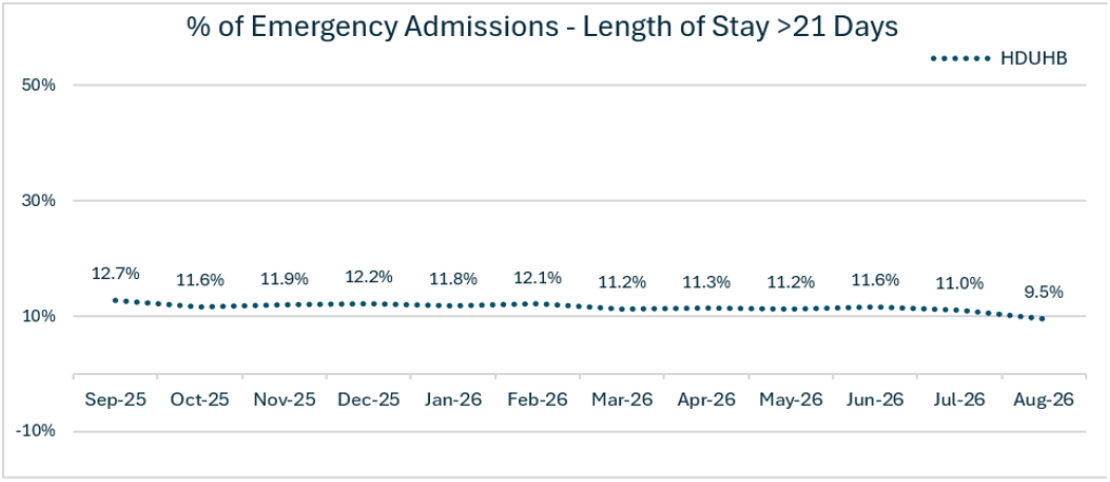
- Reduction in total days delayed
- Reduction in assessment delays
- Reduction in length of stay> 21 days
- Reduction in total length of stay and average length of stay
- Reduction in length of stay post-clinically optimised
- Reduction in the % of patients experiencing delays greater than 100 days.

This represents meaningful progress in addressing some of the most complex discharge cases within the Health Board. The Health Board performs favourably against the Wales population average for Pathway of Care Delays, reporting an overall delay rate of 11.17% compared with the all Wales position of 11.65%.

| West Wales Region | Ambition target reductions by Nov 25 | Mar 25 Baseline | Jul 26 | Jul 26 Position | Aug 26 | Aug 26 Position | Sep 26 | Sep 26 Position |
|---|---|---|---|---|---|---|---|---|
| Total Delays | 15% | 217 | 203 | 6.5% ⇩ | 249 | 14.7% ⇧ | 224 | 3.2% ⇧ |
| Days Delayed | 20% | 8,754 | 5,552 | 36.6% ⇩ | 8,136 | 7.1% ⇩ | 7,992 | 8.7% ⇩ |
| Assessment Delays | 20% | 109 | 93 | 14.7% ⇩ | 105 | 3.7% ⇩ | 87 | 20.2% ⇩ |

## Emergency admissions with a length of stay > 21 days - HDUHB

**Outcome measure:** Reduction in > 21 day Length of Stay (LoS)



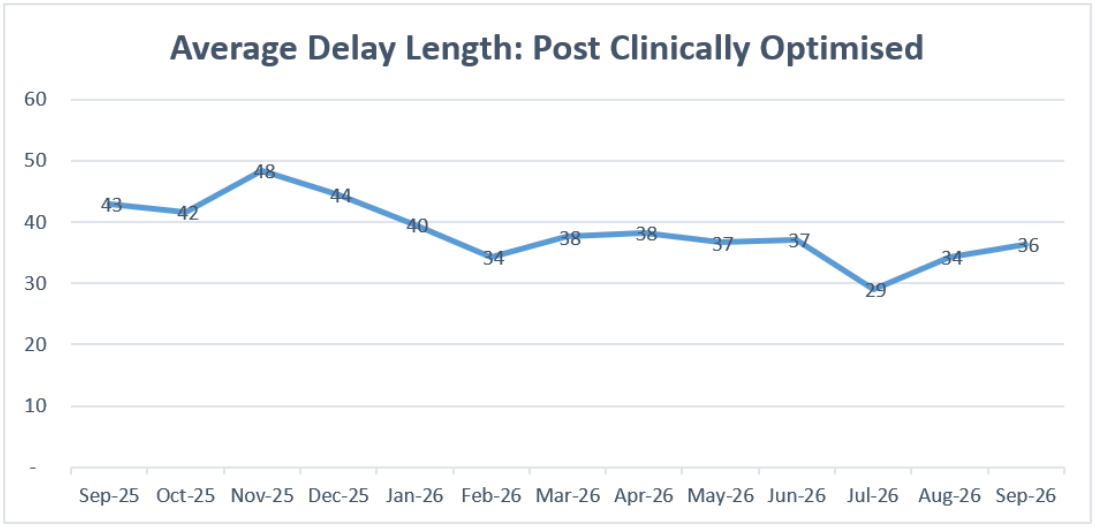

**16 September 2026** **Total Delays & Length of Stay (Days)**

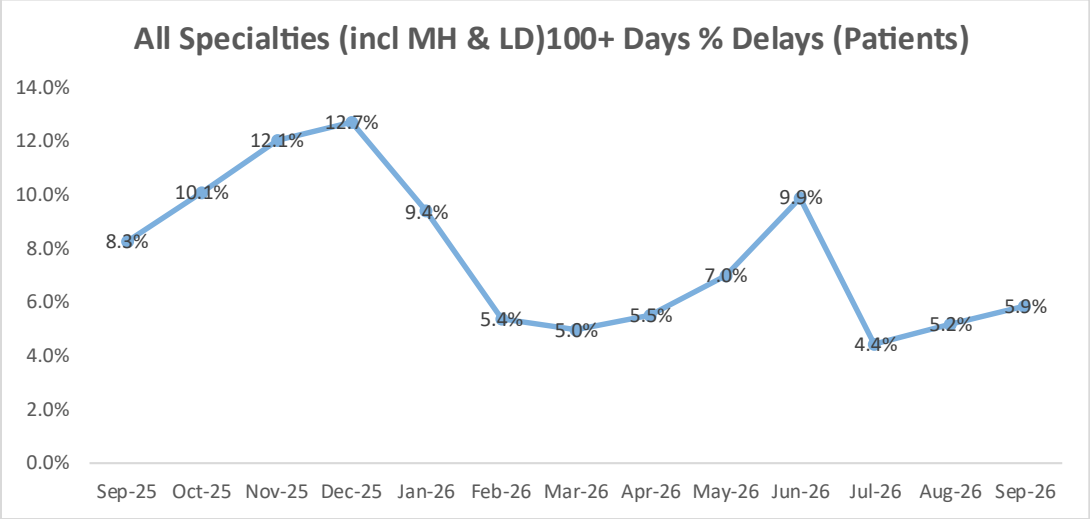
HealthBoard: HDUHB | Local Authority: Multiple selections | Region: All | Hospital Name: All | Ward Type: Multiple selections | Age Group: All | Current Speciality: All

Options: Current Month | Previous Month | Last 3 Months | Last 6 Months | Last 12 Months | LOS Breakdown | LOS by Ward Type | LOS by Assessmen... | LOS by Descriptor | LOS Charts | Descriptor: All

Total Length of Stay & Delay Length for Latest Census Date (16 September 2026)

| Census Date | Total Delays | Total Days Stayed | Total Days Delayed | Total Length of Stay | Average LOS | Proportion of LOS that is Delayed |
|---|---|---|---|---|---|---|
| 16 September 2026 | 220 | 8,557 | 7,816 | 16,373 | 74 | 47.7% |
| 19 August 2026 | 246 | 8,307 | 8,038 | 16,345 | 66 | 49.2% |
| 15 July 2026 | 198 | 5,874 | 5,447 | 11,321 | 57 | 48.1% |
| 17 June 2026 | 188 | 5,459 | 6,723 | 12,182 | 65 | 55.2% |
| 20 May 2026 | 175 | 6,064 | 6,399 | 12,463 | 71 | 51.3% |
| 15 April 2026 | 212 | 7,696 | 8,105 | 15,801 | 75 | 51.3% |
| 18 March 2026 | 211 | 6,950 | 7,928 | 14,878 | 71 | 53.3% |
| 18 February 2026 | 235 | 8,173 | 8,138 | 16,311 | 69 | 49.9% |
| 21 January 2026 | 208 | 6,780 | 8,319 | 15,099 | 73 | 55.1% |
| 17 December 2025 | 200 | 8,227 | 8,935 | 17,162 | 86 | 52.1% |
| 19 November 2025 | 199 | 9,751 | 9,415 | 19,166 | 96 | 49.1% |
| 15 October 2025 | 253 | 11,599 | 10,240 | 21,839 | 86 | 46.9% |





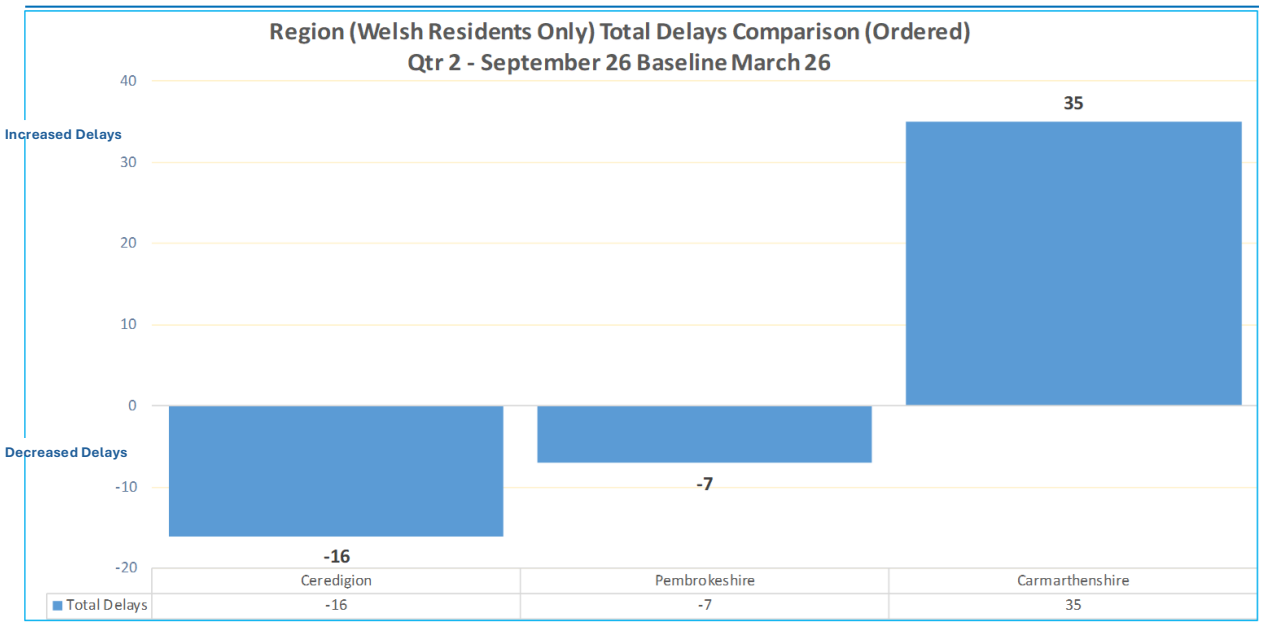

Assessment delays (including social care, continuing healthcare, nursing and allied health professional assessments) remain the largest contributing factor towards PoCD, with a marked variation between the three counties. This variation is also reflected in the number of delays and days delayed per county against the baseline position of March 2026. Access to support to facilitate discharge funded by local authority (reablement and new community care packages) and care home related issues (choice, manager's assessment and availability) also significantly contribute to PoCDs. An increasing area of concern in delays is the number of housing related issues preventing people being discharged from hospital.

Total Delays & Total Days Delayed by Descriptor Ordered for the Period of Last 3 Months (Jul-26 to Sep-26)

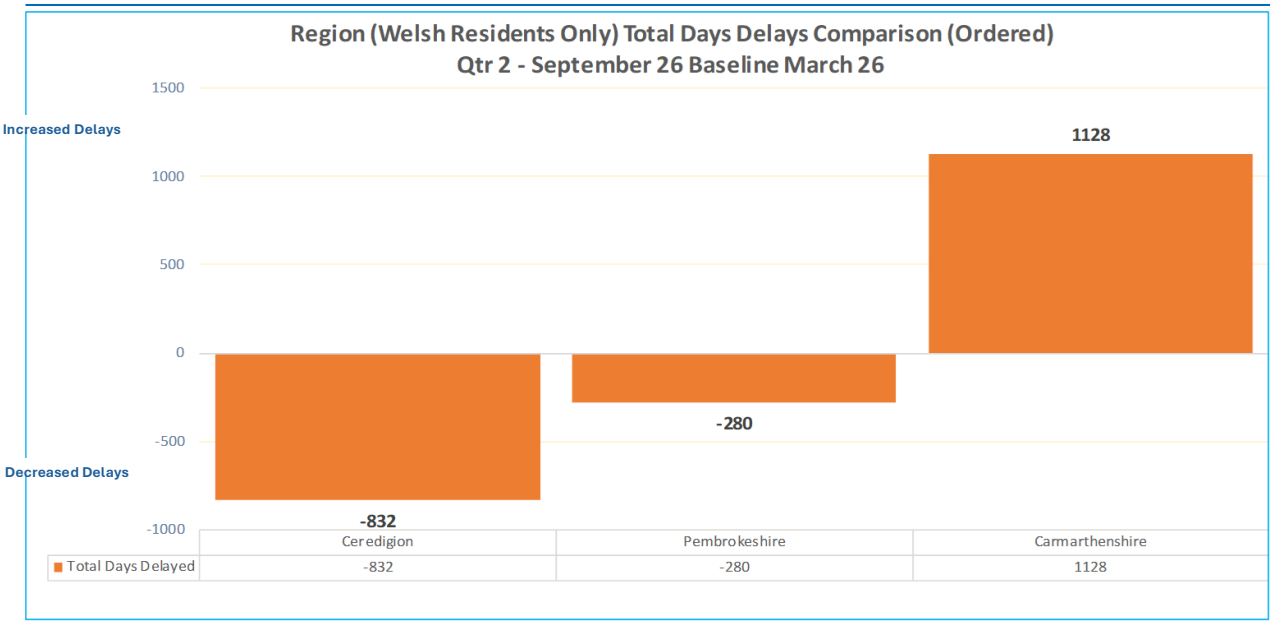
| Census Date | Wednesday, July 15, 2026 | | Wednesday, August 19, 2026 | | Wednesday, September 16, 2026 | |
|---|---|---|---|---|---|---|
| Descriptor | Total Delays | Total Days Delayed | Total Delays | Total Days Delayed | Total Delays | Total Days Delayed |
| 1.01.02 - Awaiting completion of assessment by social care | 33 | 808 | 47 | 1,176 | 43 | 1,243 |
| 2.04.01 - Awaiting reablement community care package | 27 | 415 | 43 | 1,055 | 35 | 1,192 |
| 2.03.01 - Awaiting start of new community care package funded by social care | 28 | 851 | 30 | 1,309 | 26 | 1,058 |
| 1.01.05 - Awaiting joint assessment | 14 | 155 | 9 | 228 | 9 | 177 |
| 1.01.03 - Awaiting completion of assessment Nursing | 10 | 237 | 11 | 120 | 6 | 122 |
| 1.01.07 - Awaiting completion of AHP Allied Health Professional Assessment | 10 | 213 | 5 | 61 | 11 | 273 |
| 1.01.04 - Awaiting Continuing Healthcare (CHC) Assessment | 7 | 313 | 9 | 150 | 9 | 289 |
| 3.01.13 - Identifying Residential Home | 5 | 349 | 13 | 729 | 7 | 386 |
| 1.01.12 - Mental Capacity Assessment Delays | 11 | 180 | 8 | 304 | 5 | 190 |
| 1.01.11 - Awaiting completion of best interest decision | 4 | 67 | 9 | 209 | 2 | 69 |
| 3.01.05 - Awaiting RH availability | 4 | 91 | 5 | 284 | 4 | 96 |
| 2.04.03 - Awaiting step down temp placement to a care home | 2 | 118 | 3 | 136 | 7 | 236 |
| 3.01.15 - Identifying Dementia residential home | 3 | 305 | 4 | 120 | 5 | 264 |
| 3.03.02 - No suitable abode - requires re housing | 3 | 105 | 6 | 419 | 3 | 250 |
| 3.01.06 - Awaiting NH availability | 5 | 255 | 2 | 122 | 3 | 133 |
| 3.01.12 - Awaiting Mental Health Placement | 1 | 50 | 3 | 81 | 5 | 179 |
| 3.03.03 - Home unsafe and requires attention | 4 | 317 | 1 | 196 | 4 | 256 |
| 3.01.16 - Identifying Dementia nursing home | 3 | 81 | 1 | 28 | 4 | 71 |
| 2.03.04 - Awaiting CHC community care package | 3 | 127 | 3 | 180 | 1 | 41 |
| 2.05.04 - Patient / family disputing and/or delaying to move to any stage of care / next stage of discharge | 3 | 66 | 2 | 46 | 2 | 36 |
| 3.01.14 - Identifying Nursing Home | 1 | 85 | 2 | 25 | 4 | 278 |
| 3.01.02 - Awaiting care home manager to visit, assess and provide outcome (Residential) | | | 3 | 161 | 3 | 271 |
| 3.01.04 - Awaiting completion of self-funding arrangements to placement | 1 | 62 | 2 | 132 | 3 | 174 |
| 3.01.18 - Awaiting pallitive care home Care Package (Fast track to Care Home) | | | 3 | 75 | 3 | 113 |
| 3.03.01 - Homeless | 2 | 137 | 1 | 128 | 3 | 186 |
| 1.01.01 - Awaiting Social worker allocation | 2 | 21 | 3 | 33 | | |
| 3.01.08 - Awaiting Dementia Nursing availability | 2 | 37 | 2 | 114 | 1 | 7 |
| 2.01.02 - Awaiting funding decision FNC/CHC | | | 2 | 79 | 2 | 90 |
| 2.05.01 - Patient / family care home choice | 2 | 59 | | | 2 | 133 |
| **Total** | **204** | **5,919** | **250** | **8,588** | **222** | **8,063** |

| Delay Reason | Carmarthenshire | Ceredigion | Pembrokeshire | Out of Area | Total Patient Count | Total Days Delayed | Average Days Delayed |
|---|---|---|---|---|---|---|---|
| Awaiting completion of assessment by social care | 37 | 2 | 3 | 1 | 43 | 1,243 | 29 |
| Awaiting reablement community care package | 32 | 1 | 2 | 0 | 35 | 1,192 | 34 |
| Awaiting start of new community care package funded by social care | 13 | 2 | 11 | 0 | 26 | 1,058 | 41 |
| Identifying Residential Home | 2 | 1 | 4 | 0 | 7 | 386 | 25 |
| Awaiting Continuing Healthcare (CHC) Assessment | 5 | 2 | 2 | 0 | 9 | 289 | 32 |
| Identifying Nursing Home | 4 | 0 | 0 | 0 | 4 | 278 | 20 |
| Awaiting completion of AHP Allied Health Professional Assessment | 5 | 1 | 5 | 0 | 11 | 273 | 34 |
| Awaiting care home manager to visit assess and provide outcome (Resid | 1 | 2 | 0 | 0 | 3 | 271 | 55 |
| Identifying Dementia residential home | 5 | 0 | 0 | 0 | 5 | 264 | 20 |
| Home unsafe and requires attention | 0 | 2 | 1 | 1 | 4 | 256 | 38 |
| Other | 38 | 10 | 27 | 0 | 75 | 2,553 | 37 |
| **TOTALS:** | **142** | **23** | **55** | **2** | **222** | **8063** | **36** |

## Monitoring Total Delays – West Wales




## Monitoring Days Delayed – West Wales




Across the West Wales region, a relatively small proportion (13%) of PoCD are within the control of health care alone, the majority of delays (53%) have joint responsibility, and social care have responsibility for 34% of PoCD. Regional oversight has been established to support a shared approach to PoCD.

| Service Area Leads | 15 July 2026 | 19 August 2026 | 16 September 2026 |
|---|---|---|---|
| Health Care | 26 | 30 | 29 |
| Joint | 108 | 132 | 117 |
| Social Care | 70 | 88 | 76 |
| Grand Total | 204 | 250 | 222 |

| Service Area Lead (%) | 15 July 2026 | 19 August 2026 | 16 September 2026 |
|---|---|---|---|
| Health Care | 13% | 12% | 13% |
| Joint | 53% | 53% | 53% |
| Social Care | 34% | 35% | 34% |

**PoCD – Operational Context**

Pathway of Care Delays are influenced by a combination of workforce, operational and system pressures across health and social care. Periods of annual leave, vacancies, maternity leave and sickness across any part of the system can affect the availability of timely assessment, decision-making and onward care arrangements. These pressures are compounded by variation in service capacity, competing operational demand, infection control and prevention measures and limited availability of certain community and care-sector pathways. Collectively, these factors can delay multidisciplinary assessment, discharge planning and access to the support required for patients to leave hospital safely.

A deep dive into the August 2026 PoCD census day reflects the impact of operational system pressures on PoCD performance. Key challenges on census day included:

- 27 surge beds operational on census day.
- 35 patients managed within boarding capacity.
- Workforce shortfalls of 27 Registered Nurses and 56 Health Care Support Workers.
- High levels of sickness absence and annual leave across the system.
- Limited availability within domiciliary care, reablement and care home placements.
- Medical staffing changeover period.
- Three of four acute hospital sites escalating to Red 20 status.
- 55 patients awaiting inpatient beds within Emergency Departments.
- No available adult mental health inpatient beds.
- 42 patients waiting over 12 hours in Emergency Departments.
- Significant ambulance delays and associated lost operational hours.

**What Is Working Well**

Several initiatives continue to contribute positively to performance improvement:

- Fishbowl methodology and escalation processes.
- Red to Green principles.
- Daily multidisciplinary discharge facilitation and board rounds.
- Strengths-based Collaborative Communication and assessment approaches.
- Person-centred discharge planning.
- Integrated health and social care operational working.
- Social Care and Partnership Initiatives
- Stable social work allocation processes.
- Effective social work triage arrangements.

- Senior Practitioner oversight within acute hospitals.
- Long length of stay review meetings.
- Community-based assessment models.
- Technology Enabled Care supporting Discharge to Recover and Assess (D2RA) pathways.
- Development of Trusted Assessor approaches.

Collectively, these measures are improving decision-making, reducing duplication, and supporting discharge to the most appropriate setting. Alongside these operational improvements, the Pathways of Care Transformation Grant programme within Local Authorities is supporting delivery of key initiatives (such as hospital based social worker provision, increased reablement and domiciliary care capacity) aimed at improving assessment processes, discharge flow, community-based care, reablement services and multidisciplinary working. Despite a 43% increase in hospital referrals to social services, delayed pathways increased by only 20%, suggesting that health and social care services are absorbing a significant proportion of additional demand through improved flow management and integrated working.

**Key risks and challenges**
Whilst progress remains positive on some key indicators, a number of strategic challenges and risks require ongoing attention:

- Multi-agency information sharing and documentation challenges.
- Market instability affecting placement and care provider sustainability.
- Care home and community (reablement and homecare) capacity, including access to specialist mental health beds.
- Recruitment and retention across all sectors.
- Allied health professions (AHP) staffing position across acute sites impacting on timely AHP assessments and limits access to appropriate levels of rehabilitation contributing to increased need for reablement and new packages of care on hospital discharge (Risk 2145 -Physiotherapy, Risk 2170- Occupational Therapy, Risk 2292- Speech and Language Therapy, Risk 2373- Nutrition and Dietetics).
- There is a risk that the Pathway of Care Delay (PoCD) targets will not be achieved, because delivery depends on coordinated action across the Health Board, Local Authorities and wider system partners. Only 13% of delayed pathways are attributable solely to Health Board factors; the majority are jointly owned or sit within Local Authority responsibilities. This limits the Health Board's ability to deliver the target independently and reinforces the need for shared accountability, timely escalation and delivery of agreed system actions through the established partnership governance arrangements.

**Assurance and oversight**
Monthly West Wales - UEC Pillar 3 Regional Performance and Delivery Meetings with NHS Performance and Improvement provides scrutiny and monitor regional PoCD performance and progress. Meetings are jointly attended by the health board and local authority partners.

Locally, PoCD sit within the wider UEC 3 Pillars governance and reporting structure. Progress, risks, mitigations and actions are monitored and escalated through the fortnightly Pillar 3 Oversight Group.

There are established regional arrangements to support assurance, partnership working and oversight of PoCD. A formal monthly validation process is in place to improve the accuracy,

consistency and completeness of PoCD reporting, with health, Local Authority, Long-Term Care and Allied Health Professional teams contributing to validation ahead of the monthly census submission.

The integrated regional West Wales Optimal Hospital Flow and Discharge Delivery Group meets monthly, with PoCD included as a standing agenda item to review performance, identify barriers and coordinate system action. Monthly meetings are also held with each county system to support delivery of local implementation plans, with PoCD routinely reviewed as a standing agenda item. In addition, a Hospital Discharge Memorandum of Understanding is in place and has been signed by the Health Board and each Local Authority partner, providing a shared framework for responsibilities, partnership working and escalation across the discharge pathway. The Delivery group supports the implementation of the Regional PoCD Action Plan. The action plan provides assurance that a structured and partnership-based programme is in place to improve PoCD performance. It combines governance, workforce, standardised processes, escalation arrangements and community capacity initiatives, with named leads, timescales and routine oversight.

Local Authority Transformation Grant funding to expand community and hospital-based capacity across all three counties. The grants are supporting tangible workforce expansion and service redesign across the region, focused on preventing avoidable admissions, starting discharge planning earlier and increasing community capacity.

A length of stay meeting review mapping was undertaken for each county system, which provided assurance that established length of stay review arrangements are in place at both Health Board and county level. All counties undertake regular multidisciplinary reviews through daily board rounds, flow meetings and dedicated long-stay or escalation forums. Pembrokeshire and Carmarthenshire have weekly Top 20 reviews, while Ceredigion uses twice-daily system flow meetings and weekly clinically optimised patient reviews. Mental Health and Learning Disabilities also has a dedicated weekly inpatient length of stay review. These local arrangements are supported by the monthly Health Board-wide Pathway of Care Delays process, providing collective oversight of delays, data validation and escalation. Although approaches to documentation and action tracking vary, the report confirms that each county has mechanisms to identify discharge barriers, agree actions and escalate prolonged stays. Additional local operational controls include daily multidisciplinary board rounds and discharge coordination, Red2Green, escalation processes, and integrated health and social care arrangements.

These arrangements provide assurance that PoCD performance and the contributing operational risks are subject to regular validation, review and system-level oversight. However, continued focus is required on effective discharge planning, workforce capacity, and the availability of onward care pathways to secure sustained improvement and reduce variation across the Health Board.

Further independent assurance is provided by the internal PoCD audit undertaken between July and August 2026, which concluded with an overall rating of **Reasonable Assurance**. The audit found reasonable assurance that discharge management policies and procedures reflect Welsh Government Hospital Discharge Guidance and Discharge to Recover and Assess (D2RA) Pathways Guidance, and that processes and resources support timely discharge, including allocation to a defined D2RA pathway and identification of an Expected Discharge Date at admission. Substantial assurance was provided that Pathway of Care Delays are reviewed and analysed to understand the causes of poor performance and non-compliance, and that governance arrangements are established to oversee and monitor discharge management.

Three actions were recommended to strengthen existing controls 1) review and update the Health Board Hospital Discharge Guidelines 2) improve multidisciplinary team attendance at board rounds and 3) continue the Quality Improvement Service Transformation (QIST) Team's work with wards and clinical teams to improve data quality and compliance with national guidance. Delivery of these actions will be monitored through the established Pillar 3 governance arrangement and relevant Clinical Care Groups.

## Argymhelliad / Recommendation

The Finance and Performance Committee is requested to **TAKE ASSURANCE** that established controls are in place to support the accurate reporting, oversight and improvement of Pathway of Care Delays.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery. |
| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 4. Learning, improvement and research<br>3. Data to knowledge<br>1. Leadership<br>2. Culture and valuing people |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | 4. Community by Design<br>6. Safe, Timely, High Quality Care |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 7. Improve health and well-being by focusing on prevention and early intervention, while working in partnership to ensure everyone has equal access to care and opportunities for good health |

| | |
|---|---|
| | 4. Create an inclusive culture where every voice matters, individual needs are considered and staff well-being is promoted and supported<br>5. Foster a learning culture by sharing knowledge and applying new ways of working that enhance local and global well-being<br>6. Work with partners and communities to nurture and support everyone to achieve their best well-being<br>8. Develop initiatives that build social connections and promote culture and the Welsh language as assets to support people's overall wellbeing<br>9. All HDdUHB Well-being Objectives apply |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | 2. Leaders will be bold and brave and will strategically commit to supporting a shift towards a Social Model for Health and Wellbeing.<br>4. Collaborations with partners will be strengthened and developed to make the most of the building blocks of health and wellbeing, with the goal of enabling individuals and communities to build resilience and improve health equity<br>5. A more preventative approach, including earlier identification and intervention, will be taken to support people to maintain and improve their health and wellbeing.<br>Social Model for Health and wellbeing principles<br>1. A Social Model for Health and Wellbeing will complement and integrate with other ways of working, values, principles and objectives.<br>3. Involvement with individuals and communities will take place to understand their needs and support the co-production of solutions. |
| **Gwybodaeth Ychwanegol: Further Information:** | |
| Ar sail tystiolaeth: Evidence Base: | Contained within the body of the report |
| Rhestr Termau: Glossary of Terms: | Contained within the body of the report |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting: | Not applicable |

| **Effaith: (rhaid cwblhau) Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian: Financial / Service:** | Supports improved patient flow and reduced length of stay through implementation of ward-based flow and discharge improvements. Delivery may require limited investment in digital, workforce and change support resources. |
| **Ansawdd / Gofal Claf: Quality / Patient Care:** | Expected to improve patient experience, reduce delays in discharge, minimise deconditioning, and support timely access to the right care setting. |

| | |
|---|---|
| **Gweithlu:**<br>**Workforce:** | Requires staff engagement, training and adoption of new processes. Improved flow may reduce operational pressures and support staff wellbeing. |
| **Tegwch Iechyd:**<br>**Health Equity:** | Initiative aims to ensure equitable, timely discharge planning and access to post-hospital support across all patient groups. |
| **Risg:**<br>**Risk:** | Risks include delays to implementation, workforce capacity constraints, inconsistent adoption of new processes, and digital system limitations. Mitigations include governance oversight, monitoring, training and performance review. |
| **Cyfreithiol:**<br>**Legal:** | No specific legal concerns identified. All activity will comply with relevant legislation, professional standards and organisational policies. |
| **Enw Da:**<br>**Reputational:** | Successful delivery could enhance organisational reputation through improved patient flow and discharge performance. Failure to deliver intended benefits may attract internal or external scrutiny. |
| **Gyfrinachedd:**<br>**Privacy:** | No significant privacy concerns identified. Any use or sharing of patient information will comply with information governance and data protection requirements. |
| **Cydraddoldeb:**<br>**Equality:** | No adverse equality impacts identified at this stage. Improved discharge processes are expected to have a positive impact on patient access and experience.<br><br>Has EqIA screening been undertaken? No<br>Has a full EqIA been undertaken? No |

3.3

**10:40, 20 Mins**

# 3.3 - PLANNED CARE PLAN

***Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Paula Goode (Hywel Dda UHB - Service Director for Planned and Specialist Care), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance), Lisa Humphrey (Hywel Dda UHB - General Manager)***

For assurance

## Attachments

3.3 Planned Care Plan FPC Oct 2026.pdf

3.3 Appendix 1 - Planned Care Recovery - 2026-27 - Funding Allocations - Se~.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | **27 OCTOBER 2026** |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Planned Care Plan |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Andrew Carruthers, Chief Operating officer |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Keith Jones, Director of Operational Planning and Performance |

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

## ADRODDIAD SCAA SBAR REPORT

### Sefyllfa / Situation

Welsh Government (WG) has confirmed a final Planned Care Recovery allocation of £12.850m for 2026/27. This compares with the Board approved recovery requirement of £15,497, as reflected in the Planned Care Delivery and Sustainability Plan submitted on 31 July 2026.

This allocation is £2.647m (17.1%) below the full plan requirement:

- The allocation comprises £8.628m for Referral to Treatment (RTT) 104-week delivery, £3.744m for diagnostics and £0.478m for sustainability support.
- The allocation is predicated on eradication and sustained elimination of waits over 104 weeks at the earliest achievable point, with March 2027 the latest acceptable position, alongside additional activity, productivity improvement and sustainable transformation.
- The principal residual risk is diagnostics: the Health Board's plan identified diagnostics as a system dependency for RTT and cancer recovery.

The Health Board accepted the allocation and associated delivery conditions on 30 September 2026, with a qualification that the allocation shortfall represents a significant risk to delivering both diagnostic and cancer pathway improvement ambitions within the confirmed allocation.

Delivery trajectories for all elements covered by the WG allocation have been submitted to NHS Performance & Improvement (NHS P&I), who will monitor Health Board delivery progress on behalf of WG.

### Cefndir / Background

In July 2026, the Finance and Performance Committee approved the Health Board's Planned Care Delivery and Sustainability Plan for submission to Welsh Government. This plan was subsequently endorsed by the Board in July 2026.

Alongside a range of measures to further improve planned care productivity and reduce avoidable demand, the plan:

- Sought £15.497m in-year support, including £9.036m external funding for the forecast 104-week RTT pathway delivery gap and £5.784m for diagnostic recovery solutions.
- Modelled a route from a forecast RTT 104 week pathway delivery gap of 5,672 patients to zero by March 2027 using core delivery, validation/booking, regional capacity, insourcing/ Waiting List Initiatives (WLI), outsourcing and further productivity measures.
- Described a range of diagnostic 8 week and cancer pathway diagnostic recovery measures including five mobile scanners plus insourcing for 4,786 non-obstetric ultrasound examinations, with a trajectory to zero >8-week radiology breaches by March 2027.

On 23 September 2026, Welsh Government issued a funding allocation confirmation letter to the Health Board of £12,850m. The allocation letter (Appendix 1) explicitly recognised the scale of the planned care challenge facing the Health Board and the level of assurance provided through the assessment process conducted following submission of the Health Board's plan in July 2026. It also contained a clear expectation that the funding has been allocated to support delivery of the agreed recovery plan, accelerate reductions in waiting times, improve diagnostic and treatment access, increase productivity and support the delivery of sustainable planned care transformation in line with national priorities.

Delivery trajectories for all elements covered by the WG allocation have been submitted to NHS P&I who will monitor Health Board delivery progress on behalf of WG. Weekly delivery assurance reviews with NHS P&I commenced in September 2026.

## Asesiad / Assessment

### Funding comparison and risk assessment

The confirmed allocation funds approximately 82.9% of the £15.497m July requirement. Within the £2.647m aggregate shortfall, the primary delivery risk relates to the diagnostic funding shortfall and potential implications for sustained delivery of diagnostic improvements to both 8 week diagnostic and cancer pathway improvements beyond Q3.

Whilst the itemised WG allocations for both RTT and diagnostic elements do not exactly match the structure of the Health Board's submitted plan and associated funding requirements, the table below summarises the current position:

| Area | July plan comparator | WG allocation | Variance | Committee interpretation |
|---|---|---|---|---|
| Total recovery programme | £15.497m | £12.850m | -£2.647m | Allocation is 82.9% of plan requirement |
| RTT 104-week recovery | £9.036m external funding ask | £8.628m | -£0.408m | WG funding covers specified T&O, ophthalmology, ENT, urology, dermatology and anaesthetic stabilisation schemes |
| Diagnostics | £5.784m total diagnostic requirement | £3.744m total diagnostics | -circa £2m (but not directly like-for-like) | Includes £2.894m radiology, £0.509m endoscopy, £0.121m cystoscopy and £0.220m echo |
| Enabling Costs | £0.677m external support requested | £0.478m | n/a | £0.299m programme support and £0.178m POPS |

**Referral to Treatment (RTT)**:

- Within the allocated £8.628m, the specialty specific elements are Trauma and Orthopaedics (T&O) (£3.702m across insourcing/WLI, outsourcing and regional delivery), Ophthalmology outsourcing (£1.688m), Urology (£1.050m), Ear, Nose and Throat (ENT) (£0.857m), Dermatology (£0.108m). These allocations match the Health Board's requirement as reflected in the submitted plan.
- The £0.408m shortfall relates exclusively to the forecast cost of stabilising Anaesthetic support of core capacity operating lists (Anaesthetic stabilisation) which has been funded at 75% (£1.223m) of the amount requested. The advised allocation for this element is sufficient to cover forecast costs of delivery for the remaining part of the year but does not cover additional expenditure incurred year to date.

**Diagnostics:**

- Within the allocated £3.744m, key elements include Radiology £2.894m, Endoscopy £0.509m, Echocardiography £0.220m and Cystoscopy £0.121m.
- This represents a circa £2m shortfall versus the support requirement identified by the Health Board, broadly split between a £1.2m shortfall for Radiology and £0.8m shortfall for Pathology which WG have advised falls outside the current funding specification and will require further review.
- The shortfall between the diagnostic allocation and the level of support required has significant implications for the Health Board's forecast ability to sustain combined 8 week and Cancer pathway diagnostic improvements beyond Q3. Further reviews of the Health Board's modelling of Radiology demand & capacity have been scheduled with NHS P&I during October 2026 to inform further discussions re the potential for additional support beyond Q3.

**Enabling Costs:**

- The WG allocation of £0.478m for programme support (£0.299m) and Peri-operative support (POPs) (£0.178m) is less than the total request of £0.677m. Whilst the POPs scheme is fully resourced through to March 2027, plans for application of programme support funding are currently subject to further review in light of the funding shortfall for this specific element.
- Outside of the current allocation, the potential remains for additional support of the Health Board's validation capacity, subject to agreement of a delivery proposal with NHS P&I.

Taking the above into consideration, the table below summarises the delivery consequences, dependencies and risk:

| Area | Assurance | Committee judgement / evidence |
|---|---|---|
| **104-week RTT** | **AMBER** | Funding is substantial and aligned to named recovery schemes, but delivery remains conditional on protection of core activity, additionality, productivity and trajectory achievement. WG expects earlier delivery than March 2027 wherever achievable. |
| **Diagnostics / cancer** | **RED** | The Health Board has highlighted a significant risk to delivering both diagnostic and cancer ambitions within the total allocation. Whilst improvement trajectories have been submitted for Q3, this is likely to impact delivery in Q4 after application of the current allocation for Radiology is exhausted. |

| | | |
|---|---|---|
| **Anaesthetics Stabilisation** | **AMBER** | £1.223m allocated, representing 75% of the request. This is sufficient to support the projected cost of anaesthetic support of core capacity for the remainder of the year with delivery dependent on securing appropriate Anaesthetic cover. |
| **Enabling Costs** | **AMBER** | Plans for application of programme support funding are currently subject to further review in light of the funding shortfall for this specific element |

**Delivery Assurance**

Health Board progress in delivering required volumes of core and additional activity supported by this allocation will be monitored via weekly review with NHS P&I. The majority of additional recovery activity is scheduled to commence from mid October 2026 onwards, following commencement of insource/outsource solutions delivered by independent sector partners and additional internal activity delivered above planned core capacity.

Progress in respect of planned care transformation and productivity improvements is being overseen via the Planned Care Transformation workstream of the Executive Recovery Programme.

Progress in respect of the delivery trajectories agreed with NHS P&I, additional activity delivered and associated expenditure will be reported to the Committee through to March 2027.

## Argymhelliad / Recommendation

The Finance and Performance Committee is:

- Requested to **NOTE** the final WG Planned Care Recovery allocation of £12.850m against the £15.497m provisional requirement set out in the July 2026 Planned Care Delivery and Sustainability Plan.
- **ADVISED** that the Health Board has formally accepted the allocation and conditions and has established weekly national and strengthened Executive oversight of delivery.
- Requested to **TAKE ASSURANCE** that the RTT 104 week allocation meets the Health Board's forecast requirement.
- **ALERTED** to the residual risk that the confirmed allocation may not enable full delivery of both diagnostic recovery and cancer pathway ambitions, including the lower radiology allocation relative to the July 2026 modelled solution and the further review required for pathology funding.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 2.1 The purpose of the Finance and Performance Committee is to provide advice and assurance to the Board on the following:<br>2.1.2: oversight of performance and delivery against Health Board plans and objectives, with early warning of performance issues and recommendations for improvement. |

| | |
|---|---|
| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 2. Timely |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 3. Great care |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | 6. Safe, Timely, High Quality Care |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 10. Not Applicable |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | Not Applicable |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | Planned Care Delivery & Sustainability Plan (31 July 2026); WG Funding Allocation Confirmation (23 September 2026). |
| Rhestr Termau:<br>Glossary of Terms: | Reflected in report |

| | |
|---|---|
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | Finance & Performance Committee (July 2026)<br>Public Board (July 2026) |

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | Reflected in report |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | Recovery funding is intended to shorten long waits, improve diagnostic and treatment access and support sustainable pathway transformation. |
| **Gweithlu:**<br>**Workforce:** | Anaesthetic stabilisation funding is conditional on a sustainable plan and job-plan evidence. Additional activity remains dependent on appropriate workforce capacity. |
| **Tegwch Iechyd:**<br>**Health Equity:** | • Have the potential impacts on health equity been considered? Yes/No/N/A<br>• Has an equity focussed health impact assessment been undertaken Yes/No/N/A |
| **Risg:**<br>**Risk:** | Diagnostic capacity remains the principal residual risk because it supports the 8-week diagnostic standard, RTT progression and cancer pathways. |
| **Cyfreithiol:**<br>**Legal:** | N/A |
| **Enw Da:**<br>**Reputational:** | Health Board financial stewardship. |
| **Gyfrinachedd:**<br>**Privacy:** | N/A |
| **Cydraddoldeb:**<br>**Equality:** | N/A |

**Y Grŵp Iechyd, Gofal ac Atal**
**Health, Care & Prevention Group**

**Cyfarwyddwr Gweithreidiadau, GIG Cymru**
**Director of Operations, NHS Wales**

Llywodraeth Cymru
Welsh Government

Philip Kloer
Chief Executive Officer
Hywel Dda UHB

Our Ref: JG/PCRF2026-27/FINAL

23 September 2026

Dear Phil

**Subject: Planned Care Recovery 2026-27: Funding Allocation Confirmation**

Following the issue of the Tranche 1 and Tranche 2 Planned Care Recovery funding allocation letters, and completion of the comprehensive assessment, assurance and plan refinement process undertaken jointly by NHS Wales Performance & Improvement and Welsh Government, I am writing to formally confirm the Planned Care Recovery funding allocation for your organisation for 2026-27.

The earlier Tranche 1 and Tranche 2 allocation letters were issued to enable the timely mobilisation of approved schemes, commencement of delivery and early action to reduce waiting times whilst the full assessment process was concluded. This letter now supersedes those previous allocation letters and represents the full funding determination for your organisation's 2026-27 Planned Care Recovery Programme.

The total funding allocation for your organisation is **£12,849,721**.

This confirmed allocation reflects both the scale of the planned care challenge facing the organisation and the level of assurance provided through the assessment process. The expectation is that this investment will translate into demonstrable improvements in waiting times, productivity, patient access and sustainable service transformation during 2026-27.

This funding has been allocated to support delivery of the agreed recovery plan, accelerate reductions in waiting times, improve diagnostic and treatment access, increase productivity and support the delivery of sustainable planned care transformation in line with national priorities.

**The primacy now is that the eradication of waits over 104 weeks is delivered and sustained.**



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Whilst progress is being made across NHS Wales, long waits continue to have a significant impact on patients. Recovery funding has therefore been allocated to accelerate delivery and support organisations to eliminate and sustain the elimination of waits over 104 weeks at the earliest achievable opportunity.

**Purpose of Funding**
To reaffirm, this funding is provided for the specific purpose of:

- Accelerating reductions in waits over 104 weeks.
- Increasing planned care activity and reducing overall waiting list size.
- Supporting diagnostic and treatment capacity in line with agreed delivery plans.
- Improving productivity and efficiency across planned care pathways.
- Supporting pathway validation and demand management activity.
- Delivering sustainable service transformation that reduces future demand and supports long-term recovery.
- Implementing modernised clinical pathways and operating models that improve access, productivity and patient outcomes.

The organisation should ensure that all expenditure can be clearly linked to the delivery of these objectives and that implementation remains aligned to the schemes and interventions approved through the allocation process.

**Accelerating Delivery**
In reviewing submissions across NHS Wales, it is evident that many organisations have planned on the assumption that the delivery milestone for elimination of long waits is March 2027. The Welsh Government expectation is that organisations accelerate progress wherever possible and achieve elimination of waits over 104 weeks in the shortest achievable timeframe. I am reminding organisations that starting positions vary considerably and therefore the pace and timing of delivery should also differ. Plans should therefore continue to be recalibrated to maximise available capacity, productivity and transformation opportunities, with trajectories reflecting the earliest deliverable reduction in long waits. The 104 zero position has to be delivered as soon as possible with March 2027 being the very latest.

As part of acceptance of this final allocation, organisations are expected to review all trajectories, milestones and delivery assumptions and identify opportunities to bring forward achievement dates, particularly where additional capacity, productivity improvements or pathway redesign can accelerate delivery.

**Transparency and Public Accountability**
Transparency and public accountability are fundamental requirements of this programme.
Each organisation will be expected to publish its Planned Care Recovery objectives, delivery trajectories and expected timelines on its public website.
Separate guidance will be issued regarding the format, content and publication requirements.

**Sustainable Recovery and Modernisation**
Whilst additional activity and temporary capacity solutions will continue to play an important role in reducing long waits in the short term, they cannot be the sole basis for sustainable recovery. The long-term challenge facing NHS Wales requires a greater emphasis on service redesign, pathway modernisation and productivity improvement to ensure that gains made through recovery funding can be sustained. Advice provided by National Clinical Leads and Clinical Implementation Networks has consistently highlighted that recovery funding should serve two purposes: delivering immediate reductions in waiting times whilst also accelerating the transition to a modernised planned care system that is capable of meeting future demand more effectively. Organisations are therefore expected to use this investment not only to increase activity, but also to strengthen the underlying operating model for planned care. Future success will require demonstrable progress in:

- Effective demand management.
- Referral optimisation.
- Improved advice and guidance.
- Better pathway design.
- Reductions in unnecessary follow-up activity.
- Improved clinical validation.
- Greater utilisation of Treat in Turn principles.
- Increased theatre and diagnostic productivity.
- Day Case First approaches.
- Digital enablement.
- Pathway standardisation.
- Better utilisation of regional and national capacity.

All funded schemes should therefore contribute to the transition towards sustainable, modernised and clinically led planned care services, ensuring that the benefits of this investment extend well beyond the immediate recovery period

**Conditions of Funding**
The following conditions apply to this allocation:

- Funding must be ringfenced solely for approved schemes.
- Core delivery must not deteriorate.
- Funding is conditional upon continued delivery of agreed trajectories and milestones.
- The organisation must demonstrate that funded activity is additional and contributing to reductions in waiting times and waiting list size.
- Progress will be monitored through enhanced national performance arrangements.
- Any forecast underspend must be reported immediately.
- Welsh Government reserves the right to amend, withhold, recover or redeploy funding where delivery is not demonstrated.
- Organisations must continue to maximise internal capacity before seeking further external capacity solutions.
- Organisations must demonstrate progress against expected productivity standards.

- Continued consideration of future funding support will depend upon evidence of delivery, productivity improvement, sustainable transformation and implementation of agreed actions.

**Ongoing Monitoring and Assurance**
NHS Wales Performance & Improvement will continue to monitor delivery through established national performance and assurance arrangements. The expectation is clear that organisations will demonstrate timely delivery against agreed trajectories, sustained improvement in performance, measurable productivity gains and tangible progress towards a modernised planned care system. Where delivery falls behind plan, organisations will be expected to implement corrective actions at pace and provide assurance that recovery objectives remain achievable.

The scale of investment provided reflects the importance Welsh Government and NHS Wales place on reducing long waits and restoring timely access to care. This funding should therefore be viewed as both an opportunity and an obligation: an opportunity to accelerate recovery for patients and an obligation to deliver demonstrable improvements in access, productivity, sustainability and outcomes.

The expectation remains that organisations will pursue the earliest achievable eradication of waits over 104 weeks and sustain that position thereafter.

**Next steps**
Chief Executives should write to me within 7 days of receipt of this letter to confirm acceptance of the allocation and agreement to the conditions, expectations and responsibilities set out herein.

I would like to thank you and your teams for your continued commitment to improving planned care services and delivering better outcomes for patients across Wales.

Yours sincerely



**Jeremy Griffith**

Director of Operations
NHS Wales

cc:
Jacqueline Totterdell, Chief Executive, NHS Wales
Hywel Jones, Director of Finance, Welsh Government
Julie Broughton, Deputy Head of Financial Management (NHS Budgets), Welsh Government
Nick Wood, Deputy Chief Executive NHS Wales, Welsh Government
Steven Thomas, Head of Planned Care Policy, Welsh Government

Andrew Carruthers, Chief Operating Officer, Hywel Dda UHB
Huw Thomas, Director of Finance, Hywel Dda UHB
Claire Green, Director of Finance and Resource Allocation, NHS Wales P&I
Corrina Casey, Director of Performance and Delivery, NHS Wales P&I
Deb Lewis, Specialist Operational Adviser, NHS Wales P&I
Phil Barry, Director of Operational Improvement, NHS Wales P&I
Brett Denning, Assistant Director Strategic Programme for Planned Care, NHS Wales

## Appendix

| RTT 104 Week Delivery | | | | |
|---|---|---|---|---|
| Speciality | Solution | Volume | Allocation | Comment |
| T&O | Insourcing / WLI | 450 | £2,250,000 | As per conditions set out in the letter above. |
| T&O | Outsourcing | 109 | £991,246 | |
| T&O | Regional | 182 | £460,460 | |
| Ophthalmology | Outsourcing | 1200 | £1,688,400 | |
| ENT | Insourcing / WLI | 229 | £687,000 | |
| ENT | Outsourcing | 68 | £170,000 | |
| Urology | Insourcing / WLI | 210 | £1,050,000 | |
| Dermatology | Outsourcing | 43 | £108,425 | |
| Anaesthetic Stabilisation | | | £1,222,500 | Following review of the additional information on HDUHB's anaesthetic provision, 75% of the requested funding has been allocated. This is conditional on submission of a sustainable anaesthetic plan, including the movement of sessions between sites, and provision of job plans to NHS Wales Performance & Improvement for review. |
| | | **Total** | **£ 8,628,031** | |

| Diagnostics | | | | |
|---|---|---|---|---|
| Speciality | Solution | Volume | Allocation | Notes |
| Endoscopy | Insourcing / WLI | 588 | £509,000 | As per conditions above. |
| Urology (Cystoscopy) | Insourcing / WLI | 260 | £121,000 | As pathology is not a reportable diagnostic service, it falls outside the scope of the funding specification set out in the ministerial advice. NHS Wales Performance & Improvement and Welsh Government will undertake a further review of pathology funding requests. |
| Cardiology (echo) | | 2368 | £220,000 | |
| Radiology | | | £2,893,985 | |
| | | **Total** | **£3,743,985** | |

| Sustainability | | |
|---|---|---|
| Scheme | Allocation | Notes |
| Programme Support Team Costs | £299,371 | A HDUHB validation proposal will be considered on the submission of a validation plan to P&I. |
| POPS | £178,334.00 | |
| **Total** | **£477,705** | |

3.4

**11:00, 20 Mins**

# 3.4 - OPERATIONAL RESPONSE TO VALUE AND PRODUCTIVITY

***Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)***

For approval

## Attachments

3.4 CCG Value Opportunities Assessment FPC Oct 2026.pdf




Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# Finance and Performance Committee

## Clinical Care Group (CCG) Value Opportunities Assessment

27 October 2026

# CCG Value Opportunities Assessment Overall Summary:

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- This Clinical Care Group (CCG) Value Opportunities Assessment summarises the self-assessment reviews undertaken by each CCG during May/June 2026. CCGs were requested to review and assess progress in respect of the value tables, national Enabling Actions and low value opportunities previously issued within the Health Board
- The self-assessment undertaken by each CCG suggests incremental progress in pathway redesign, prevention, demand management and reduction of low-value care. However, whilst there is some evidence that several high-impact initiatives are increasingly embedded, measurable benefits are difficult to quantify via existing reporting systems
- The greatest opportunities appears to lie in accelerating implementation, reducing unwarranted variation and scaling proven interventions to maximise productivity, release capacity, improve outcomes and support financial sustainability
- For each CCG, this slide set highlights where progress is increasingly embedded, areas of partial implementation, top 5 opportunities for acceleration during 2026/27 by CCG, alongside highlighted delivery risks and Health Board support required
- Following consideration by the Value & Sustainability Group in September 2026, a peer review of CCG self-assessments will be conducted during Autumn 2026, aligned to the planning round, to further test the scale of opportunities to be progressed at pace

# CCG Value Opportunities Assessment
## Top priorities for escalation during 2026/27:

GIG CYMRU NHS WALES
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The self-assessments undertaken by each CCG suggest the following areas as high priority opportunities for acceleration across the Health Board, with supporting context highlighted in the addendum section

| Priority | Focus: |
|---|---|
| **Scale Proven Community Models** | Single Point of Access (SPoA), Hospital at Home, Frailty, Falls and Reablement |
| **Improve Elective Productivity** | Theatre utilisation, outpatient transformation and ophthalmology redesign |
| **Transform Mental Health Access** | Attention Deficit Hyperactivity Disorder (ADHD) pathway redesign, open access services and stepped-care delivery |
| **Accelerate Digital & AI Adoption** | AI-supported diagnostics, clinical decision support and pathway analytics |
| **Sustain Transformation Capacity** | Targeted investment, workforce development and executive sponsorship to move from pilot/established initiatives to full Health Board implementation. |

# CCG Value Opportunities Assessment
## Highlighted delivery risks and support required:

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The self-assessments undertaken by each CCG suggest the following thematic delivery risks to accelerated progress and the suggested support required, with supporting context highlighted in the addendum section

| Thematic Delivery Risks | Health Board Support Required |
|---|---|
| Workforce capacity | Workforce and change/transformation capacity support |
| Funding sustainability | Investment (re)prioritisation to enable scale up |
| Variation in clinical adoption | Executive sponsorship of pathway redesign |
| Digital infrastructure and analytical capacity | Digital enablers to accelerate progress |

# CCG Value Opportunities Assessment:
## Next Steps

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- Engagement with CCGs to share feedback and sense check summary reflections drawn (Complete)

- Formal consideration at COO Integrated Operational Delivery Group to agree
  - Prioritised CCG value focus for remainder of 2026/27 (October 2026)
  - Cross CCG value opportunities to be prioritised (October 2026)

- Conduct a CCG Peer Review of self-assessment undertaken during Autumn 2026, aligned to the planning round, to further test the scale of opportunities to be progressed at pace

- Agree programme of work to be supported by consultancy days from Swansea University (October 2026 – March 2027)

# CCG Value Opportunities Assessment:
## Recommendation

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University Health Board

# The Committee is requested to:

- CONSIDER this summary assessment of the self-assessment reviews undertaken in each Clinical Care Group,
- NOTE delivery risks and suggested areas for support highlighted by CCGs
- SUPPORT the next steps outlined

# Addendum Slides

# CCG Value Opportunities Assessment: Addendum - CCG Specific Assessments

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The following addendum slides summarise the assessments per CCG, highlighting:

- A summary overview
- What this means strategically?
- Increasingly embedded areas
- Partially implemented areas
- Top 5 opportunities for acceleration
- Key risks to delivery
- Organisational support required

# Planned & Specialist Care
## Summary:

- Overall, Planned & Specialist Care demonstrates increasing maturity across the Value and Enabling Actions portfolio, with a significant number of opportunities fully embedded and already delivering measurable improvements in access, productivity, diagnostic efficiency and reduction of low-value care

- Examples include Faecal Immunochemical Test (FIT)-first colorectal pathways, Faecal Calprotectin triage, Magnetic Resonance Imaging (MRI)-first prostate cancer diagnostics, endoscopy surveillance optimisation, ENT referral management, dermatology pathway redesign and established low-value orthopaedic procedure controls.

- Significant gains in diagnostic productivity, outpatient demand management and cancer pathway optimisation are evident.

- However, a number of high-impact opportunities remain only partially implemented, particularly around theatre productivity, outpatient delivery transformation, ophthalmology redesign, virtual fracture clinics, cancer pathway optimisation and selected urology pathways.

- These represent the greatest opportunities for accelerating value delivery in 2026/27.

# Planned & Specialist Care
## What this means strategically?:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- The CCG has moved beyond simple efficiency programmes and is now demonstrating how pathway redesign can simultaneously improve access, release capacity and improve quality.
- The strongest opportunities arise where:
  - Demand can be prevented rather than managed.
  - Diagnostics move upstream.
  - Clinical pathways become risk stratified.
  - Patients are managed digitally or through self-management models.
  - Outpatient and follow-up activity is reduced.
  - Theatre capacity is utilised more effectively.
- The strategic challenge now is scaling, standardising and sustaining implementation across all sites and specialties.
- The greatest value opportunity for 2026/27 is likely to come from combining:
  - Theatre productivity improvement.
  - Outpatient transformation.
  - Ophthalmology redesign.
  - Further diagnostic optimisation.
  - Removal of residual low-value activity.
- Collectively these areas offer the largest opportunity to reduce waiting lists whilst improving productivity without requiring significant additional recurrent investment.

# Planned & Specialist Care
## Increasingly embedded areas:

| Theme | Detail |
|---|---|
| **Diagnostics and Referral Optimisation** | • FIT-first lower GI pathway fully embedded with 90–95% return rates.<br>• 75% reduction in unnecessary outpatient demand.<br>• Straight-to-test rates improved by 75%.<br>• Faecal Calprotectin pathway embedded through Health Pathways. |
| **Cancer Diagnostics** | • MRI-first prostate pathway fully operational.<br>• Twice weekly MRI Multi Disciplinary Team (MDT) established.<br>• Approximately six-week reduction in diagnostic times.<br>• Direct-access MRI supports straight-to-test prostate cancer pathways. |
| **Endoscopy Transformation** | • Full implementation of British Society of Gastroenterology (BSG) surveillance guidance.<br>• FIT-first and surveillance validation programmes reducing unnecessary colonoscopy demand.<br>• Capacity released for urgent and cancer pathways. |
| **Low Value Care Reduction** | Embedded practice across:<br>• Arthroscopic knee surgery for Osteo Arthritis (OA).<br>• Shoulder decompression without conservative therapy.<br>• ENT referral criteria.<br>• Dermatology benign lesion pathways.<br>• MRI lumbar spine without red flags.<br>• Computed Tomography Pulmonary Angiogram (CTPA) without Wells score.<br>• Routine pre-operative chest X-rays. |
| **Referral Management / Health Pathways** | • 321 published pathways.<br>• 79 national pathways led by Hywel Dda.<br>• Over 71,000 page views.<br>• Significant growth in pathway adoption and referral optimisation. |

# Planned & Specialist Care
## Partially implemented areas:

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| Theme | Detail |
|---|---|
| **Theatre Productivity** | • Theatre utilisation remains 79.7% versus Getting It Right First Time (GIRFT) target of 85%.<br>• Significant variation exists between specialties.<br>• Theatre transformation programme established but benefits not yet fully realised. |
| **Outpatient Transformation** | • Increasing use of virtual appointments.<br>• Clinical validation expanding.<br>• PIFU (Patient Initiated Follow-Up)/SOS (See on Symptom) models developing.<br>• Scope remains to reduce low-value review activity and improve consultant capacity |
| **Urology Value Opportunities** | Several opportunities remain partially adopted:<br>• Bladder cancer cystoscopy surveillance optimisation.<br>• Prostate Specific Antigen (PSA) monitoring optimisation.<br>• Microscopic haematuria imaging pathways.<br>• Urodynamic testing redesign. |
| **Low Value Care Reduction** | Progress evident via Wales General Ophthalmic Services (WGOS) transfers and community pathways, however:<br>• Glaucoma follow-up redesign incomplete.<br>• Treat-and-extend diabetic maculopathy not implemented.<br>• Cataract pre-assessment redesign remains outstanding. |

# Planned & Specialist Care
## Top 5 opportunities to accelerate in 2026/27:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Theme | Why? | Potential Benefits |
|---|---|---|
| **Theatre Productivity and High Volume Low Complexity (HVLC) Delivery** | • Current utilisation 79.7% versus target 85%.<br>• Significant specialty variation.<br>• Direct impact on RTT recovery and productivity targets. | • Greater throughput.<br>• Reduced waiting times.<br>• Improved value from existing workforce and estate. |
| **Ophthalmology Pathway Redesign** | • Large waiting list burden.<br>• Additional opportunity through glaucoma redesign, treat-and-extend models and cataract pathway optimisation. | • Large capacity release.<br>• Follow-up waiting list reduction.<br>• Improved patient access. |
| **Outpatient Transformation (Validation, PIFU, Virtual Care)** | • Significant validation benefits already demonstrated.<br>• Clinical validation not yet fully embedded.<br>• Opportunity to expand virtual pathways and CNS/AHP-led care. | • Reduced follow-up backlog.<br>• Increased new patient capacity.<br>• Reduced unnecessary reviews. |
| **Urology Low Value Care Programme** | Multiple partially implemented pathways:<br>• PSA monitoring.<br>• Cystoscopy surveillance.<br>• Microscopic haematuria imaging.<br>• Urodynamics. | • Improved diagnostic capacity.<br>• Better utilisation of clinical resources.<br>• Reduced unnecessary investigations. |
| **Cytosponge and Endoscopy Alternatives** | • Pilot already operational.<br>• Potential to reduce significant surveillance endoscopy demand. | • Greater endoscopy capacity.<br>• Reduced patient burden.<br>• Lower procedural costs. |

# Planned & Specialist Care
## Key risks to delivery:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Workforce Capacity** | • Theatre staffing fragility.<br>• Limited ophthalmology staffing.<br>• Specialist clinical leadership capacity constraints.<br>• Limited administrative support for pathway redesign.<br>. |
| **Funding Sustainability** | • Cytosponge pilot funding unresolved.<br>• Fracture Liaison Service funding beyond September 2026 requires confirmation.<br>• Continued reliance on outsourced MRI capacity. |
| **Variation in Clinical Adoption** | • Inconsistent implementation between specialties and sites.<br>• Variable adoption of virtual clinics.<br>• Urology and ophthalmology redesign not yet standardised. |
| **Digital and Analytical Infrastructure** | • Need for better pathway monitoring.<br>• Requirement for decision support tools.<br>• Dependence on data, audit and reporting capability to sustain improvement. |

# Planned & Specialist Care
## Health Board support required:

| Issue | Detail |
|---|---|
| **Executive Sponsorship** | • Mandate pathway redesign where evidence base is established.<br>• Support reduction of low-value activity through organisational policy. |
| **Investment Priorities** | • Cytosponge business case approval.<br>• Sustained MRI capacity funding.<br>• Fracture Liaison Service funding.<br>• Ophthalmology transformation support. |
| **Digital Enablement** | • Patients Know Best (PKB) expansion.<br>• Clinical decision support.<br>• Automated surveillance scheduling.<br>• Enhanced pathway analytics. |
| **Workforce and Change Capacity** | Progress evident via WGOS transfers and community pathways, however:<br>• Glaucoma follow-up redesign incomplete.<br>• Treat-and-extend diabetic maculopathy not implemented.<br>• Cataract pre-assessment redesign remains outstanding. |

# Community & Integrated Medicine
## Summary:

- Overall, Community & Integrated Medicine demonstrates steady progress across urgent and emergency care, flow optimisation, frailty, diabetes and community integration programmes.

- Significant foundations are now in place through the implementation of Single Point of Access (SPoA), Hospital at Home, community falls response, Optimal Hospital Flow initiatives, diabetes pathway redesign and strengthened system-wide discharge arrangements.

- However, many opportunities remain at the "established" rather than fully embedded stage, with benefits still dependent on workforce expansion, community capacity, digital maturity and consistent implementation across county systems.

- The greatest opportunity for 2026/27 lies in scaling integrated community models that reduce avoidable admissions, accelerate discharge and improve management of frailty and chronic disease outside hospital.

# Community & Integrated Medicine
## What this means strategically?:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- The Community & Integrated Medicine portfolio is moving beyond traditional service redesign and increasingly towards integrated whole-system models focused on prevention, admission avoidance, recovery at home and maximising patient independence.
- The strongest opportunities arise where:
  - Frailty is managed proactively.
  - Patients can remain at home through integrated community services.
  - Admission avoidance pathways are strengthened.
  - Rehabilitation and recovery occur outside hospital.
  - Diabetes and long-term conditions are managed through risk stratification and population health approaches.
  - Flow optimisation is embedded consistently across all sites and partner organisations.
- The strategic challenge is achieving consistent Health Board-wide implementation and ensuring sufficient workforce and community capacity to realise the benefits.
- The greatest opportunity for 2026/27 is likely to come from combining:
  - Community urgent response expansion.
  - Hospital at Home scaling.
  - Acute frailty implementation.
  - Falls prevention and response.
  - Diabetes pathway redesign and population health management.
- Collectively these initiatives offer the greatest opportunity to reduce emergency admissions, improve patient experience, optimise bed utilisation and strengthen financial sustainability.

# Community & Integrated Medicine
## Increasingly embedded areas:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Theme | Detail |
|---|---|
| **Community Flow and Discharge Improvement** | Significant implementation activity has occurred through:<br>• SAFER and Red2Green methodology.<br>• Optimal Hospital Flow Framework.<br>• Pathway of Care Delays (POCD) programme.<br>• Trusted Assessor implementation programme.<br>• Preventing Deconditioning programme.<br>• Discharge to Recover and Assess (D2RA) training and implementation programme. . |
| **Single Point of Access (SPoA) Development** | Substantial progress has been made with:<br>• Approved 7-day Community Health Services, Same Day Emergency Care (SDEC) and Hospital at Home model.<br>• SPoA Transport Model operating at full specification.<br>• Community Streaming Hub dashboard implementation.<br>• County-based implementation groups established. |
| **Diabetes Value Programme** | • Diabetes Planning & Delivery Group established.<br>• Patient-Reported Outcome Measures (PROM) collection using International Consortium for Health Outcomes Measurement (ICHOM) standards.<br>• STAR methodology being applied to Type 2 Diabetes and Gestational Diabetes pathways.<br>• Enhanced focus on high-value, high-impact diabetes interventions. |
| **Falls Response and Prevention** | • Health Board approved 7-day falls response model.<br>• Community care home falls programme implemented.<br>• 128 staff trained across 28 care homes.<br>• Additional falls response capacity planned across all counties. |

# Community & Integrated Medicine
## Partially implemented areas:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Theme | Detail |
|---|---|
| **Acute Frailty Service** | Although planning work is progressing well:<br>• Acute Frailty Service implementation remains in development.<br>• Steering group arrangements only recently established.<br>• Further service redesign is required. |
| **First Contact Practitioners (FCPs)** | • Existing FCP provision reviewed.<br>• Benefits identified for primary care sustainability.<br>• Long-term funding remains unresolved beyond March 2027.<br>• Further expansion including podiatry pathways requires investment. |
| **Reablement** | • Integrated model operational in Carmarthenshire.<br>• Alternative arrangements exist in Pembrokeshire and Ceredigion.<br>• Variation in commissioning arrangements limits consistency.<br>• Service remains only partially implemented across the Health Board. . |
| **UEC Pathway Improvements** | Significant planning and governance progress is evident, however:<br>• Risks remain around ED crowding.<br>• Staffing fragility continues.<br>• Community capacity remains a limiting factor.<br>• Full delivery of Welsh Government expectations has not yet been achieved. |

# Community & Integrated Medicine
## Top 5 opportunities to accelerate in 2026/27:

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

| Theme | Why? | Potential Benefits |
|---|---|---|
| **Single Point of Access (SPoA), Hospital at Home & Community Response** | • Approved business case now in place.<br>• County implementation structures established.<br>• Opportunity for significant admission avoidance and reduced conveyance. | • Reduced emergency admissions.<br>• Faster patient response.<br>• Improved community-based care.<br>• Reduced pressure on acute hospitals. |
| **Acute Frailty Service Implementation** | • Frailty remains a major driver of admissions and length of stay.<br>• Planning infrastructure now established.<br>• Major opportunity to reduce avoidable hospital attendance. | • Reduced admissions.<br>• Earlier intervention.<br>• Reduced deconditioning.<br>• Improved patient outcomes. |
| **Falls Prevention and Community Falls Response** | • Strong implementation momentum.<br>• Approved 7-day response model.<br>• High volume impact across older populations. | • Reduced admissions.<br>• Reduced fractures.<br>• Improved independence. |
| **Diabetes HVHI Programme** | • STAR methodology underway.<br>• Significant opportunity to improve prevention and complication management.<br>• Clear links to frailty, admissions and long-term sustainability. | • Reduced complications.<br>• Reduced admissions.<br>• Better long-term outcomes. |
| **Health Board-wide Reablement & Flow Optimisation** | • Current variation between counties.<br>• Opportunity to standardise OT-led reablement, D2RA and Red2Green approaches.<br>• Significant impact on discharge performance. | • Reduced length of stay.<br>• Improved discharge performance.<br>• Increased system capacity. |

# Community & Integrated Medicine
## Key risks to delivery:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Workforce Capacity** | • Community workforce recruitment challenges.<br>• Frailty workforce requirements.<br>• FCP sustainability beyond current funding.<br>• Specialist therapy capacity constraints. . |
| **Community Capacity** | • Insufficient community step-down capacity.<br>• Variable county-system maturity.<br>• Dependence on external partners and local authorities. |
| **Financial Sustainability** | • Ongoing funding requirements for Hospital at Home and community response services.<br>• Limited scalability of current FCP model.<br>• Resource constraints affecting prevention programmes. |
| **Variation in Implementation** | • Different commissioning arrangements across counties.<br>• Variable adoption of reablement models.<br>• Inconsistent maturity of operational flow processes. |
| **Data and Digital Maturity** | • Ongoing development of SPoA dashboard reporting.<br>• Falls intelligence infrastructure still emerging.<br>• Need for stronger outcome tracking and benefits realisation. |

# Community & Integrated Medicine
## Health Board support required:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Executive Sponsorship** | • Continue prioritising community transformation as a core strategic objective.<br>• Support system-wide implementation of Health Board-wide models. |
| **Investment Priorities** | • Acute Frailty Service implementation.<br>• Hospital at Home expansion.<br>• Community response workforce.<br>• Falls prevention and response programmes.<br>• Long-term sustainability of FCP services. |
| **Digital Enablement** | • SPoA analytics and dashboard development.<br>• Falls intelligence systems.<br>• Population health risk stratification.<br>• Outcome measurement infrastructure. |
| **Workforce & Change Capacity** | • Transformation support for community redesign.<br>• Additional therapy and frailty capacity.<br>• Dedicated improvement and programme management resource.<br>• Analytical support for benefits realisation. |

# Mental Health & Learning Disabilities
## Summary:

- Overall, Mental Health & Learning Disabilities demonstrates strong progress in developing modern, tiered and community-based models of care, with several opportunities already embedded across psychological therapies, neurodevelopmental services and crisis support.

- Significant progress has been achieved through psychoeducation programmes, digital therapy platforms, stepped-care psychological therapy models, 24/7 mental health support, early intervention in psychosis and neurodevelopmental support pathways.

- However, a number of the highest-value opportunities remain only partially implemented, particularly around Community Mental Health Team (CMHT) caseload redesign, ADHD demand management, crisis alternatives, open access mental health support, digital transformation and neurodevelopmental pathway redesign.

- These represent the greatest opportunities for accelerating value delivery during 2026/27.

# Mental Health & Learning Disabilities
## What this means strategically?:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

- The MHLD portfolio is increasingly shifting away from traditional specialist-service dependency towards population-level, tiered and preventative models of care.
- The strongest opportunities arise where:
  - Support can be provided without formal diagnosis.
  - Digital and self-directed interventions become the first point of support.
  - Patients access the lowest effective intervention first.
  - Group interventions replace low-value one-to-one activity where clinically appropriate.
  - Crisis support is delivered in community settings rather than hospital environments.
  - Neurodevelopmental demand is managed through screening, triage and open-access support models.
- The strategic challenge is managing unprecedented demand whilst accelerating transformation at scale.
- The greatest opportunity for 2026/27 is likely to come from combining:
  - Open access mental health support.
  - Advanced stepped-care implementation.
  - ADHD pathway redesign.
  - Digital therapies and virtual support.
  - Community crisis alternatives and early intervention.
- Collectively these areas offer the greatest opportunity to improve access, reduce waiting times, increase workforce productivity and improve patient outcomes without relying solely on workforce growth.

# Mental Health & Learning Disabilities
## Increasingly embedded areas:

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

| Theme | Detail |
|---|---|
| **Group Psychoeducation and Psychological Therapies** | • Psychoeducation groups have operated across the whole organisational footprint for four years.<br>• Five structured Intensive Psychological Therapies Service (IPTS) treatment groups have been introduced and now form part of the routine patient journey.<br>• Positive outcome evaluation work is underway with strong patient feedback. |
| **Neurodevelopmental Support Without Diagnosis** | • Advice and support hubs are being established across the service footprint.<br>• Pre-diagnostic workshops are already in place.<br>• Patients Know Best (PKB) implementation is underway.<br>• Focus has shifted towards need-led support rather than waiting for formal diagnosis. |
| **Objective Assessment Processes** | • Comprehensive collateral information is routinely obtained before assessment.<br>• Administrative processes have reduced delays and cancelled appointments.<br>• Objective testing and structured information gathering are now embedded practice. |
| **Early Intervention and Low Value Care Reduction** | • Early Intervention in Psychosis pathways are fully embedded.<br>• Community wraparound arrangements are standard practice.<br>• Routine neuroimaging for uncomplicated first episode psychosis has been eliminated.<br>• Increasing focus on prudent prescribing and deprescribing approaches within dementia services. |

# Mental Health & Learning Disabilities
## Partially implemented areas:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Theme | Detail |
|---|---|
| **CMHT Caseload Rationalisation** | • Primary care caseload management has been implemented and routine referral pathways are being introduced.<br>• Full implementation remains incomplete across all counties. |
| **Digital & Virtual Therapy** | • SilverCloud is fully available and digital self-help programmes are well established.<br>• Tiered digital pathways continue to develop.<br>• Utilisation and population awareness remain below full potential. |
| **Crisis Alternatives to Admission** | • CAMHS Hub, Sanctuary provision, Crisis Teams and 24/7 clinical coordination are established.<br>• Twice-daily multi-agency operational management arrangements are in place.<br>• Reduced Section 136 activity and reductions in CAMHS admissions reported.<br>• Further crisis pathway development remains required. |
| **ADHD Pathway Redesign** | • Opportunity recognised as highly significant - current waiting list exceeds 38 years.<br>• Full options appraisal remains underway.<br>• Pre-assessment tools have not yet been implemented. |
| **Open Access and Stepped Care Transformation** | • Primary Care Liaison Service established as a key enabler with over 2,000 referrals managed annually through the tiered model.<br>• Welsh Government pilot status secured for Open Access and One-at-a-Time Therapy (OAAT(T)).<br>• Further implementation, communication and scaling remains required. |

# Mental Health & Learning Disabilities
## Top 5 opportunities to accelerate in 2026/27:

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

| Theme | Why? | Potential Benefits |
|---|---|---|
| **Open Access Mental Health Support Model** | • Repeatedly identified across multiple value opportunities.<br>• Central to reducing demand on specialist services.<br>• Supported through Welsh Government pilots and national policy direction. | • Earlier intervention.<br>• Reduced referral demand.<br>• Improved access.<br>• Better patient experience. |
| **ADHD Pathway Redesign and Pre-Assessment Tools** | • Current waiting list exceeds 38 years.<br>• Significant opportunity for triage, screening and digital profiling.<br>• Full options appraisal already underway | • Improved capacity.<br>• Reduced assessment burden.<br>• Better prioritisation of clinical time. |
| **Stepped-Care Psychological Therapy Model** | • Primary Care Liaison Service (PCLS) already managing substantial referral volumes.<br>• IPTS group-based interventions demonstrating positive engagement.<br>• Open Access pilot provides significant opportunity for scale. | • Reduced waiting times.<br>• Increased throughput.<br>• Better allocation of specialist resources. |
| **Crisis Alternatives and Community Crisis Pathways** | • Infrastructure already established.<br>• Demonstrable reductions in admissions and Section 136 activity.<br>• Additional crisis pathway development planned. | • Reduced admissions.<br>• Improved patient experience.<br>• Better flow through acute services. |
| **Dementia Wellbeing and Prudent Prescribing Programme** | • Innovative dementia coach model already established.<br>• Strong focus on deprescribing and non-pharmacological intervention.<br>• Opportunity for Health Board-wide scaling. | • Improved dementia care.<br>• Reduced inappropriate prescribing.<br>• Reduced crisis escalation. |

# Mental Health & Learning Disabilities
## Key risks to delivery:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Workforce Capacity** | • Recruitment delays impacting stepped-care development.<br>• Limited specialist workforce available to meet rising demand.<br>• Clinical leadership and transformation capacity constraints. . |
| **Demand Growth** | • Extreme neurodevelopmental demand, particularly ADHD services.<br>• Rising complexity within secondary mental health services.<br>• Continued pressure on community and crisis services. |
| **Funding Sustainability** | • CAMHS crisis hub funding currently confirmed only until March 2027.<br>• Open access transformation requires ongoing investment.<br>• Transformation and digital programmes require sustained support. |
| **Digital and Infrastructure Dependencies** | • Dependence on digital platforms and AI-enabled solutions.<br>• Transition to new digital platforms requires support and adoption.<br>• Hardware and digital access remain constraints. |
| **Variation in Adoption** | • CMHT redesign not fully implemented across counties.<br>• Neurodevelopmental pathways remain inconsistent.<br>• Open access model not yet fully embedded. |

# Mental Health & Learning Disabilities
## Health Board support required:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Executive Sponsorship** | • Endorsement of open access and distributed safety approaches.<br>• Support for whole-system mental health transformation.<br>• Alignment with national policy developments. |
| **Investment Priorities** | • ADHD pathway redesign.<br>• CAMHS crisis hub sustainability.<br>• Dementia Wellbeing Service expansion.<br>• Open access mental health support development. |
| **Digital Enablement** | • AI-supported case management solutions.<br>• Digital profiling tools.<br>• PKB implementation.<br>• Digital therapy infrastructure and staff equipment. |
| **Workforce and Change Capacity** | • Programme management support.<br>• Communication and engagement expertise.<br>• Additional Band 5 workforce for group interventions.<br>• Analytical support for benefits realisation and outcome reporting. |

# Allied Health & Health Sciences
## Summary:

- Overall, Allied Health & Health Sciences demonstrates increasing maturity across the Value and Enabling Actions portfolio.

- Significant progress has been achieved through established radiology governance, advanced practitioner-led referral management, group-based rehabilitation models, malnutrition screening, dysphagia pathways and the systematic reduction of low-value diagnostics.

- The majority of opportunities assessed are operating with increasing prevalence

- The primary strategic opportunity for 2026/27 is scaling proven approaches, optimising productivity and accelerating digital, AI-enabled and preventative models across diagnostic and therapy services.

# Allied Health & Health Sciences
## What this means strategically?:

- The Allied Health & Health Sciences portfolio is now focused on optimisation, digital transformation and scaling value.
- The strongest opportunities arise where:
  - Clinical decision-making occurs earlier in pathways.
  - Diagnostic demand is reduced before tests are requested.
  - Rehabilitation is delivered at scale.
  - Digital technologies reduce unwarranted variation.
  - Patients receive more self-management and group-based interventions.
  - Community-based prevention reduces downstream demand.
- The strategic challenge is ensuring that successful approaches are consistently implemented across all services and county systems.
- The greatest opportunity for 2026/27 is likely to come from combining:
  - AI-enabled diagnostics.
  - Therapy productivity models.
  - Virtual fracture clinic expansion.
  - Enhanced reablement.
  - Nutritional optimisation and prevention programmes.
- Collectively, these initiatives have the potential to release workforce capacity, reduce diagnostic demand, improve access and enhance patient outcomes without requiring significant new infrastructure.

# Allied Health & Health Sciences
## Increasingly embedded areas:

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

| Theme | Detail |
|---|---|
| **Radiology Demand Management** | Controls are now embedded to reduce unnecessary diagnostic activity although measurable benefits remain difficult to quantify:<br>• Clinical review and challenge of imaging requests through IR(ME)R processes. With Advanced Practitioner and sonographer-led vetting<br>• MRI referral guidance routinely applied + robust controls preventing inappropriate MRI lumbar spine requests.<br>• CTPA requests without Wells score/D-dimer pathway no longer accepted and routine pre-operative chest X-rays largely eliminated. |
| **Therapy Productivity** | The Physiotherapy service has established a broad range of group-based rehabilitation programmes including:<br>• ESCAPE (Enabling Self-management and Coping with Arthritic Pain using Exercise) Pain, Pelvic Health, Spinal Rehabilitation, Upper and Lower Limb Programmes, Pulmonary Rehabilitation, Arthroplasty Rehabilitation and Hydrotherapy Programmes. |
| **Dietetics and Nutrition** | Strong implementation has been achieved through:<br>• Consistent Malnutrition Universal Screening Tool (MUST) screening, Health Pathways integration, Malnutrition Pathway for Wales alignment, Frailty pathway support and Organisation-wide dietetic leadership. |
| **Dysphagia and Patient Safety** | • Yale Swallow Screen implemented.<br>• Stroke-led implementation programme established.<br>• Health Board-wide training programme underway + strong alignment with all-Wales standards. |
| **Low Value Diagnostic Reduction** | Inappropriate imaging requests challenged at source. Embedded reductions include:<br>• MRI lumbar spine without red flags.<br>• CTPA without appropriate clinical risk stratification.<br>• Routine pre-operative chest X-rays. |

# Allied Health & Health Sciences
## Partially implemented areas:

| Theme | Detail |
|---|---|
| **AI Supported Radiology Triage** | • Currently being explored with CGI.<br>• Significant future productivity potential.<br>• Benefits not yet realised at scale. |
| **First Contact Practitioners (FCP)** | • Comprehensive review completed.<br>• Value recognised for primary care sustainability.<br>• Long-term funding unresolved beyond March 2027.<br>• Podiatry integration remains underdeveloped. |
| **Occupational Therapy (OT)-Led Reablement** | • Operational in Carmarthenshire.<br>• Different operating models across Pembrokeshire and Ceredigion.<br>• Variation in commissioning arrangements limits consistency.<br>• Not yet standardised Health Board-wide. |
| **Oral Nutritional Supplements (ONS) Prescribing Discipline** | • Invest-to-save model demonstrating potential.<br>• Additional workforce recently recruited.<br>• Further gains constrained by capacity and system resource allocation. |

# Allied Health & Health Sciences
## Top 5 opportunities to accelerate in 2026/27:

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

| Theme | Why? | Potential Benefits |
|---|---|---|
| **AI-Supported Radiology Triage** | • Early-stage exploration already underway.<br>• Significant reporting and prioritisation opportunity.<br>• Supports demand growth without equivalent workforce growth. | • Faster reporting.<br>• Improved prioritisation.<br>• Productivity gains.<br>• Reduced backlog risk. |
| **Enhanced OT-Led Reablement** | • Existing variation across counties.<br>• Opportunity to establish a consistent operating model.<br>• Strong links to frailty, discharge and independence outcomes. | • Reduced care package dependency.<br>• Improved patient outcomes.<br>• Reduced system demand. |
| **ONS Prescribing Optimisation** | • Significant opportunity identified.<br>• Strong clinical evidence base.<br>• Existing infrastructure already in place. | • Financial savings.<br>• Improved prescribing quality.<br>• Better allocation of dietetic resource. |
| **Future FCP Model Review** | • Review completed.<br>• Opportunity to redesign model around greatest system benefit.<br>• Potential expansion into podiatry pathways. | • Improved primary care sustainability.<br>• Enhanced demand management.<br>• Better patient access. |

# Allied Health & Health Sciences
## Key risks to delivery:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Workforce Capacity** | • Therapy workforce capacity constraints.<br>• Dietetic resource limitations.<br>• Sustainability of FCP workforce.<br>• Clinical leadership capacity for service redesign. |
| **Funding Sustainability** | • FCP funding beyond March 2027 unresolved.<br>• Investment required for AI-enabled diagnostics.<br>• Ongoing pressures on transformation funding |
| **Variation in Service Models** | • OT-led reablement varies across counties.<br>• Virtual fracture clinic implementation inconsistent.<br>• Variable maturity of integrated pathways. |
| **Digital Readiness** | • AI diagnostic tools not yet implemented.<br>• Data and reporting capability requires enhancement.<br>• Need for benefits realisation infrastructure. |

# Allied Health & Health Sciences
## Health Board support required:

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Issue | Detail |
|---|---|
| **Executive Sponsorship** | • Support standardisation of successful models.<br>• Endorse wider adoption of evidence-based pathways.<br>• Continue prioritisation of value-based care. |
| **Investment Priorities** | • AI-supported radiology capability.<br>• Reablement service development.<br>• Sustainability of FCP services.<br>• Expansion of virtual fracture clinic models. |
| **Digital Enablement** | • Diagnostic decision support.<br>• AI deployment infrastructure.<br>• Enhanced analytics and reporting capability.<br>• Improved outcome measurement systems. |
| **Workforce and Change Capacity** | • Dedicated transformation support.<br>• Clinical leadership time.<br>• Analytical and benefits realisation support.<br>• Service improvement capacity. |



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3.5

**11:20, 15 Mins**

# 3.5 - WORKFORCE IMPROVEMENT PROGRAMME

***Lisa Gostling (Hywel Dda UHB - Director of Workforce & OD/Deputy CEO), James Severs (Hywel Dda UHB - Executive Director of Allied Health Professions and Health Science), Mark Henwood (Hywel Dda UHB - Executive Medical Director), Nadine Gould (Hywel Dda UHB - Deputy Director of Nursing, Quality & Patient Experience)***

**Clinical Leads to Present on their Professions**

For assurance

**Attachments**

3.5 Workforce Improvement Programme Update FPC Oct 2026.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | **27 OCTOBER 2026** |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Workforce Improvement Programme Update |
| **CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:** | Lisa Gostling, Executive Director of Workforce and OD/ Deputy Chief Executive |
| **SWYDDOG ADRODD: REPORTING OFFICER:** | Lisa Gostling, Executive Director of Workforce and OD/ Deputy Chief Executive |

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

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

To meet growing demand and significant financial challenges, we must make the best possible use of all our resources, particularly our workforce. The programmes outlined in this paper were introduced to improve workforce sustainability, strengthen productivity and reduce avoidable expenditure, enabling us to protect services and continue investing in patient care. Improving attendance, workforce deployment and establishment management will support a more resilient organisation for our staff and the communities we serve. Managers are central to this work: creating capacity, supporting staff and delivering sustainable service improvement.

## Cefndir / Background

The workforce improvement programme has now been in place since 25 August 2026. There are ten working groups around six themed areas. These themes are:

Theme 1 – Sickness Absence Management
Theme 2 – Band 7 – 9 Workforce Growth
Theme 3 – Admin & Clerical Workforce Growth
Theme 4 – Variable Pay Reduction

- Medical
- Nursing & HCSW
- Ancillary & Estates
- Allied Health Professions and Health Sciences
- Admin & Clerical

Theme 5 – Workforce Controls (Establishment Control)
Theme 6 – Recurrent Savings Delivery (OCP process to deliver recurrent 5% CIP Savings)

This update report is provided to highlight progress to date, issues arising and outline next steps.

## Asesiad / Assessment

Progress against the six themes is detailed below:

### Theme 1 – Sickness Absence Management

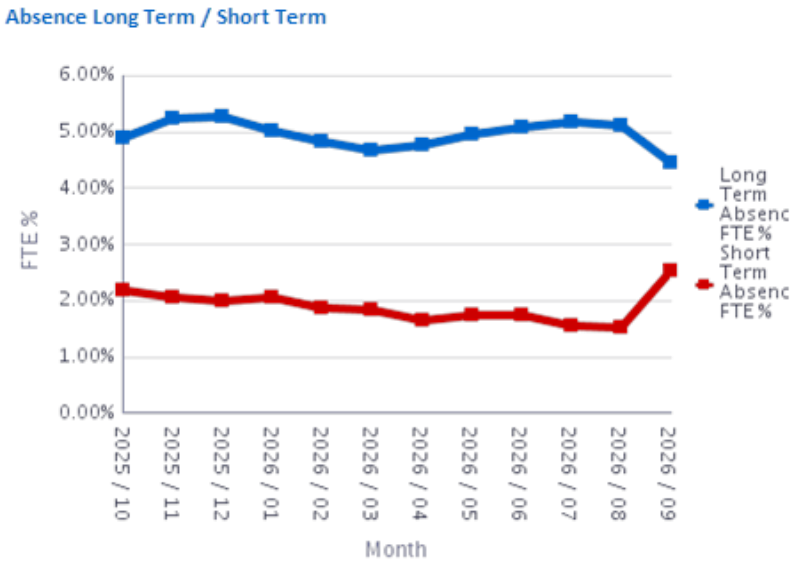
Significant progress has been made in improving long-term sickness absence oversight, with structured reviews, return-to-work planning, and case management activities completed across multiple cohorts, strengthening operational control and consistency in decision-making across services. Baseline information (people off sick on 30 June 2026) of people who had been off since between 2022 and 2025 reported at 106 individuals. The number of people within that time period as at 31 August the number had reduced to 65. In-month sickness absence recorded at 31 August 2026 was 6.56%, with baseline July 2026 information being 6.69%. The target for September 2026 is 6.5%.

### Risk to Plan

Robust plans are in place for the management of long-term sickness; however, the latest scabies outbreak could impact on absence rates. Plans are in place to ensure the same coding is used for staff absent as a result of this, so that separate sickness reports can be produced to ensure absence linked to intervention can also be tracked.

| Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 | Aug-26 | Sept 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.80% | 7.08% | 7.31% | 7.27% | 7.05% | 6.70% | 6.49% | 6.42% | 6.69% | 6.81% | 6.69% | 6.56% | 6.84% |

Whilst sickness absence rates have increased, long-term sickness rates have reduced linked to this work programme have seen a decrease and the increase noted is linked to short term sickness specifically linked with reported cases of cough, cold and flu, (instances increased from 126 in August to 436 in September).



871 individuals were absent on long-term sickness on 31 July 2026, with 692 being recorded as absent on 30 September 2026.

**Theme 2 – Band 7-9 Workforce Growth**

The focus of this programme is to initially identify the number of workforce in bands 7 – 9 in both clinical and non-clinical areas. The group will then consider the growth for each of these groups and undertake an analysis on whether the growth is proportionate and supports specialist and senior decision making. It will then determine if an area has grown out of proportion and with the remainder of their establishment is disproportionate develop workforce plans to support the reduction of workforce at the relevant bands.

To date the programme has:

- Identified the number of roles for each directorate at each band.
- Undertaken an analysis of administrative growth.

**Theme 3 – Admin & Clerical Workforce Growth – Recruitment Controls**

Significant progress has been made with regards to the actions defined in this programme. The scope of this programme was extended to include newly created posts and all managerial posts. From 1 September 2026, recruitment controls were established to ensure that recruitment into these roles was only supported via internal processes. This could not include appointment of volunteers or bank workers. Any requests for exceptions are made to the Executive Team.

Whilst an increase in vacancies was noted in August, requests for external recruitment have reduced, with none being received throughout September. At present, we have not seen evidence of a reduction in our Admin and Clerical workforce, which is linked to new recruits still joining the Health Board from interviews prior to the change in practice in September.

A formal Financial control group has been established to consider these requests, along with agency requests, on a weekly basis.

**Vacancies advertised during 2026**

| Month | Administrative and Clerical |
|---|---|
| Jan | 34 |
| Feb | 27 |
| Mar | 27 |
| Apr | 29 |
| May | 43 |
| June | 43 |
| July | 38 |
| Aug | 58 |
| Sep | 26 |

**August and September breakdown**

| w/c | A&C |
|---|---|
| 03-Aug | 13 |
| 10-Aug | 5 |
| 17-Aug | 13 |
| 24-Aug | 27 |
| 31-Aug | 5 |
| 07-Sep | 5 |
| 14-Sep | 4 |
| 21-Sep | 5 |
| 28-Sep | 8 |
| 5-Oct | 5 |

**Theme 4a – Nursing Variable Pay**

The Nursing and Midwifery workforce actions have made significant progress since they began. The following areas have been completed or are in progress:

- The "No HCSW agency usage" control initiative was completed on **14 September 2026**, supporting immediate reductions in agency dependency.
- Mapping of Newly Qualified Nurse intake impacts was completed on **25 September 2026**, enabling improved workforce planning alignment.
- Monthly financial improvement plans are in place, with all ward areas knowing the expected variable pay reduction associated with new joiners.
- Health Care Support Worker apprentices commenced 28 September 2026; after their 2 week induction programme, they will support further reduction of variable pay in ward areas. It is anticipated this programme will continue, with new apprentices being recruited throughout the year.
- The top 10 highest use of variable pay wards have been identified and work to ensure roster efficiency is underway, to reduce variable pay in addition to the recruitment measures identified above.

**Risk to Plan**

The Scabies outbreak could have a negative impact on variable pay linked to the dependencies with the sickness absence programme.

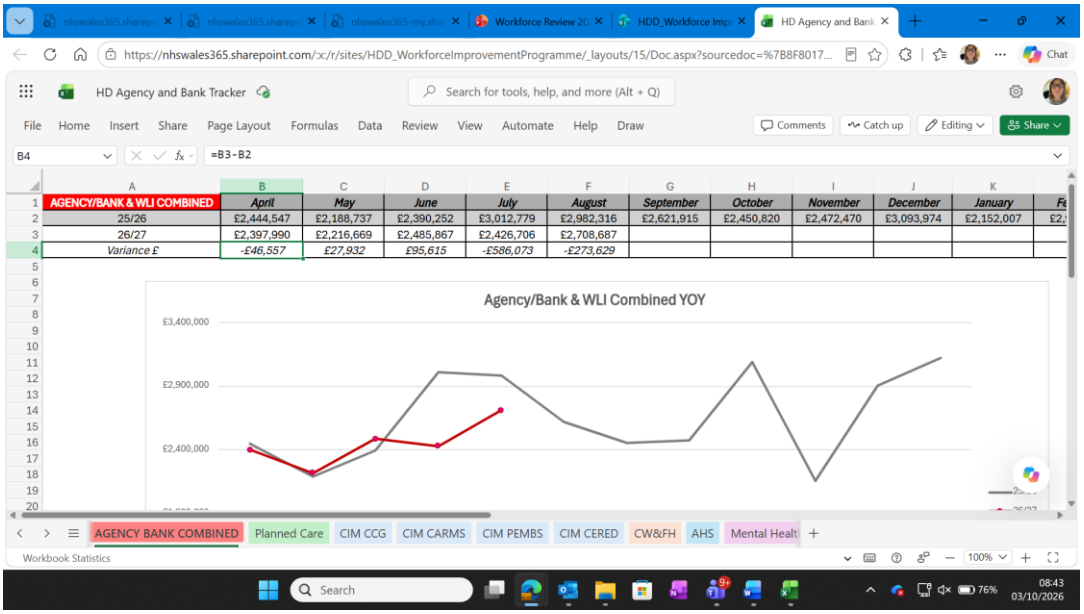
**Theme 4b – Medical Variable Pay**

The Medical Variable Pay workstream, whilst delivering many actions, has not yet been able to demonstrate progress with reduced variable pay. This continues to be an issue with pressure on services and the need to cover fragile rotas. Progress since the formal establishment of the Improvement Programme includes:

- Establishment of baseline metrics, rota compliance confirmation, and data quality tracking outputs were completed during September 2026, enabling improved visibility of workforce activity and spend.

- Job planning compliance reached 90% by 30 September 2026.
- Deep dives have been undertaken into the Rostering system and links to the job planning system. RLDatix, the supplier of the systems, will audit two areas to identify whether we are using both systems to their optimum and present areas of improvement. This will provide greater clarity around staffing requirements and compliance with job planning commitments. Once this has been completed, greater grip and control can be exercised with medical rostering practice.
- All agency workers, reasons for usage and links to recruitment have been shared with CCGs to support safe exit arrangements.
- The Occupational Health team is reviewing all working arrangements which have health related exclusions, to ensure they are relevant and where not to support individuals to return to normal working practices.
- Work will begin throughout October 2026 to create greater clarity on roster management, compliance and the commencement of the development of a 10 year plan to stabilise the medical workforce.

| VARIABLE PAY - Bank & Agency Tracker | | | | | | | |
|---|---|---|---|---|---|---|---|
| Month | October | November | December | January | February | March | Total |
| 26/27 Monthly ceiling spend to achieve -10% Variable Pay | £92,889.00 | £92,889.00 | £92,889.00 | £92,889.00 | £92,889.00 | £92,889.00 | **£557,334** |
| 26/27 Invoiced spend - Variable Pay | | | | | | | |
| Variance to plan - Variable Pay | | | | | | | £557,334 |
| 26/27 Monthly ceiling spend to achieve 30% agency reduction targ | £33,481 | £33,481 | £33,481 | £33,481 | £33,481 | £33,481 | **£200,886** |
| 26/27 Invoiced spend - Agency | | | | | | | |
| Variance to plan - Agency | | | | | | | £200,886 |




## Financial Pressure Heat Map

| Division | Premium Pay Pressure |
|---|---|
| Community & Integrated Medicine | 🔴🔴🔴🔴🔴 |
| Planned & Specialist Care | 🔴🔴🔴🔴 |
| Primary Care | 🟠🟠🟠 |
| Mental Health | 🟢🟢 |
| Corporate Medical | 🟢 |

**Medical & Dental Workforce Growth Heat Map**

| Division | Headcount Growth Since Apr-25 | Assessment |
|---|---|---|
| Community & Integrated Medicine | 🔴🔴🔴🔴🔴 | Highest growth |
| Planned & Specialist Care | 🔴🔴🔴🔴 | Strong growth |
| Women & Children | 🔴🔴🔴 | Moderate growth |
| Primary Care | 🔴🔴🔴 | Moderate growth |
| Mental Health | 🔴🔴 | Controlled growth |
| Corporate Medical | 🟢 | Stable |

Based on consultant, specialty doctor, SAS doctor, trust grade and GP growth visible across the establishment dataset.

**Theme 4c – Allied Health Professions/Health Sciences Variable Pay**

Variable pay within Allied Health and Health sciences is linked with fragile substantive workforce and links with requirements from other services to deliver key diagnostics. Work to date however has included:

- Identification of all variable pay and reasons for usage
- Development of a standard operating procedure for the booking of variable pay, as controls identified were not robust
- Scoping of impact of introducing rostering systems is being undertaken, to ensure value for money and impact on variable pay by creating visibility of requirements.

**Theme 4d - Estates & Facilities Variable Pay**

Significant work within this improvement programme has been undertaken in relation to facilities. To date, limited progress has been made for the estates workforce and this will be further explored during October 2026. Within facilities the following actions have been completed:

- Standard operating procedures for the booking of annual leave are in place.
- Standard operating procedures for the use of rostering are in place.
- Savings trajectories have been issued to all areas linked to the above and recruitment of substantive workforce.
- Further work is underway to ensure roster efficiency, working closely with the rostering teams.
- Removal of legacy weekly pay arrangements will shortly be completed. These actions strengthened financial governance and improved consistency of workforce payment controls across Estates & Facilities services.

**Theme 4e – Admin and Clerical Variable Pay**

Admin and Clerical variable pay is not a key financial driver for the organisation; however, analysis has identified a number of services where regular bank and overtime usage occurs, primarily in Out of Hours, Emergency Department receptions, Medical Records, waiting list management, investigation officer support and other areas supporting patient flow and operational delivery. Discussions with senior service managers, alongside a review of year to

date spend and historical approval requests, indicate that much of it supports core operational functions, often where there are direct implications for patient care, statutory requirements, performance targets and service resilience.

Initial findings also suggest that Admin and Clerical variable pay is often a symptom of wider workforce and operational pressures, rather than the root cause. Targeted discussions are, therefore, underway with managers in higher-spend areas, to better understand the underlying drivers and identify opportunities to reduce reliance on variable pay through alternative workforce models, workforce planning, recruitment, roster effectiveness and onboarding processes.

An increase in the use of variable pay was recorded in September 2026, Bank £21,699 (August) to £24,829 (September) and overtime £47,23 (August) to £56,913 (September).

**Theme 5 - Workforce Controls**

This improvement programme is to align ESR/staffing information with Oracle budgetary information. Finance and workforce teams are working together to cleanse systems to ensure that, by 31 March 2027, all services have clarity on funded establishments. This will ensure that controls can be clearly in place for future staffing requests. Planned and Specialist Care is the first service for which this has been undertaken and the CCG leads are engaged in the process. Once the system cleansing has been undertaken, it will highlight any inconsistencies; enabling decisions to be made around how anomalies are addressed, which could either include funding support or workforce reduction programmes and service redesign.

Workforce Control activities delivered include:

- Establishment reports were successfully developed and completed on **10 September and 14 September 2026,** providing foundational workforce visibility.
- Manager establishment sign-off processes were successfully launched and completed on **28 September 2026,** strengthening accountability at service level.
- Fixed-term contract and secondment identification work has commenced.

**Risk to Plan**

Capacity within the workforce intelligence team is a key constraint. The small team is supporting each of the nine workstreams, supporting business as usual reporting and also leading the readiness assessment process for the introduction of Porth Pobl, the new workforce solution, for which the Health Board is an early adopter.

**Theme 6 – Recurrent Savings Delivery (OCP Process to delivery recurrent 5% CIP Savings)**

The Organisational Change Programme (OCP) improvement programme will achieve financial savings, as new OCPs are rolled out across the organisation. Progress to date includes:

- Draft finance and workforce summary content developed and integrated into OCP documentation, supporting improved alignment between workforce planning and financial oversight.
- Revised OCP process to include pre-engagement phase in addition to formal consultation phase. This will support individuals being included in decisions around their work and teams. Whilst introducing this phase adds a step, it is not anticipated to elongate the OCP process.
- The new process will be piloted within Workforce & OD during October 2026.

**Argymhelliad / Recommendation**

The Finance and Performance Committee is asked to:

- **NOTE** progress made within the Workforce Improvement Programmes
- **TAKE ASSURANCE** that actions will support the delivery of sustainable workforce models and reduce variable pay
- **DISCUSS** the contents of the report

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 3.1 The Committee will, in respect of its provision of advice and assurance to the Board:<br>3.1.1 Receive assurances on the financial governance and control environment in operation across the Health Board. This will be achieved a programme of deep dive reviews into the following themes, which mirror the national Value and Sustainability Board:<br>3.1.1.1 Workforce |
| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 1. Leadership<br>2. Culture and valuing people |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | 1. Striving teams |

| | |
|---|---|
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | 1. Healthy, Thriving Teams<br>5. People First, Digital Always |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 3. Create people-centred employment and development opportunities that support workforce transformation, reflect the changing needs of health and social care, and nurture leadership at every level |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | 1. A Social Model for Health and Wellbeing will complement and integrate with other ways of working, values, principles and objectives. |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | NHS Wales analysis of workforce |
| Rhestr Termau:<br>Glossary of Terms: | CCGs – Clinical Care Groups<br>CIP – Cost Improvement Programme<br>ESR – Electronic Staff Record<br>HCSW – Health Care Support Worker<br>SAS doctor – Specialty, Associate Specialist, and Specialist doctor |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | Not applicable |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Improvement on financial position |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Improvement on patient care and quality by increase in substantive workforce caring for patients rather than variable workforce |

| | |
|---|---|
| **Gweithlu:**<br>**Workforce:** | Improvement in working conditions for staff if managed well |
| **Tegwch Iechyd:**<br>**Health Equity:** | Not applicable |
| **Risg:**<br>**Risk:** | Not applicable |
| **Cyfreithiol:**<br>**Legal:** | Not applicable |
| **Enw Da:**<br>**Reputational:** | Not applicable |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | Not applicable |

4

**11:35, 0 Mins**

# 4 - FINANCE

4.1

**11:35, 10 Mins**

# 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 approval

## Attachments

4.1 Financial Performance Assurance Report - M6 FPC Oct 2026.pdf

4.1 Appendix 1 - P06-27 Finance Performance Report.pdf

4.1 Appendix 2 - Hywel Dda UHB Accountable Officer Letter October 2026.pdf

4.1 Appendix 3 - FY28 Annual plan approach, principles and assumptions.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | **27 OCTOBER 2026** |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Financial Performance Assurance Report – Month 6 2026/27 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Huw Thomas, Executive Director of Finance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Andrew Spratt, Deputy Director of Finance<br>Jennifer Thomas, Head of Corporate Reporting |

| **Pwrpas yr Adroddiad** (dewiswch fel yn addas)<br>**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 financial position to date, against the 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

Following approval by the Finance and Performance Committee on 24 February 2026, budgets were delegated to Executive Directors and Clinical Care Group / Executive Function leads during March 2026.

At its meeting on 26 March 2026, the Board endorsed and approved submission of the 2026/27 Annual Plan to Welsh Government. The financial plan includes a planned deficit of £41.0m, after delivery of £42.8m savings, and does not meet the statutory duty to break even over a three-year period.

The Board recognised that approving a budget with a planned deficit constituted a novel and contentious action. In line with requirements, the Accountable Officer wrote to the Director General Health, Social Care and Early Years Group in Welsh Government to formally advise of this position.

Welsh Government has confirmed its expectation that the Health Board should plan to deliver, as a minimum, the 2025/26 outturn position of £22.1m. The submitted forecast therefore remains above the target control total, and Welsh Government has stated that the deteriorating finance and performance position is unacceptable and unsupportable.

Ongoing dialogue with Welsh Government continues, with the Health Board required to improve the forecast position beyond the revised Annual Plan deficit and demonstrate a

credible route to financial recovery through strengthened savings delivery, grip and control, and routine monitoring through established governance routes.

The reported deficit has improved by £3.5m, from the Annual Plan position of £41.0m to £37.5m. This movement is wholly attributable to the Health Board's share of the all-Wales reduction in the Welsh Risk Pool risk assessment and does not represent an underlying improvement in operational performance. The year-end forecast remains under review. Without a material improvement in performance and the delivery of robust mitigating actions, the forecast is likely to deteriorate in future reporting periods.

## Asesiad / Assessment

### Month 6 Summary

- **In-month deficit:** £3.6m including £1.8m reduction due to year-to-date impact of Welsh Risk Pool risk share adjustment (£0.2m worse than plan).
- **Savings gap:** £10.0m (£32.8m delivered against a £42.8m target).
- **Forecast deficit:** £37.5m, following a £3.5m reduction due to a national Welsh Risk Pool Risk share adjustment, but dependent on £20.2m of required mitigations actions.
- **Overall:** High risk to delivery of the forecast deficit.

The latest financial position is summarised as follows:

| Key Driver (£'m) | Current month variance to breakeven | Year to Date variance to breakeven | End of Year forecast to breakeven |
|---|---|---|---|
| Planned Deficit | 3.4 | 20.5 | 41.0 |
| Unidentified / (Identified) savings gap / (improvement) | 0.1 | 3.4 | 10.0 |
| Under / (Over) delivery of savings schemes | 0.0 | 0.0 | 0.0 |
| Core operational variation | 0.1 | 6.0 | 6.7 |
| Gross Forecast | 3.6 | 29.9 | 57.7 |
| Future Mitigating Actions | 0.0 | 0.0 | (20.2) |
| **Reported Position** | **3.6** | **29.9** | **37.5** |

**Appendix 1** provides a detailed assessment of the current financial position, including the assumptions relating to future mitigating actions that are not yet fully identified but are required to deliver the reported financial forecast.

**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.

### 1. Mid-Year Financial Position Assessment and Accountable Officer Letter

The reported deficit has improved by £3.5m, from the Annual Plan position of £41.0m to £37.5m. This movement is wholly attributable to the Health Board's share of the all-Wales reduction in the Welsh Risk Pool risk assessment and does not represent an underlying improvement in operational performance. The year-end forecast remains under review. Without a material improvement in performance and the delivery of robust mitigating actions, the forecast is likely to deteriorate in future reporting periods.

An Accountable Officer letter was sent to Jacqueline Totterdell, Director General Health and Social Services Health and Social Services Group of Welsh Government, on 13 October 2026, **Appendix 2** refers, setting out the Health Board's latest financial position at Month 6 and actions for the next 6 weeks.

Key actions over the six-week period include establishing a Delivery Control Centre to track delivery; introducing a clinically led Workforce Cell to scrutinise variable-pay requests; strengthening Executive oversight, internal escalation and evidence-based grip-and-control assessments; and accelerating targeted action on workforce costs, productivity, commissioned care, prescribing, procurement and non-pay expenditure. Progress will be reviewed by the Board on 26 November 2026, with any resulting forecast implications reported to Welsh Government in early December.

**Implication:**
The latest Month 6 position remains subject to close review through the six-week action plan set out in the Accountable Officer letter. The plan will strengthen delivery oversight and grip and control, accelerate targeted action across key cost pressures, and test the deliverability of mitigating actions and recurrent improvements. Progress will inform the Board's review on 26 November 2026 and any subsequent revision to the forecast reported to Welsh Government in early December.

There is a risk that the organisation's cash position becomes unsustainable if the forecast deteriorates, or if further Welsh Government support is not confirmed. This may require implementation of a cash management strategy and continued escalation through established governance routes.

**2. Savings Plan Credibility and Workforce Improvement Programmes**

- £32.8m of savings have been identified against the £42.8m annual target, leaving a £10.0m under-identification gap.
- The Month 6 savings position represents an improvement from Month 5, although delivery remains below the annual target.
- The level of recurrent savings remains insufficient to provide a sustainable route to financial recovery, increasing reliance on non-recurrent measures.
- Further opportunities continue to be assessed through the six-week action plan, including targeted action on workforce costs, productivity, commissioned care, prescribing, procurement and non-pay expenditure.
- The Workforce Improvement Programmes continue to focus on reducing variable pay, agency and premium workforce costs through tighter scrutiny, improved rostering, sickness reviews and establishment control, supported by recruitment restrictions for administrative, clerical and management roles.
- An All-Wales comparison of savings delivery by income and expenditure category is included within **Appendix 1**.

**Implication:**
Although the savings position has improved since Month 5, the remaining £10.0m identification gap and insufficient recurrent delivery mean the forecast remains high risk. Without accelerated conversion of opportunities into sustainable recurrent savings, the Health Board will be unable to demonstrate a credible route to financial recovery or strengthen external confidence in the deliverability of its financial plan.

The Health Board continues to rely on converting underspends to savings, which do not improve the overall financial position, and there has not been a material conversation of these non-recurrent actions to recurrent, thus not improving the underlying deficit.

**3. Underlying Deficit and FY28 Planning cycle**
The underlying recurrent deficit is currently assessed at £62.1m, compared with the £40.8m assumption underpinning the Annual Plan. This is distinct from the reported 2026/27 forecast outturn of £41.0m, which includes the benefit of non-recurrent savings and further mitigating

actions. The underlying deficit reflects the low level of recurrent savings currently identified alongside continued core operational pressures. However, there is an improvement from the Month 5 position due to the Welsh Risk Pool change of £3.5m being recognised as a recurring benefit.

Work on the annual plan for 2027-30 has commenced, **Appendix 3** refers to the Planning principles, timelines and approach that has been set out for the coming year for Committee approval. A first draft of the plan will be presented to the Committee in December 2026

**Implication:**
The £62.1m underlying recurrent deficit represents a significant structural imbalance and remains materially above the £40.8m assumption underpinning the Annual Plan. This increases the scale of sustainable recurrent action required and will be a key consideration in developing the 2027–30 Annual Plan. The six-week action plan must, therefore, accelerate recurrent savings delivery and reduce reliance on non-recurrent measures to establish a credible route to financial recovery.

**4. Operational Cost Pressures and Run-Rate Drivers**
The key Month 6 pressures increasing the expenditure run rate are:

- Workforce and premium staffing pressures, including medical locums, agency, bank and additional hours required to cover vacancies, sickness and service fragility, particularly across Community and Integrated Medicine, Planned and Specialist Care, Mental Health and Learning Disabilities, and Pathology.
- Continuing Healthcare, commissioned care and out-of-area placement pressures, including increased package acuity, outsourced psychiatric intensive care capacity and wider commissioned activity above plan.
- Clinical capacity, outsourcing and dual-running costs across radiology, theatres and specialties, incurred to protect access, safety and continuity of care.
- Prescribing and medicines pressures, including drug-price and concessionary cost increases, alongside higher clinical supplies and emergency activity commissioned from neighbouring organisations.
- Estates maintenance, national energy prices and other operational non-pay pressures, partially offset by favourable movements in Primary Care contract expenditure, central income, vacancies and other corporate areas.

**Implication:**
These operational pressures continue to increase the expenditure run rate, constrain financial control and heighten reliance on non-recurrent mitigations. The six-week action plan will intensify targeted action across workforce costs, productivity, commissioned care, prescribing, procurement and non-pay expenditure, with strengthened oversight through the Delivery Control Centre. Unless these actions deliver evidenced and sustainable reductions, the £37.5m forecast deficit will remain high risk and may require revision following the Board's review on 26 November 2026.

**5. Clawback of Dental Ringfence allocation funding**
Welsh Government has confirmed that Health Boards are expected to fully utilise their ring-fenced dental allocation to support NHS dental services in 2026/27. There is an ongoing review of the dental financial position and delivery plans to maximise utilisation of the ring-fenced allocation and mitigate potential funding recovery. Current revised ringfenced underspend as at Quarter 2 is £5.1m

**Implication:**
The Health Board will need to fully deploy its ring-fenced dental allocation in support of NHS dental service delivery or risk in-year recovery of any forecast underspend. The cost of additional actions required to utilise the allocation is not currently included within the £37.5m forecast deficit and could therefore increase the reported deficit if expenditure is incurred in 2026/27.

While any 2026/27 recovery would not affect the 2027/28 baseline, sustained underspends may lead Welsh Government to consider recurrent adjustments to future baseline allocations.

**6. Accountability, Escalation and Grip**
Despite progress in Month 6 savings delivery, run rates have not materially improved in both Planned and Specialist Care and Community Integrated Medicine (CIM). Level 4 remains in place for the Chief Operating Officer (COO) for both Clinical Care Groups, with no material impact experienced to date. The COO remains at Level 4 escalation for both Clinical Care Groups for the fourth consecutive month, with limited progress against agreed mitigating actions and recovery plans.

- Executive Directors continue to hold ultimate accountability for their areas under the Ways of Working approach, supported by monthly Formal Executive Team reporting.
- The COO portfolio remains at Alert status, with two Level 4 areas, alongside one Level 3, one Level 2 and one Level 1 area.
- **Appendix 1** confirms the status for all other portfolios.
- Enhanced grip and control arrangements remain essential to ensure escalation translates into measurable improvement and delivery of recovery actions.

**Implication:**
Although the revised arrangements provide a clearer framework for accountability, there is increased concern that they are not operating effectively, as two areas have remained at Level 4 escalation for four consecutive months. This indicates that escalation has not yet translated into sufficient progress against mitigating actions and recovery plans, requiring continued targeted executive oversight and clear, time-bound recovery actions.

**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.

**Ministerial Priorities and Enabling Actions**
**Requirements include:**

- 30% reduction in on-contract agency spend and variable pay from the 2025/26 outturn.
- Elimination of off-contract agency.
- Elimination, by 30 September 2026, of all agency Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff.
- Reduction in out-of-area placements.
- Delivery of productivity improvements.
- Strengthened workforce planning and sickness management.

**Current position:**

- On-contract agency and premium workforce pressures continue due to service fragility, vacancies and sickness cover, with an increase of 6.7% above previous year.
- Off-contract agency has been reduced to nil.
- Medical locum usage, nursing bank and overtime remain material drivers in some portfolios.
- Additional Clinical Services, Admin & Clerical and Estates & Ancillary agency is nil.

- Mental Health and Learning Disabilities continues to experience demand and cost pressures for outsourced out-of-area Psychiatric Intensive Care beds, with reduction plans requiring further development and delivery assurance.

**Implication:**
Delivery against ministerial priorities is mixed. The elimination of off-contract agency is positive, but the targeted reduction in on-contract agency, premium workforce usage and demand-led pressures present ongoing risks to financial credibility and delivery of the recovery trajectory.

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

**1. Capital**
The capital programme remains forecast to deliver within the Capital Resource Limit (CRL) at £38.6m, comprising £30.5m All Wales Capital Programme funding and £8.1m discretionary capital. Delivery is currently assessed as low risk, based on the CRL fixing update that is due to be submitted to Welsh Government by 31 October 2026. A number of individual capital schemes have medium risks flagged, but these are not expected at this stage to present a risk to overall delivery of the capital programme.

**2. In-Year Investment Decisions**
In-year investment decisions made outside the Annual Plan process require appropriate scrutiny and approval through Finance and Performance Committee and onward approval by Board where required. Any financial consequences that cannot be fully mitigated will create an in-year negative central budget reserve and a recurrent funding requirement for future planning. The current summary of in-year investment decisions creating negative reserves of £1.103m part year effect and £1.249m full-year effect is:

| Item Description | Part Year Effect | Full Year Effect | Approval status |
|---|---|---|---|
| Band 2/3 Funding shortfall | 812 | 812 | Presented to June 2026 Finance and Performance Committee |
| Resident Doctors contract | 291 | 437 | Approved via Chair's Action on 4 June 2026. 8 months, FYE £437k |
| Nurse Staffing Levels | 0 | 0 | Presented to July Public Board, £18k PYE saving, £36k FYE saving |
| **Grand Total** | **1,103** | **1,249** | |

## Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **SCRUTINISE** and **CHALLENGE** the Month 6 financial position and £37.5m forecast deficit, recognising that the £3.5m improvement is wholly attributable to the all-Wales Welsh Risk Pool adjustment rather than underlying operational performance, and that delivery remains high risk and dependent on £20.2m of mitigating actions that are not yet fully confirmed;
- **SEEK ASSURANCE** that the six-week action plan provides a credible recovery trajectory by producing a robust, evidence-based assessment of the likely year-end outturn, closing the £10.0m savings identification gap, increasing recurrent savings, reducing operating expenditure, testing the deliverability of the £20.2m mitigating actions and addressing the £62.1m underlying recurrent deficit, with any required revision to the forecast identified promptly;
- **SEEK ASSURANCE** that clear, time-bound recovery actions are being implemented across all Alert and Advise portfolios – particularly Community and Integrated Medicine and

Planned and Specialist Care – with defined operational ownership and executive accountability, recognising the material risks to financial sustainability arising from reliance on non-recurrent measures, the £57.7m gross forecast position, the £20.2m mitigating-action requirement, the highest-rated corporate risk score and potential cash implications;

- **ACKNOWLEDGE** the further financial risk arising from potential recovery of unspent ring-fenced dental funding, and that the likely Quarter 3 position must be reflected in any revised forecast;
- **ENDORSE** the timelines, principles, approach and focus areas for the 2027–30 financial planning cycle; and
- **NOTE** that the capital programme remains forecast to deliver within the Capital Resource Limit as will be confirmed to Welsh Government by 31 October 2026, with there being limited scope to utilise further capital funds should Welsh Government make them available, due to the constrained internal capacity resulting from the Quarter 4 profile of the remaining schemes in this financial year.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 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:<br>3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers;<br>3.1.5.2 Performance against the savings requirement.<br>3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy. |
| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | 2326 (score 25) Risk to achieving 2026/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non-recurrent funding. |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |

| | |
|---|---|
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | All Planning Goals Apply |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 9. All HDdUHB Well-being Objectives apply |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | 7. All Apply |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | Monitoring returns to Welsh Government based on HDdUHB's financial reporting system. |
| Rhestr Termau:<br>Glossary of Terms: | BGH – Bronglais General Hospital<br>CHC – Continuing Healthcare<br>EOY – End of Year<br>FNC – Funded Nursing Care<br>FYE – Full Year Effect<br>GGH – Glangwili General Hospital<br>GMS – General Medical Services<br>HSCEY – Health, Social Care and Early Years<br>MHLD – Mental Health & Learning Disabilities<br>NICE – National Institute for Health and Care Excellence<br>OCP – Organisational Change Policy/Process<br>OOH – Out of Hours<br>PPH – Prince Philip Hospital<br>PSPP– Public Sector Payment Policy<br>RTT – Referral to Treatment Time<br>T&O – Trauma & Orthopaedics<br>TCT – Target Control Total<br>WG – Welsh Government<br>WGH – Withybush General Hospital<br>WRP – Welsh Risk Pool<br>WTE – Whole Time Equivalent<br>YTD – Year to date |

| | |
|---|---|
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | Finance Team<br>Management Team<br>Executive Team |

| **Effaith: (rhaid cwblhau)**<br>**Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:**<br>**Financial / Service:** | Financial implications are inherent within the report. |
| **Ansawdd / Gofal Claf:**<br>**Quality / Patient Care:** | The impact on patient care is assessed within the savings schemes. |
| **Gweithlu:**<br>**Workforce:** | The report considers the financial implications of our workforce. |
| **Tegwch Iechyd:**<br>**Health Equity:** | The report considers the financial implications of heath equity. |
| **Risg:**<br>**Risk:** | Financial risks are detailed in the report. |
| **Cyfreithiol:**<br>**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:**<br>**Reputational:** | Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders |
| **Gyfrinachedd:**<br>**Privacy:** | Not applicable |
| **Cydraddoldeb:**<br>**Equality:** | Not applicable |




# 2026/27 Financial Performance Report
# Finance and Performance Committee

Month 06 Reporting – September 2026/27

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- Savings Performance
- Core Operational Variation
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- Trend Analysis
- Staffing Establishment Reports
- Revenue vs Plan Variance Matrices
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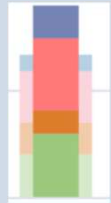
## Key

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 |

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# Executive Summary

The following slides provide an overview of the organisation's current financial position and the actions required to strengthen delivery. They set out accountability and escalation arrangements; the timetable for the mid-year forecast assessment; the highest-priority decisions and savings actions; progress against any internal escalation improvement commitment; and the principal in-month, year-to-date and year-end drivers against plan. Together, they highlight the planned deficit, material savings gaps and the need for accelerated, accountable action.



1. Thriving teams



2. Healthier communities



3. Great care



4. Positive futures

# Financial Accountability Status



## Background and Context

The Ways of Working consciously sets out to evolve the culture of the organisation away from imposed controls and executive scrutiny, to one of owned delivery, enhanced value and a focus on productivity and efficiency.

Executive Directors assume ultimate accountability for their areas under this approach. The Formal Executive Team receives a monthly update on the status of financial accountability, to ensure the Accountable Officer (CEO) can discharge their duties and hold relevant individuals to account, aligned to the internal escalation framework.

## Latest Update

Despite progress in Month 6 savings delivery, run rates continue to rise in both Planned and Specialist Care and Community Integrated Medicine (CIM). Level 4 remains in place for the COO for both Clinical Care Groups, with no material impact experienced to date.

| Executive Director Portfolio | Status | Explanation (Number of portfolios and their escalation levels) |
|---|---|---|
| Chief Executive | Assure | Delivering breakeven and savings |
| Chief Operating Officer | Alert (4th Month) | Continuation of 2 x Level 4 in Community and Integrated Medicine and Planned & Specialist Care (Savings and Breakeven gap), 1 x Level 3, 1 x Level 2, 1 x Level 1 |
| Executive Medical Director | Advise | 1 x Level 2 (Savings gap), 1 x Level 1 |
| Executive Director of Nursing, Quality and Patient Experience | Assure | Delivering breakeven and savings |
| Executive Director of Workforce and Organisational Development | Assure | Delivering breakeven and savings |
| Executive Director of Finance | Assure | Delivering breakeven and savings |
| Executive Director of Strategy and Planning | Advise | 1 x Level 3 (Savings and Breakeven gap), 1 x Level 1 |
| Executive Director of Public Health | Assure | Delivering breakeven and savings |
| Executive Director of Allied Health Professions and Health Sciences | Advise | 1 x Level 3 (Savings and Breakeven gap) |

# Mid-Year Financial Position Assessment

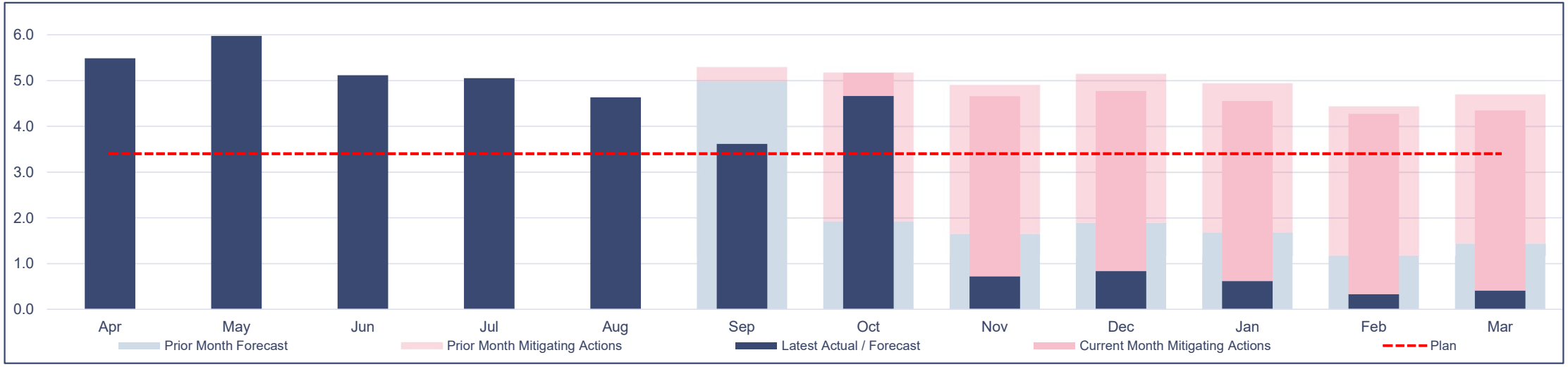


## Key Update

The reported deficit has improved from the Annual Plan position of £41.0m to £37.5m. This improvement is wholly attributable to the Health Board's share of the revised Welsh Risk Pool assessment (£3.5m) and does not reflect an underlying improvement in operational performance. The Health Board will continue to review the likely year-end position, including the extent to which non-recurrent measures can be converted into sustainable recurrent improvements during Quarter 3. An update will be shared at the In-Committee Board on 13 October 2026 with a six-week action plan, with a conclusion by Month 8 submission deadline of the Monthly Monitoring Return (MMR) to Welsh Government.

The reported in-month deficit position has improved as a result of the year-to-date recognition of the Welsh Risk Pool, a significant improvement trajectory is required to achieve the reported £37.5m deficit. **The average monthly deficit of £5.0m reported in Months 1 to 6 would need to reduce to £1.3m across the remainder of the year.**

| 16 September | 24 September | 7 October | 13 October | 27 October | 26 November | 11 December |
|---|---|---|---|---|---|---|
| **Formal Exec Team** | **Board Meeting** | **Formal Exec Team** | **In-Committee Board** | **F&P Committee** | **Board Meeting** | **Month 8 MMR** |
| Month 5 update and likelihood of change | Recommendation to advise Board of changes | Month 6 update and final check-point before WG | Month 6 update before sending Accountable officer letter | Review of latest recovery actions and timelines | Recommendation to advise Board of changes | Submission to WG of latest financial forecast |



# Recurrent Conversion of Savings



## Key Update

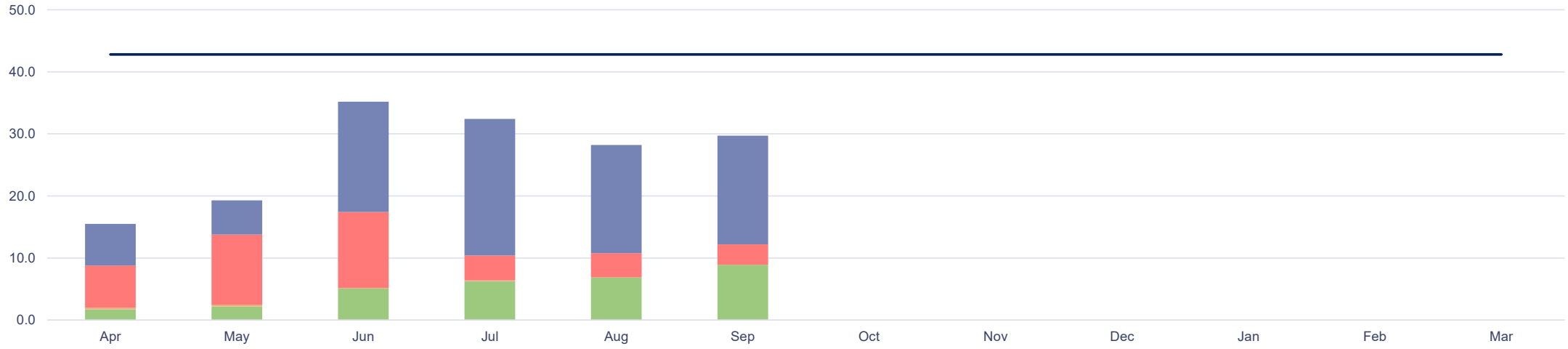
**The targeted M6 deadline for converting non-recurrent savings to recurrent savings has not resulted in a material improvement in recurrent delivery to date.**

Identified in-year savings total £32.8m against the £42.8m target, leaving a £10.0m identification gap. All identified savings are forecast to deliver, but only £7.8m are recurrent and £25.0m are non-recurrent.

Green-rated recurrent savings plans, measured on a full-year-effect basis, have increased from £1.7m in April 2026 to £8.9m. This strengthens delivery confidence but is not equivalent to realised recurrent savings. Most of the opportunity remains in Blue and Red categories, with a full-year recurrent savings gap of £33.9m.

Executive Directors should confirm recovery actions for outstanding conversions, with named scheme owners, revised delivery dates and quantified recurrent benefits. Reporting should distinguish planned conversions from recurrent savings actually delivered to demonstrate progress in reducing the underlying deficit.

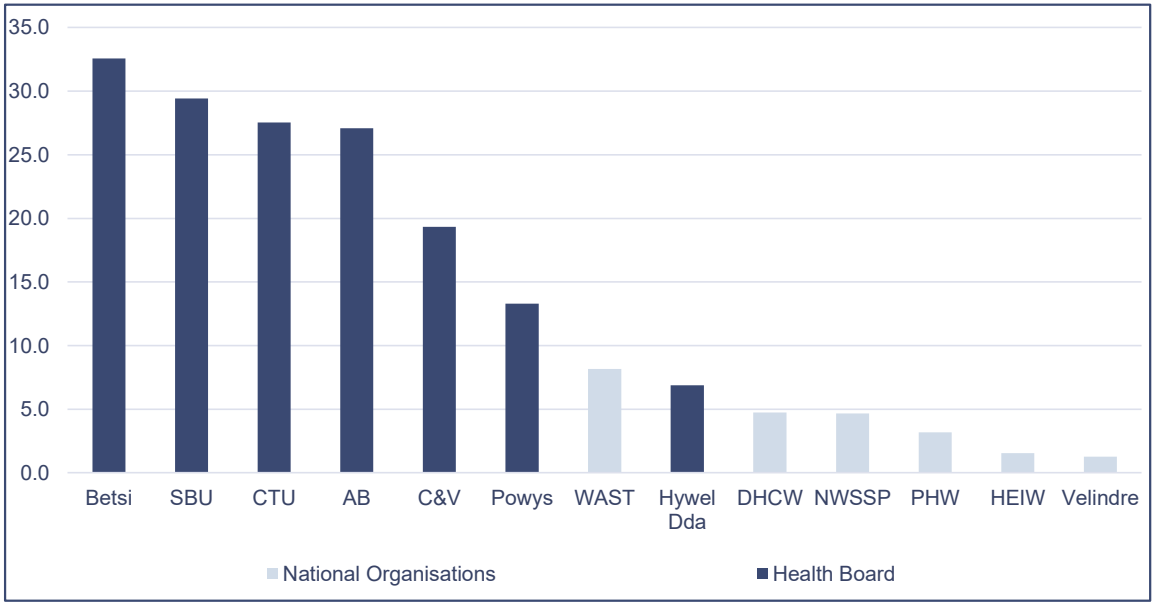
## Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)



# National Savings Position as at Month 5



## Recurrent Cash Releasing Savings by Health Board / National Organisation (£'m)




## Key Update

At the end of Month 5 Hywel Dda had identified **£6.9m of recurrent cash-releasing savings, less than one-third of the £22.3m national Health Board average and the lowest of the seven Health Boards**.

The recurrent gap to the national average is £15.4m, with Hywel Dda **ranked sixth or seventh across almost every major savings category.**

Recurrent savings remain significantly below the national average across Workforce, CHC and Medicines Management, indicating that the challenge is spread across several savings areas.

This reinforces that the recurrent challenge is structural. Without a material step-change in sustainable savings, there is a significant risk of continued reliance on non-recurrent measures, increasing the underlying financial challenge into 2027/28.

A more detailed breakdown will be shared with the relevant CCGs and Executive functions.

| Savings Category (£'m) | Workforce | Medicines Management | Procurement and Non-Pay | Continuing Healthcare | Variation and Reconfiguration | Other | Grand Total |
|---|---|---|---|---|---|---|---|
| All Wales Health Board Total | 48.2 | 49.1 | 28.1 | 15.8 | 5.3 | 9.6 | **156.2** |
| Hywel Dda | 1.5 | 3.2 | 2.0 | 0.0 | 0.0 | 0.1 | **6.9** |
| National Health Board Average | 6.9 | 7.0 | 4.0 | 2.2 | 0.8 | 1.4 | **22.3** |
| Gap to Average | 5.4 | 3.8 | 2.0 | 2.2 | 0.8 | 1.3 | **15.4** |
| Health Board Wales Ranking (1-7) | 7th | 6th | 6th | 7th | Joint 4th-7th | 6th | **7th** |

# Actionable Insights – Top Priority Alerts



| Action / Decision | £'m | Description | Owner | Status | Due Date |
|---|---|---|---|---|---|
| **Mid Year Forecast Assessment** | **TBC** | The reported deficit has improved by £3.5m, from the Annual Plan position of £41.0m to £37.5m. This movement is wholly attributable to the Health Board's share of the all-Wales reduction in the Welsh Risk Pool risk assessment and does not represent an underlying improvement in operational performance. The year-end forecast remains under review. Without a material improvement in performance and the delivery of robust mitigating actions, the forecast is likely to deteriorate in future reporting periods. | Andrew Spratt | In-progress | **13 October** |
| **Dental Allocation Underspend Risk** | **5.1** | Welsh Government have confirmed that forecast dental funding underspends will be recovered. On going review of the dental financial position and delivery plans to maximise utilisation of the ring-fenced allocation and mitigate potential funding recovery. Current revised ringfenced underspend as at Q2 £5.1m | Rhian Bond | On Going | **November** |
| Identification and delivery of robust **savings plans** | **10.0** | Whilst there has been a significant shift in the identification and conversion of underspends, there remains an identification gap to achieve the plan. There is an inequity across services with some over-delivering against target, and others under-delivering. | All Executive Directors, e*xc. Workforce, Finance and CEO* | Ongoing, urgent action to continue as part of de-risking the annual plan | **Overdue** |
| **Recurrent Conversion of Savings (In Year Rec Gap)** | **33.9** | The current savings position includes a significant element of non-recurrent benefit. Further work with is required to maximise recurrent savings opportunities and reduce the underlying financial deficit. | All Executive Directors | Ongoing, urgent action to reduce the underlying position following the initial Month 6 deadline. | **Overdue** |
| **Medical pay and rostering** Additional cover at premium costs | **7.2** | Continuing use of additional medical cover, including premium locum and agency in BGH, WGH, Planned Care and Mental Health. | Mark Henwood | Further Committee update to be presented in December. | **15 December** (Finance & Performance Committee) |

# Position Overview – Executive Summary



**The Health Board's Planned Deficit is £41.0m with a Savings Target of £42.8m. Gross forecast position is £57.7m, with required mitigating actions of £20.2m to be finalised, to achieve the revised reported end of year forecast position of £37.5m following the £3.5m Welsh Risk Pool improvement. Total savings delivery are £32.8m, leaving a delivery gap of £10.0m against the savings target.**

## Financial Management

The in-month financial position is a deficit of £3.6m, which is an adverse variance against the £3.4m deficit plan. This is driven by a core operational overspend of £1.9m, offset by a £1.8m year-to-date recognition of the Welsh Risk Pool improvement, and a £0.1m under identification of savings, with £3.5m savings identified against the savings target of £3.6m.

| 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** | **3.4** | **3.4** | **20.5** | **41.0** | **41.0** |
| Unidentified / (Identified) savings gap / (improvement) | 0.6 | 0.1 | 3.4 | 12.3 | 10.0 |
| Under / (Over) delivery of savings schemes | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Core operational variation | 0.6 | 0.1 | 6.0 | 7.6 | 6.7 |
| **Gross Forecast** | **4.6** | **3.6** | **29.9** | **60.9** | **57.7** |
| Future Mitigating Actions | 0.0 | 0.0 | 0.0 | (19.9) | (20.2) |
| **Reported Position** | **4.6** | **3.6** | **29.9** | **41.0** | **37.5** |

## Key Measures

BRAG based on Plan £30.0m (Risk rating = Impact x Likelihood)

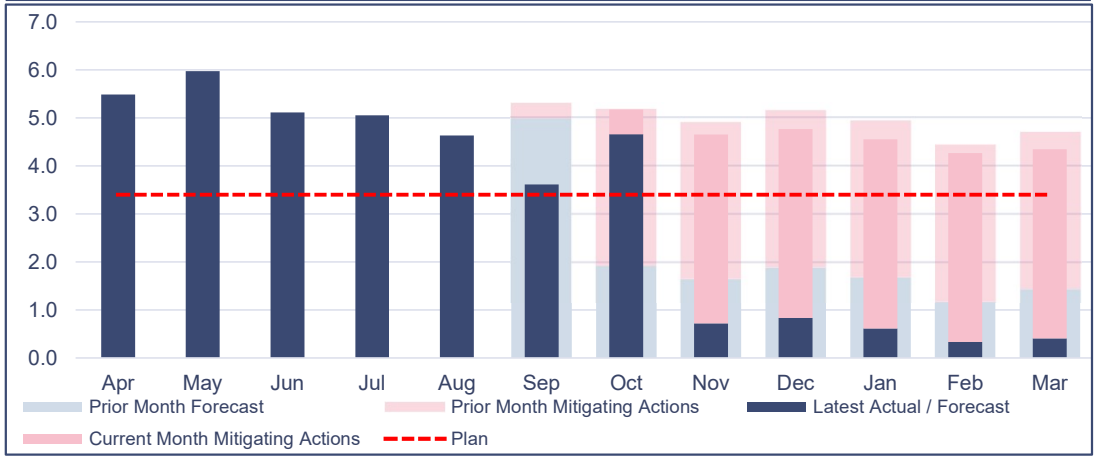
| | | |
|---|---|---|
| **Core Operational Variation** | **Risk #2326** 5 x 5 = 25 | The in-month core operational overspend of £0.1m largely relates to Medical locum agency usage to cover sickness and vacancies £1.0m, drugs price and concessions increase £0.6m, Continuing Healthcare packages increase £0.6m, Theatres and Radiology outsourcing of activity and consumables expenditure £0.5m, offset by Welsh Risk Pool risk share year to date reduction £1.8m, Dental contracts hand-back £0.6m and General Medical Services supplementary services underspend £0.2m. |
| **Cash** | | The Health Board will require strategic cash assistance in-year in line with the forecast deficit and working capital balances. Support will be required at the end of February or beginning of March 2027, and if it is not confirmed by December 2026, the cash management strategy would need to be implemented in the short term to support. |
| **Savings** | | Of the annual savings target of £42.8m, £32.8m has been identified and forecast to fully deliver on an in-year basis resulting in a £10.0m under-identification gap. Of the schemes identified, £7.8m are recurrent savings and £25.0m are non-recurrent savings. There's a continued action to forecast savings into future periods as well as converting at pace the pipeline schemes into credible Green and Amber plans, alongside a commitment to convert non-recurrent savings to recurrent savings. |
| **Capital** | **N/A** | Delivery against the capital programme is currently assessed as minimal risk. A number of individual capital schemes have medium risks flagged against them; however, these are not expected currently to present a risk to the overall delivery of the capital programme. Fluid management of discretionary schemes continue. |
| **Underlying Deficit** | **Risk #1199** 5 x 5 = 25 | The planned underlying deficit is £40.8m, with delivery of £42.8m recurrent savings. £8.9m recurrent savings have been identified, leaving a recurrent savings gap of £33.9m. After recognising £10.3m recurrent mitigating actions, cost pressures relating to the Healthcare Support Workers £0.8m and Resident Doctors contract £0.4m, and the adjustment for the WRP improvement of £3.5m, the underlying deficit is £62.1m. The organisation acknowledges the need to improve its financial trajectory to achieve breakeven by 2027/28, a requirement of the £26.0m conditionally recurrent funding, alongside a commitment to convert non-recurrent savings to recurrent savings. |

# Change from Prior Month Actual Position



| Key Driver (£'m) | Prior Month Reported Position | Current Month Reported Position | Movement |
|---|---|---|---|
| **Planned Deficit** | **3.4** | **3.4** | **0.0** |
| Savings gap / (improvement) | 0.6 | 0.1 | (0.5) |
| Under / (Over) delivery of savings schemes | 0.0 | 0.0 | 0.0 |
| Core Operational Variation | 0.6 | 0.1 | (0.5) |
| **Gross Forecast** | **4.6** | **3.6** | **(1.0)** |
| Future Mitigating Actions | 0.0 | 0.0 | 0.0 |
| **Reported Net Position** | **4.6** | **3.6** | **(1.0)** |

**In-Month Revenue Deficit Trajectory (£'m)**




| Unidentified Savings Gap (£'m) | Change |
|---|---|
| English Provider Services accountancy gain | (0.3) |
| Clinical Streaming Hub delay in investments expenditure | (0.2) |
| **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** |

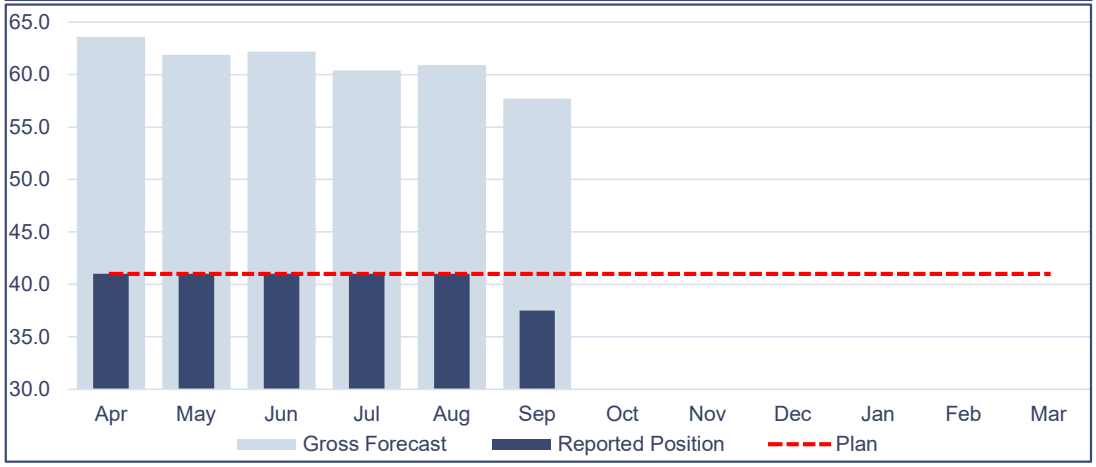
| Core Operational Variation (£'m) | Change |
|---|---|
| Primary Care reduction in General Medical Services contract in prior month | 0.4 |
| Community and Integrated Medicine Nursing enhanced rates and agency | 0.4 |
| Planned and Specialist Care Theatres loan kits and implants expenditure | 0.3 |
| Community & Integrated Medicine Medical sickness cover & retro payments | 0.3 |
| Planned Care Medical variable pay saving under delivery & retro payments | 0.3 |
| Estates YTD energy increase in expenditure in line with NWSSP schedule | 0.2 |
| Central Income Cost Recovery Unit over-achievement | (0.2) |
| Pharmacy drugs price and concessions year to date increase in prior month | (0.4) |
| Welsh Risk Pool risk share reduction – year to date impact in-month | (1.8) |
| **Movement in Core Operational Variation** | **(0.5)** |

# Change from Prior Gross Forecast



| Key Driver (£'m) | Prior Month End of Year Forecast | End of Year Forecast | Movement |
|---|---|---|---|
| **Planned Deficit** | **41.0** | **41.0** | **0.0** |
| Savings gap / (improvement) | 12.3 | 10.0 | (2.3) |
| Under / (Over) delivery of savings schemes | 0.0 | 0.0 | 0.0 |
| Core Operational Variation | 7.6 | 6.7 | (0.9) |
| **Gross Forecast** | **60.9** | **57.7** | **(3.2)** |
| Future Mitigating Actions | (19.9) | (20.2) | (0.3) |
| **Reported Net Position** | **41.0** | **37.5** | **(3.5)** |

**End of Year Revenue Deficit Trajectory (£'m)**




| Unidentified Savings Gap (£'m) | Change |
|---|---|
| Planned Care Rheumatology, Ophthalmology and Critical Care drugs | (0.6) |
| Community & Integrated Medicine Nintedanib drug loss of exclusivity | (0.5) |
| Community & Integrated Medicine Medical and Nursing expenditure savings | (0.4) |
| English Provider Services accountancy gain | (0.3) |
| Clinical Streaming Hub delay in investments expenditure | (0.2) |
| Pay vacancy savings within Mental Health and Planned and Specialist Care | (0.2) |
| Cost Recovery over achievement of income | (0.1) |
| **Movement in Unidentified Savings Gap** | **(2.3)** |

| Core Operational Variation (£'m) | Change |
|---|---|
| Pharmacy drugs price and concessions increase in July PARS Report | 0.6 |
| Community & Integrated Medicine Continuing Healthcare packages | 0.6 |
| Estates energy increase in expenditure in line with NWSSP schedule | 0.5 |
| Community & Integrated Medicine Nursing agency and enhanced pay | 0.5 |
| Primary Care continuation of Dental Orthodontic contract until end of year | 0.4 |
| Planned Care Medical variable pay saving under delivery & additional hours | 0.3 |
| Community & Integrated Medicine IBD and immunology drugs increase | 0.3 |
| Planned Care Drugs underspend to savings, offset by Oncology reduction | 0.3 |
| Community & Integrated Medicine reduction in Medical variable pay agency | (0.9) |
| Welsh Risk Pool risk share reduction in line with NWSSP schedule | (3.5) |
| **Movement in Core Operational Variation** | **(0.9)** |

# Financial Summary – Key Drivers vs Plan



## In-Month

### Reported Position
**£3.6m**
Planned Deficit **£3.4m**
Prior Month Forecast **£5.0m**

### Savings Identification Gap
**£0.1m**
Savings Target **£3.6m**
Total Identified **£3.5m**

### Savings Delivery Gap
**£0.0m**
Savings Delivery **£3.5m**
Prior Month Delivery **£3.0m**

### Core Operational Variation
**£0.1m**
Prior Month Variation **£0.6m**

## Year to Date

### Reported Position
**£29.9m**
Planned Deficit **£20.5m**

### Savings Identification Gap
**£3.4m**
Savings Target **£21.4m**
Total Identified **£18.0m**

### Savings Delivery Gap
**£0.0m**
Savings Delivery **£18.0m**
Prior Month Delivery **£14.5m**

### Core Operational Variation
**£6.0m**
Prior Month Variation **£5.9m**

## End of Year

### Reported Position
**£37.5m**
Planned Deficit **£41.0m**
Prior Annual Forecast **£41.0m**

### Savings Identification Gap
**£10.0m**
Savings Target **£42.8m**
Total Identified **£32.8m**

### Savings Delivery Gap
**£0.0m**
Savings Delivery **£32.8m**
Prior Month Delivery **£30.5m**

### Core Operational Variation
**£6.7m**
Prior Month Variation **£7.6m**

### Gross Forecast
**£57.7m**
Prior Gross Forecast **£60.9m**
Mitigating Actions **£20.2m**

### Net Risks / (Opportunities)
**£8.7m**
Prior Month **£9.0m**
Highly Probable Items

### Capital Position
**£38.6m**
Annual Plan **£38.6m**
Prior Annual Forecast **£38.0m**

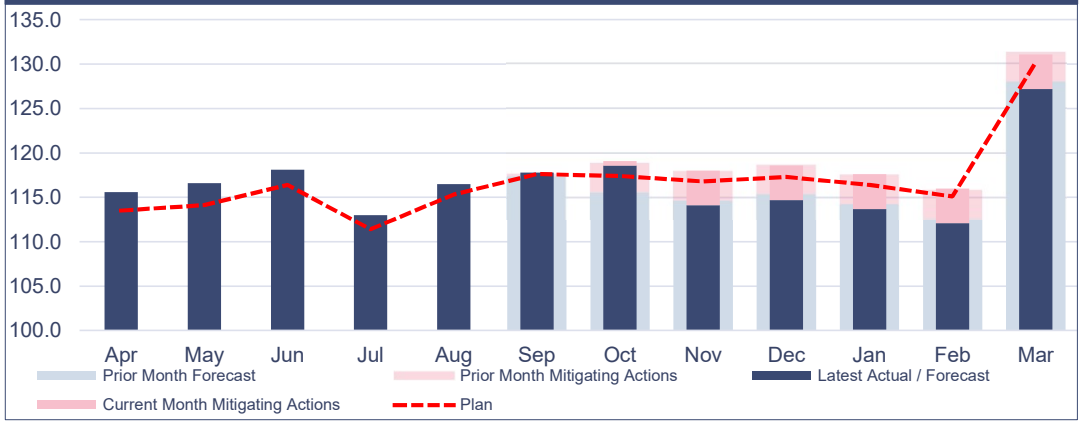
### Underlying Deficit
**£62.1m**
Annual Plan **£40.8m**
Prior Month **£67.6m**

# Financial Summary



| In-Month Actual | YTD Actual | EOY Forecast | 3-Year Growth | In-Year Growth | YTD Extrapolation |
|---|---|---|---|---|---|
| £117.8m | £697.6m | £1,418.0m | 8.0% | (0.3)% | £1,395.2m |
| Variance to Plan **£0.2m** | Variance to Plan **£9.4m** | Variance to Plan **£16.7m** | 2023-24 Outturn **£1,313m*** | 2025-26 Outturn **£1,422m*** | Risk / (Opp) **£(22.8)m** |

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




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Pay** | **59.5** | **59.9** | **60.6** | **359.8** | **719.7** | **720.8** | | **(1.1)** |
| Administration and Estates | 12.2 | 12.3 | 12.5 | 73.9 | 147.8 | 147.6 | | 0.1 |
| Allied Health, Scientists and Other | 7.5 | 7.5 | 7.4 | 44.5 | 89.1 | 89.3 | | (0.2) |
| Medical and Dental | 13.9 | 14.2 | 14.3 | 84.1 | 168.1 | 167.1 | | 1.0 |
| Nursing, Midwifery and Clinical Support | 25.8 | 26.0 | 26.4 | 157.4 | 314.7 | 316.7 | | (2.0) |
| **Non Pay** | **61.3** | **63.9** | **64.3** | **380.7** | **761.4** | **782.1** | | **(20.7)** |
| Clinical Services and Supplies | 4.6 | 4.1 | 4.4 | 26.1 | 52.1 | 52.1 | | 0.1 |
| Commissioned Healthcare Services | 37.0 | 36.6 | 36.4 | 221.8 | 443.7 | 447.7 | | (4.0) |
| Drugs and Prescribing | 14.2 | 13.8 | 13.9 | 80.7 | 161.5 | 160.9 | | 0.5 |
| Other Non-Pay | 5.5 | 9.4 | 9.6 | 52.1 | 104.1 | 121.4 | | (17.2) |
| **Income** | **(7.8)** | **(7.3)** | **(7.2)** | **(43.0)** | **(85.9)** | **(84.9)** | | **(1.0)** |
| **Net Income and Expenditure** | **113.0** | **116.5** | **117.8** | **697.6** | **1,395.2** | **1,418.0** | | **(22.8)** |
| **Allocations** | **108.0** | **111.9** | **114.2** | **667.7** | **1,335.4** | **1,360.4** | | |
| **Gross Position** | **5.1** | **4.6** | **3.6** | **29.9** | **59.8** | **57.7** | | |
| **Reported Position *** | **5.1** | **4.6** | **3.6** | **29.9** | **59.8** | **37.5** | | |

## Key Information

Month 4, July, reduction in expenditure relating to a decrease in Capital Charges due to reduced impairments adjustment £4.0m, with a corresponding reduction in Revenue Resource Limit.

Month 8, November, onwards includes a reduction in expenditure due to mitigating actions of £20.2m anticipated within Pay £10.0m and Non Pay £10.2m, resulting in a corresponding risk for Pay and Non Pay due to the future months forecast being lower than year to date expenditure levels.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £14.3m, with a corresponding increase in Revenue Resource Limit, resulting in an opportunity within Non Pay due to future months forecast expenditure being higher than year to date expenditure levels.

Note an opportunity within Commissioned Healthcare Services due to Primary Care delay in General Medical Services and Cluster project plans expenditure anticipated in future months.

***Reported Position for end of year includes £20.2m of assumed mitigating actions to deliver the £37.5m Reported Position.**
***Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m**

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

# Income and Expenditure Insight

The following slides provide a detailed review of income and expenditure across pay and non-pay categories. They compare monthly trends and the latest forecast with plan, explain key movements and highlight the assumptions, risks and opportunities affecting the year-end outlook. This analysis supports executive scrutiny of financial performance and the actions required to deliver the forecast position.



1. Thriving teams



2. Healthier communities



3. Great care



4. Positive futures

# Total Pay Insights



**In-Month Actual**
**£60.6m**
Variance to Plan **£0.8m**

**YTD Actual**
**£359.8m**
Variance to Plan **£3.5m**

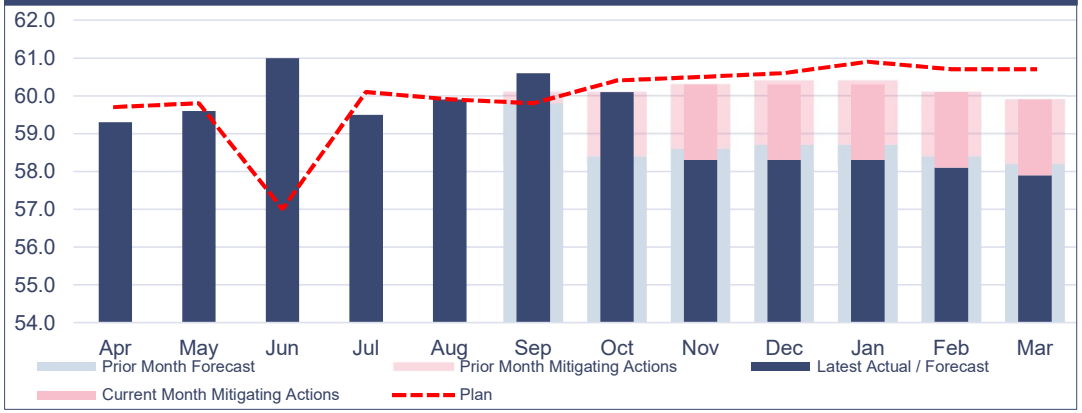
**EOY Forecast**
**£720.8m**
Variance to Plan **£0.6m**

**3-Year Growth**
**20.0%**
2023-24 Outturn **£600.9m***

**In-Year Growth**
**8.7%**
2025-26 Outturn **£662.9m***

**YTD Extrapolation**
**£719.7m**
Risk / (Opp) **£(1.1)m**

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Substantive** | **54.5** | **54.6** | **55.3** | **329.2** | **658.3** | **664.0** | | **(5.7)** |
| Administration and Estates | 11.9 | 11.9 | 12.1 | 71.8 | 143.7 | 143.8 | | (0.2) |
| Allied Health, Scientists and Other | 7.2 | 7.2 | 7.1 | 43.1 | 86.3 | 86.5 | | (0.3) |
| Medical and Dental | 11.5 | 11.5 | 11.7 | 69.2 | 138.3 | 139.6 | | (1.3) |
| Nursing, Midwifery and Clinical Support | 23.8 | 24.0 | 24.4 | 145.0 | 290.1 | 294.1 | | (4.0) |
| **Variable** | **4.0** | **4.2** | **4.3** | **24.8** | **49.6** | **46.5** | | **3.1** |
| Administration and Estates | 0.3 | 0.3 | 0.4 | 2.0 | 4.1 | 3.8 | | 0.3 |
| Allied Health, Scientists and Other | 0.2 | 0.2 | 0.1 | 1.0 | 2.1 | 2.0 | | 0.1 |
| Medical and Dental | 1.8 | 2.0 | 2.1 | 11.4 | 22.7 | 21.4 | | 1.3 |
| Nursing, Midwifery and Clinical Support | 1.6 | 1.7 | 1.7 | 10.3 | 20.7 | 19.3 | | 1.4 |
| **Agency (Premium)** | **1.0** | **1.1** | **1.0** | **5.9** | **11.8** | **10.3** | | **1.5** |
| Administration and Estates | - | - | - | - | - | - | | - |
| Allied Health, Scientists and Other | 0.1 | 0.1 | 0.1 | 0.4 | 0.7 | 0.8 | | (0.0) |
| Medical and Dental | 0.6 | 0.7 | 0.6 | 3.5 | 7.1 | 6.1 | | 1.0 |
| Nursing, Midwifery and Clinical Support | 0.3 | 0.3 | 0.3 | 2.0 | 4.0 | 3.4 | | 0.6 |
| **Total Expenditure** | **59.5** | **59.9** | **60.6** | **359.8** | **719.7** | **720.8** | | **(1.1)** |
| **Plan** | **60.1** | **59.9** | **59.8** | **356.3** | **712.6** | **720.1** | | |
| **Gross Variance to Plan** | **(0.6)** | **0.0** | **0.8** | **3.5** | **7.0** | **0.6** | | |
| **Reported Variance to Plan *** | **(0.6)** | **0.0** | **0.8** | **3.5** | **7.0** | **(9.3)** | | |

## Key Information

Month 3, June, increase in expenditure due to year to date payment of the FY26-27 Medical and Dental 3.5% pay award £1.4m, offset by a reduction in the plan relating to the exercise to convert year to date core operational underspends to savings, with £4.8m savings being identified for pay vacancies.

Month 5, August, increase from prior month expenditure largely relating to Community and Integrated Medicine and Planned and Specialist Care increase in Medical fill rate cover.

Month 6, September, deviation from prior month forecast largely relating to increase in Medical variable pay expenditure within Cancer and Scheduled Care and Community and Integrated Medicine within Carmarthenshire partly relating to retrospective additional duty hours claims.

Month 8, November, onwards includes a reduction in expenditure due to mitigating actions of £10.0m anticipated within Substantive to deliver from Month 8 to 12. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date levels.

***Reported Variance to Plan for end of year includes £10.0m of assumed mitigating actions to deliver the £37.5m Reported Position.**
***Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m**

# Substantive Insights



**In-Month Actual**
**£55.3m**
Variance to Plan **£(3.1)m**

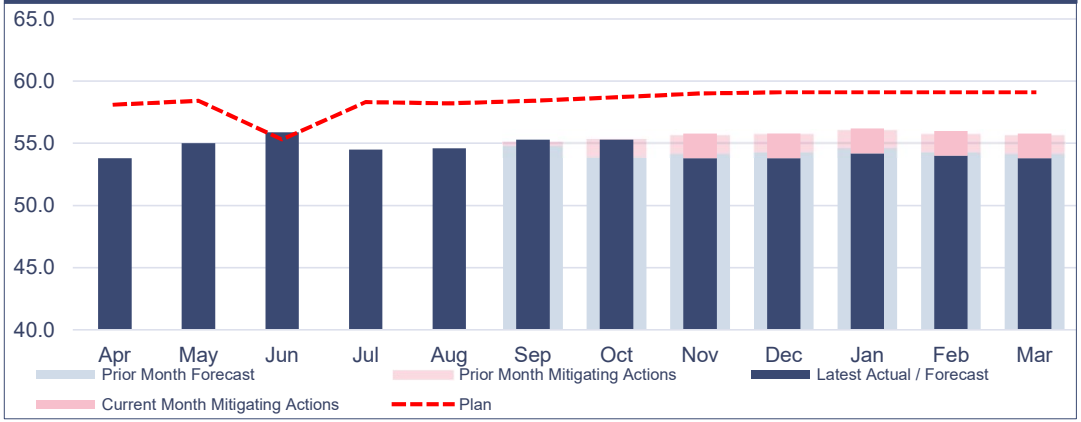
**YTD Actual**
**£329.2m**
Variance to Plan **£(17.5)m**

**EOY Forecast**
**£664.0m**
Variance to Plan **£(36.6)m**

**In-Year Growth**
**8.5%**
2025-26 Outturn **£611.7m**

**YTD Extrapolation**
**£658.3m**
Risk / (Opp) **£(5.7)m**

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Pay Groups** | **54.5** | **54.6** | **55.3** | **329.2** | **658.3** | **664.0** | | **(5.7)** |
| Administration and Estates | 11.9 | 11.9 | 12.1 | 71.8 | 143.7 | 143.8 | | (0.2) |
| Allied Health, Scientists and Other | 7.2 | 7.2 | 7.1 | 43.1 | 86.3 | 86.5 | | (0.3) |
| Medical and Dental | 11.5 | 11.5 | 11.7 | 69.2 | 138.3 | 139.6 | | (1.3) |
| Nursing, Midwifery and Clinical Support | 23.8 | 24.0 | 24.4 | 145.0 | 290.1 | 294.1 | | (4.0) |
| **Functions** | **54.5** | **54.6** | **55.3** | **329.2** | **658.3** | **664.0** | | **(5.7)** |
| Chief Operating Officer Management | 0.7 | 0.7 | 0.7 | 4.9 | 9.8 | 9.5 | | 0.4 |
| Community and Integrated Medicine | 16.8 | 16.7 | 17.1 | 101.3 | 202.7 | 207.3 | | (4.6) |
| Mental Health and Learning Disabilities | 6.1 | 6.1 | 6.1 | 36.8 | 73.5 | 73.6 | | (0.1) |
| Operational Allied Health and Health Sciences | 5.8 | 5.8 | 5.7 | 34.7 | 69.5 | 69.2 | | 0.2 |
| Planned and Specialist Care | 13.9 | 13.9 | 14.1 | 83.6 | 167.2 | 167.9 | | (0.6) |
| Primary Care | 1.4 | 1.3 | 1.4 | 8.0 | 16.1 | 16.0 | | 0.0 |
| Executive Functions | 9.7 | 10.0 | 10.1 | 59.8 | 119.5 | 120.5 | | (1.0) |
| **Total Expenditure** | **54.5** | **54.6** | **55.3** | **329.2** | **658.3** | **664.0** | | **(5.7)** |
| **Plan** | **58.3** | **58.2** | **58.4** | **346.7** | **693.4** | **700.6** | | |
| **Gross Variance to Plan** | **(3.9)** | **(3.6)** | **(3.1)** | **(17.5)** | **(35.1)** | **(36.6)** | | |
| **Reported Variance to Plan *** | **(3.9)** | **(3.6)** | **(3.1)** | **(17.5)** | **(35.1)** | **(46.6)** | | |

## Key Information

Month 3, June, increase in expenditure due to year to date payment of the FY26-27 Medical and Dental 3.5% pay award £1.4m, with a corresponding increase in Revenue Resource Limit. Note a reduction in the plan relating to the conversion of year to date core operational underspends to savings, with £4.8m savings identified for pay vacancies.

Month 8, November, onwards includes a reduction in expenditure due to mitigating actions of £10.0m to deliver from Month 8 to 12. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date expenditure levels.

Note an opportunity within Community and Integrated Medicine due recruitment plans in relation to Urgent and Emergency Care and Clinical Streaming Hubs investments and Newly Registered Nurses intake anticipated later in the year, with future months forecast expenditure therefore being higher than year to date levels.

***Reported Variance to Plan for end of year includes £10.0m of assumed mitigating actions to deliver the £37.5m Reported Position.**

# Variable Insights



**In-Month Actual**
**£4.3m**
Variance to Plan **£3.1m**

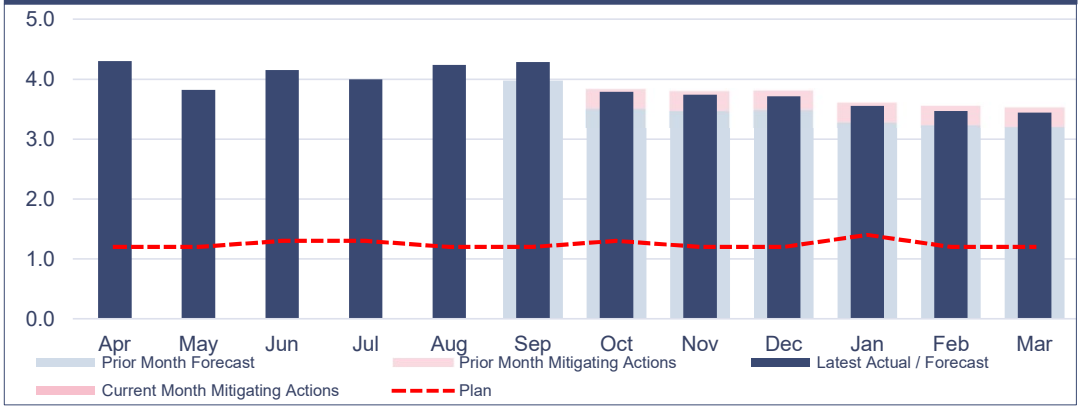
**YTD Actual**
**£24.8m**
Variance to Plan **£17.3m**

**EOY Forecast**
**£46.5m**
Variance to Plan **£31.6m**

**In-Year Growth**
**(12.6)%**
2025-26 Outturn **£53.2m**

**YTD Extrapolation**
**£49.6m**
Risk / (Opp) **£3.1m**

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Pay Groups** | **4.0** | **4.2** | **4.3** | **24.8** | **49.6** | **46.5** | | **3.1** |
| Administration and Estates | 0.3 | 0.3 | 0.4 | 2.0 | 4.1 | 3.8 | | 0.3 |
| Allied Health, Scientists and Other | 0.2 | 0.2 | 0.1 | 1.0 | 2.1 | 2.0 | | 0.1 |
| Medical and Dental | 1.8 | 2.0 | 2.1 | 11.4 | 22.7 | 21.4 | | 1.3 |
| Nursing, Midwifery and Clinical Support | 1.6 | 1.7 | 1.7 | 10.3 | 20.7 | 19.3 | | 1.4 |
| **Functions** | **4.0** | **4.2** | **4.3** | **24.8** | **49.6** | **46.5** | | **3.1** |
| Chief Operating Officer Management | - | - | - | 0.1 | 0.1 | 0.1 | | (0.0) |
| Community and Integrated Medicine | 1.5 | 1.9 | 1.8 | 10.1 | 20.1 | 19.1 | | 1.0 |
| Mental Health and Learning Disabilities | 0.2 | 0.2 | 0.3 | 1.3 | 2.7 | 2.7 | | (0.0) |
| Operational Allied Health and Health Sciences | 0.3 | 0.2 | 0.2 | 1.4 | 2.9 | 3.0 | | (0.2) |
| Planned and Specialist Care | 1.2 | 1.3 | 1.3 | 7.6 | 15.3 | 13.3 | | 1.9 |
| Primary Care | 0.4 | 0.3 | 0.4 | 2.3 | 4.6 | 4.7 | | (0.1) |
| Executive Functions | 0.5 | 0.3 | 0.3 | 2.0 | 4.0 | 3.5 | | 0.5 |
| **Total Expenditure** | **4.0** | **4.2** | **4.3** | **24.8** | **49.6** | **46.5** | | **3.1** |
| **Plan** | **1.3** | **1.2** | **1.2** | **7.5** | **15.0** | **15.0** | | |
| **Gross Variance to Plan** | **2.7** | **3.0** | **3.1** | **17.3** | **34.6** | **31.6** | | |

## Key Information

Month 2, May, reduction in bank expenditure due to inability to fill shifts within Community and Integrated Medicine and Primary Care, and reduction in patient acuity within Mental Health, alongside reduction in Waiting List Initiative activity within Planned and Specialist Care Nursing.

Month 6, September, deviation from prior month forecast largely relating to increase in Medical variable pay expenditure within Cancer and Scheduled Care and Community and Integrated Medicine within Carmarthenshire partly relating to retrospective additional duty hours claims.

Month 7, October, onwards includes a reduction in Medical variable expenditure within Cancer and Scheduled Care and Community and Integrated Medicine, resulting in corresponding risks due to future expenditure anticipated being lower than year to date levels. Reduction in variable pay is anticipated within Carmarthenshire due to increased substantive and fixed term onboarding anticipated. The substantive recruitment of Newly Registered Nurses within Community and Integrated Medicine also results in lower reliance anticipated on Medical variable pay.

Note a further risk within Planned and Specialist Care Nursing due to future months forecast expenditure being lower than year to date expenditure levels.

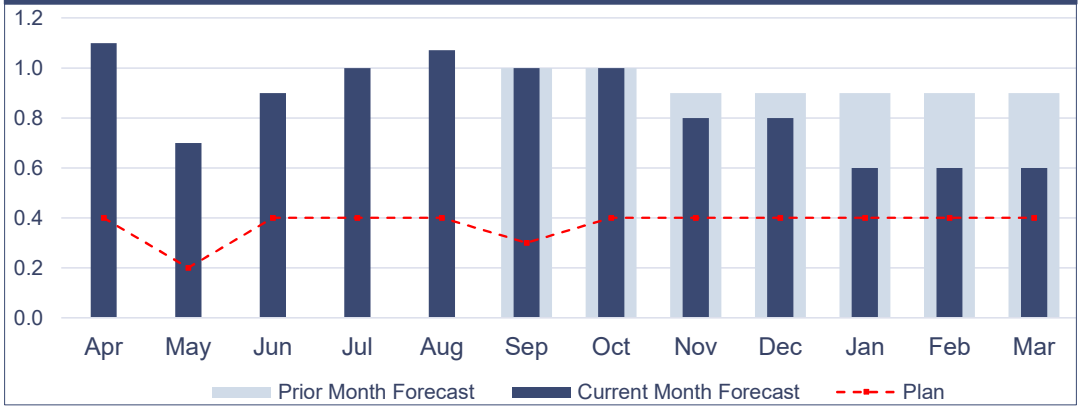
Note that the previously assumed Variable mitigating actions have been removed as Variable pay reductions within Planned and Specialist Care are no longer anticipated to materialise.

# Agency Insights



| In-Month Actual | YTD Actual | EOY Forecast | 3-Year Growth | In-Year Growth | YTD Extrapolation |
|---|---|---|---|---|---|
| £1.0m | £5.9m | £10.2m | (69.2)% | (1.9)% | £11.8m |
| Variance to Plan **£0.7m** | Variance to Plan **£3.7m** | Variance to Plan **£5.7m** | 2023-24 Outturn **£33.1m** | 2025-26 Outturn **£10.4m** | Risk / (Opp) **£1.5m** |

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Pay Groups** | **1.0** | **1.1** | **1.0** | **5.9** | **11.8** | **10.3** | | **1.5** |
| Administration and Estates | - | - | - | - | - | - | | - |
| Allied Health, Scientists and Other | 0.1 | 0.1 | 0.1 | 0.4 | 0.7 | 0.8 | | (0.0) |
| Medical and Dental | 0.6 | 0.7 | 0.6 | 3.5 | 7.1 | 6.1 | | 1.0 |
| Nursing, Midwifery and Clinical Support | 0.3 | 0.3 | 0.3 | 2.0 | 4.0 | 3.4 | | 0.6 |
| **Functions** | **1.0** | **1.0** | **1.0** | **5.9** | **11.8** | **10.2** | | **1.5** |
| Chief Operating Officer Management | - | - | - | - | - | - | | - |
| Community and Integrated Medicine | 0.6 | 0.7 | 0.5 | 3.8 | 7.7 | 5.8 | | 1.9 |
| Mental Health and Learning Disabilities | 0.1 | 0.1 | 0.1 | 0.4 | 0.8 | 0.7 | | 0.0 |
| Operational Allied Health and Health Sciences | 0.2 | 0.2 | 0.2 | 1.1 | 2.1 | 2.1 | | 0.0 |
| Planned and Specialist Care | 0.1 | 0.1 | 0.2 | 0.8 | 1.7 | 1.8 | | (0.2) |
| Primary Care | - | - | - | - | - | - | | - |
| Executive Functions | - | - | - | (0.2) | (0.5) | (0.2) | | (0.2) |
| **Total Expenditure** | **1.0** | **1.0** | **1.0** | **5.9** | **11.8** | **10.3** | | **1.5** |
| **Plan** | **0.4** | **0.4** | **0.3** | **2.1** | **4.3** | **4.6** | | |
| **Gross Variance to Plan** | **0.6** | **0.6** | **0.7** | **3.7** | **7.5** | **5.7** | | |

## Key Information

Month 2, May, reduction in Agency expenditure from prior month within Medical and Nursing across various areas, with a reduction in plan following recognition of saving, alongside a further reduction in expenditure within Operational Allied Health.

Month 5, August, increase in Medical Agency expenditure from prior month within Community and Integrated Medicine Pembrokeshire system.

Month 8, November, onwards reduction in Medical agency expenditure from prior month forecast within Pembrokeshire and Carmarthenshire, due to increased substantive and fixed term onboarding anticipated in Quarter 4. The substantive recruitment of Newly Registered Nurses within Community and Integrated Medicine also results in lower reliance anticipated for Medical dual running and cover of vacancies and sickness. This results in a risk within Community and Integrated Medicine due to future expenditure anticipated being lower than year to date levels.

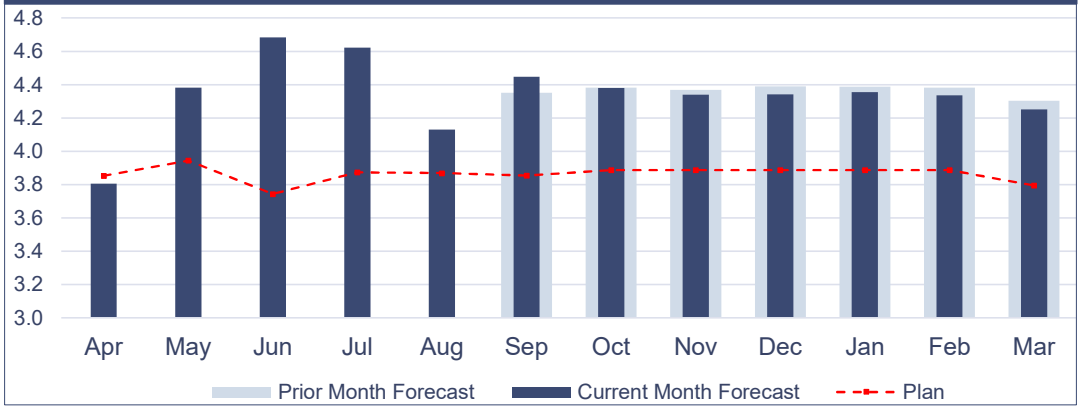
A further risk is seen within Community and Integrated Medicine Nursing due to the year to date agency expenditure not anticipated to continue to the same level in future months due to the recruitment of Newly Registered Nurses and therefore a reduced reliance on agency.

# Clinical Services and Supplies Insights



| In-Month Actual | YTD Actual | EOY Forecast | 3-Year Growth | In-Year Growth | YTD Extrapolation |
|---|---|---|---|---|---|
| £4.4m | £26.1m | £52.1m | 15.7% | 0.7% | £52.1m |
| Variance to Plan **£0.5m** | Variance to Plan **£3.0m** | Variance to Plan **£5.7m** | 2023-24 Outturn **£45.0m** | 2025-26 Outturn **£51.7m** | Risk / (Opp) **£0.1m** |

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Functions** | **4.6** | **4.1** | **4.4** | **26.1** | **52.1** | **52.1** | | **0.1** |
| Chief Operating Officer Management | - | - | - | 0.1 | 0.3 | 0.4 | | (0.1) |
| Community and Integrated Medicine | 1.2 | 1.2 | 1.2 | 7.1 | 14.3 | 14.3 | | - |
| Mental Health and Learning Disabilities | - | - | - | 0.1 | 0.2 | 0.2 | | - |
| Operational Allied Health and Health Sciences | 1.1 | 1.1 | 1.1 | 6.8 | 13.5 | 13.8 | | (0.2) |
| Planned and Specialist Care | 2.3 | 1.8 | 2.0 | 11.7 | 23.5 | 23.1 | | 0.4 |
| Primary Care | - | - | 0.1 | 0.2 | 0.4 | 0.4 | | - |
| Executive Functions | (0.1) | - | - | - | (0.1) | - | | (0.1) |
| **Total Expenditure** | **4.6** | **4.1** | **4.4** | **26.1** | **52.1** | **52.1** | | **0.1** |
| **Plan** | **3.9** | **3.9** | **3.9** | **23.1** | **46.3** | **46.4** | | |
| **Gross Variance to Plan** | **0.7** | **0.2** | **0.5** | **3.0** | **5.9** | **5.7** | | |

## Key Information

Month 2, May, and Month 3, June, reflects an increase driven by Planned and Specialist Care Theatres and Dermatology outsourcing and insourcing of activity and consumables purchases including loan kits and implants alongside an increase within Operational Allied Health relating to Radiology outsourcing of services and activity.

Month 5, August, reduction in expenditure within Theatre consumables reflects lower elective activity due to Anaesthetist shortages and the prioritisation of cancer pathway patients.

Month 6, September, increase in expenditure compared to prior month forecast relating to increase in loan kits purchases within Planned and Specialist Care.

Note a risk within Planned and Specialist Care due to the increase in outsourcing of Theatres activity and consumable purchases not anticipated to continue to the same level in future months.
Note an opportunity within Operational Allied Health due to the increase in Radiology outsourcing from Month 3 onwards anticipated to continue at this increased level in future months.

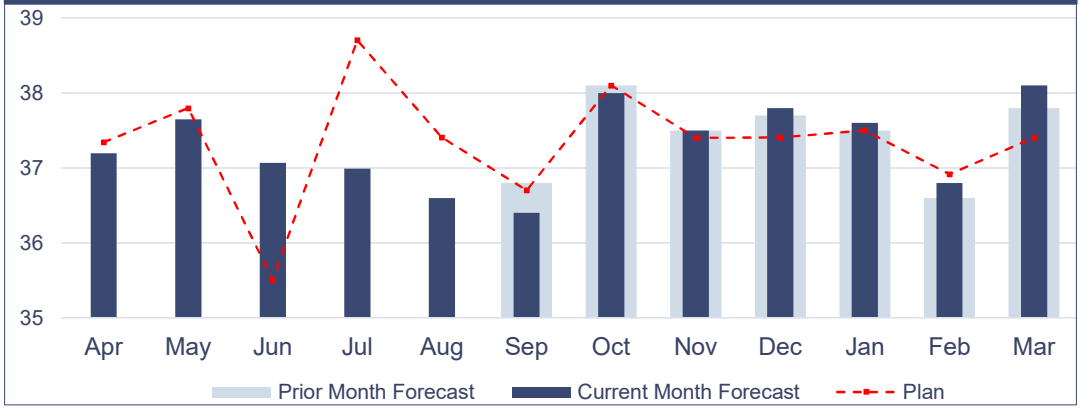
Forecast overspend relating to Theatres, Dermatology, Anaesthetics, Urology and Ophthalmology outsourcing in Planned and Specialist Care £2.4m, offset by Ophthalmology drugs underspend and Radiology outsourcing and dual running of services £2.2m offset by vacancies and Community and Integrated Medicine insulin pumps, sleeping machines and other consumables spend £1.3m.

# Commissioned Healthcare Services Insights



| In-Month Actual | YTD Actual | EOY Forecast | 3-Year Growth | In-Year Growth | YTD Extrapolation |
|---|---|---|---|---|---|
| £36.4m | £221.8m | £447.7m | 16.0% | 3.% | £443.7m |
| Variance to Plan **£(0.4)m** | Variance to Plan **£(1.7)m** | Variance to Plan **£(0.5)m** | 2023-24 Outturn **£385.9m** | 2025-26 Outturn **£434.2m** | Risk / (Opp) **£(4.0)m** |

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Functions** | **37.0** | **36.6** | **36.4** | **221.8** | **443.7** | **447.7** | | **(4.0)** |
| Chief Operating Officer Management | - | - | - | - | 0.1 | 0.1 | | - |
| Community and Integrated Medicine | 2.9 | 3.0 | 3.0 | 17.6 | 35.2 | 35.6 | | (0.4) |
| Mental Health and Learning Disabilities | 4.1 | 3.9 | 3.9 | 23.5 | 47.0 | 47.1 | | (0.1) |
| Operational Allied Health and Health Sciences | 0.4 | 0.5 | 0.4 | 2.8 | 5.5 | 5.5 | | 0.1 |
| Planned and Specialist Care | 0.4 | 0.5 | 0.4 | 3.3 | 6.6 | 6.3 | | 0.3 |
| Primary Care | 10.5 | 9.7 | 10.2 | 61.6 | 123.3 | 127.6 | | (4.3) |
| Executive Functions | 18.6 | 19.0 | 18.4 | 113.1 | 226.1 | 225.7 | | 0.4 |
| **Total Expenditure** | **37.0** | **36.6** | **36.4** | **221.8** | **443.7** | **447.7** | | **(4.0)** |
| **Plan** | **38.7** | **37.4** | **36.7** | **223.5** | **447.0** | **448.2** | | |
| **Gross Variance to Plan** | **(1.7)** | **(0.8)** | **(0.4)** | **(1.7)** | **(3.3)** | **(0.5)** | | |

## Key Information

Month 2, May, increase from prior month due to year to date recognition of Pharmaceuticals Company expenditure in line with pass through Joint Commissioning Committee funding.

Month 3, June, reduction in plan due to year to date Primary Care Dental underspends recognised as savings, offset by an increase in plan in Month 4, July, due to reversal of the saving to core underspends.

Month 5, August, reduction in expenditure from prior month relating to Primary Care General Medical Services Global Sum reduction in year to date expenditure due to delay in project plans.

Month 6, September, reduction in expenditure from prior month forecast due to English Provider Services accountancy gain £(0.3)m.

Month 7, October, increase in expenditure relating to commencement of Primary Care vaccination programmes.

Month 11, February, and Month 12, March, increase in expenditure from prior month forecast due to continuation of Dental Orthodontic contract to the end of the year.

Monthly fluctuations in expenditure largely relating to number of days in the month and the corresponding expenditure of Continuing Healthcare packages, with significant reduction in Month 11, February.

Note an opportunity within Primary Care due to the delay in General Medical Services and Cluster project plans expenditure anticipated in future months.

# Drugs and Prescribing Insights



**In-Month Actual**
**£14.0m**
Variance to Plan **£0.2m**

**YTD Actual**
**£80.7m**
Variance to Plan **£0.2m**

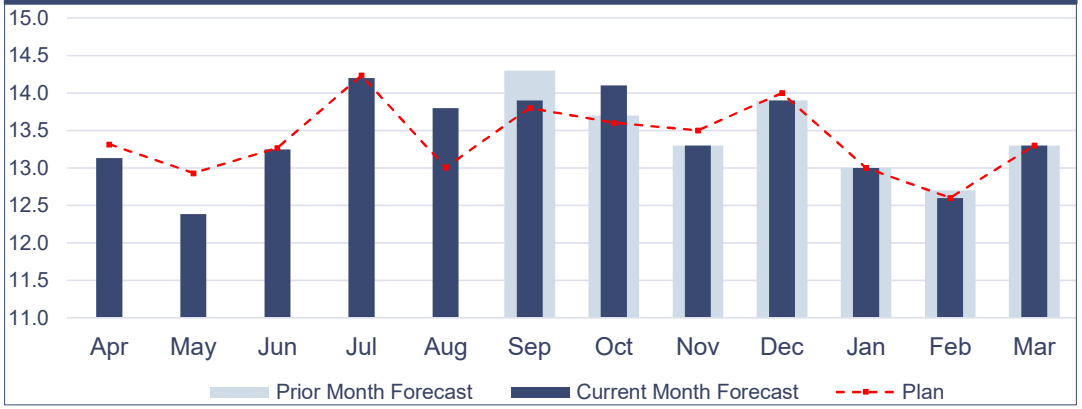
**EOY Forecast**
**£160.9m**
Variance to Plan **£0.3m**

**3-Year Growth**
**8.2%**
2023-24 Outturn **£148.7m**

**In-Year Growth**
**8.1%**
2025-26 Outturn **£148.8m**

**YTD Extrapolation**
**£161.5m**
Risk / (Opp) **£0.5m**

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Functions** | **14.2** | **13.8** | **14.0** | **80.7** | **161.5** | **160.9** | | **0.5** |
| Chief Operating Officer Management | - | - | - | - | - | - | | - |
| Community and Integrated Medicine | 1.8 | 1.6 | 1.4 | 9.7 | 19.3 | 19.0 | | 0.3 |
| Mental Health and Learning Disabilities | 0.1 | 0.1 | 0.1 | 0.6 | 1.2 | 1.4 | | (0.1) |
| Operational Allied Health and Health Sciences | 0.5 | 0.4 | 0.5 | 2.8 | 5.6 | 5.7 | | - |
| Planned and Specialist Care | 3.4 | 3.2 | 3.1 | 19.3 | 38.6 | 38.0 | | 0.6 |
| Primary Care | - | - | - | 0.1 | 0.1 | 0.1 | | - |
| Executive Functions | 8.4 | 8.5 | 8.8 | 48.3 | 96.6 | 96.8 | | (0.2) |
| **Total Expenditure** | **14.2** | **13.8** | **14.0** | **80.7** | **161.5** | **160.9** | | **0.5** |
| **Plan** | **14.2** | **13.0** | **13.8** | **80.5** | **161.0** | **160.6** | | |
| **Gross Variance to Plan** | **(0.0)** | **0.8** | **0.2** | **0.2** | **0.4** | **0.3** | | |

## Key Information

Monthly fluctuations in expenditure largely relating to the number of prescribing days in the month and therefore the corresponding expenditure on drugs based on activity.

Month 4, July, increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with Prescribing Audit Report.

Month 6, September, reduction in expenditure from prior month forecast largely relating to Planned and Specialist Care reduction in Homecare drugs including Oncology, Dermatology and Rheumatology drugs and Nintedanib reduction in drugs expenditure within Community and Integrated Medicine.

Month 7, October, increase in expenditure from prior month forecast largely relating to Pharmacy drugs price and concessions increase from £8.74 to £8.82 in line with July Prescribing Audit Report.

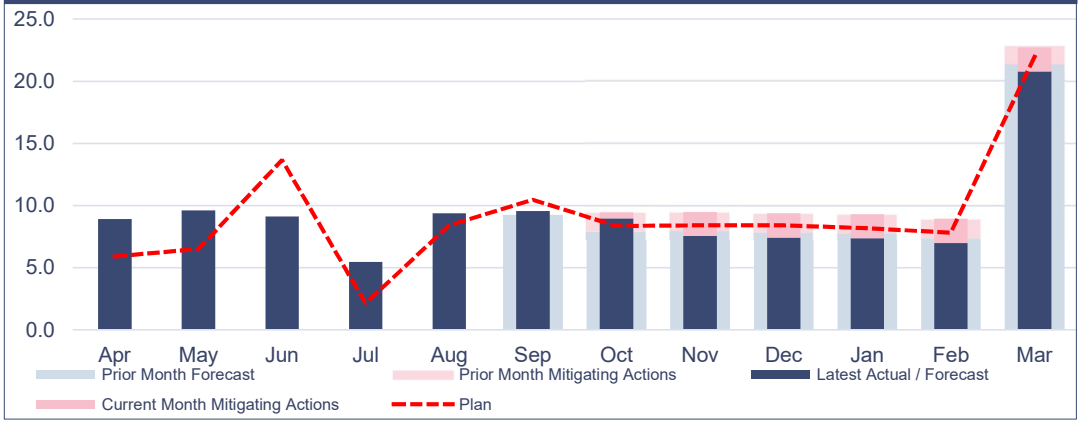
Note a risk within Planned and Specialist Care due to Ophthalmology and Rheumatology expenditure anticipated to reduce in future months.

# Other Non-Pay Insights



| In-Month Actual | YTD Actual | EOY Forecast | 3-Year Growth | In-Year Growth | YTD Extrapolation |
|---|---|---|---|---|---|
| £9.6m | £52.1m | £121.4m | 11.6% | 22.5% | £104.1m |
| Variance to Plan **£(0.9)m** | Variance to Plan **£5.0m** | Variance to Plan **£11.2m** | 2023-24 Outturn **£108.8m** | 2025-26 Outturn **£99.1m** | Risk / (Opp) **£(17.3)m** |

## Expenditure Monthly Trend (£'m)




| Expenditure Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Functions** | **5.5** | **9.4** | **9.6** | **52.1** | **104.1** | **121.4** | | **(17.3)** |
| Chief Operating Officer Management | 0.2 | 0.1 | 0.2 | 1.0 | 2.0 | 1.9 | | 0.1 |
| Community and Integrated Medicine | 0.9 | 0.9 | 0.9 | 5.1 | 10.2 | 10.1 | | 0.1 |
| Mental Health and Learning Disabilities | 0.2 | 0.2 | 0.2 | 1.3 | 2.6 | 2.6 | | - |
| Operational Allied Health and Health Sciences | 0.2 | 0.2 | 0.2 | 1.2 | 2.3 | 2.4 | | (0.1) |
| Planned and Specialist Care | 0.3 | 0.3 | 0.3 | 1.9 | 3.8 | 3.9 | | (0.1) |
| Primary Care | 0.1 | 0.1 | 0.2 | 0.9 | 1.7 | 1.5 | | 0.2 |
| Executive Functions | 3.6 | 7.5 | 7.6 | 40.7 | 81.5 | 99.0 | | (17.5) |
| **Total Expenditure** | **5.5** | **9.4** | **9.6** | **52.1** | **104.1** | **121.4** | | **(17.3)** |
| **Plan** | **2.1** | **8.4** | **10.5** | **47.0** | **94.1** | **110.1** | | |
| **Gross Variance to Plan** | **3.3** | **1.0** | **(0.9)** | **5.0** | **10.0** | **11.2** | | |
| **Reported Variance to Plan *** | **3.3** | **1.0** | **(0.9)** | **5.0** | **10.0** | **1.0** | | |

## Key Information

Month 3, June, increase in plan following the conversion of year to date pay and drugs core operational underspends to savings, offset by the savings target assumed within non-pay.

Month 4, July, reduction in expenditure largely due to a decrease in Capital Charges £4.0m, with a corresponding reduction in Revenue Resource Limit.

Month 7, October, onwards includes a reduction in expenditure due to mitigating actions requirement of £10.2m anticipated within Non-Pay to deliver from Month 7 to Month 12. Mitigating actions result in a risk for Non Pay due to the future months forecast being lower than year to date expenditure levels.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £14.3m, with a corresponding increase in Revenue Resource Limit. Note an opportunity within Executive Functions as forecast capital expenditure in future periods, particularly Month 12, is higher than year-to-date expenditure levels.

Forecast overspend of £11.2m largely relates to the £10.0m savings identification gap against target assumed within Non-Pay, Estates maintenance and energy increase £1.7m, Community and Integrated Medicine maintenance, security and transportation costs £1.2m, offset by Welsh Risk Pool risk share reduction £(3.5)m.

***Reported Variance to Plan for end of year includes £10.2m of assumed mitigating actions to deliver the £37.5m Reported Position.**

# Income Insights



**In-Month Actual**
**£7.1m**
Variance to Plan **£0.0m**

**YTD Actual**
**£43.0m**
Variance to Plan **£(0.7)m**

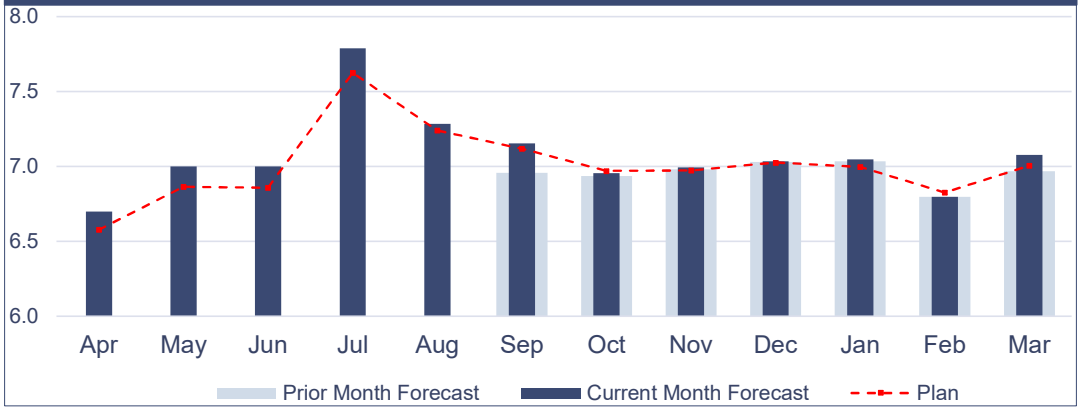
**EOY Forecast**
**£84.9m**
Variance to Plan **£(0.8)m**

**3-Year Growth**
**15.1%**
2023-24 Outturn **£73.7m**

**In-Year Growth**
**2.4%**
2025-26 Outturn **£82.9m**

**YTD Extrapolation**
**£85.9m**
(Risk) / Opp **£1.0m**

## Income Monthly Trend (£'m)




| Income Trajectory Analysis (£'m) | P04-27 | P05-27 | P06-27 | YTD | YTD Extrap. | EoY Forecast | EoY Var | Risk / (Opp) |
|---|---|---|---|---|---|---|---|---|
| **Functions** | **7.7** | **7.3** | **7.1** | **43.0** | **85.9** | **84.9** | | **1.0** |
| Chief Operating Officer Management | - | - | - | 0.2 | 0.4 | 0.4 | | - |
| Community and Integrated Medicine | 0.3 | 0.4 | 0.3 | 2.1 | 4.1 | 4.0 | | 0.1 |
| Mental Health and Learning Disabilities | 0.3 | 0.3 | 0.2 | 1.6 | 3.1 | 2.7 | | 0.4 |
| Operational Allied Health and Health Sciences | 0.3 | 0.3 | 0.3 | 1.7 | 3.4 | 3.4 | | 0.1 |
| Planned and Specialist Care | 0.5 | 0.5 | 0.4 | 3.0 | 6.1 | 5.9 | | 0.2 |
| Primary Care | 0.2 | 0.2 | 0.2 | 1.2 | 2.4 | 2.3 | | 0.1 |
| Executive Functions | 6.1 | 5.6 | 5.6 | 33.2 | 66.3 | 66.1 | | 0.2 |
| **Total Income** | **7.7** | **7.3** | **7.1** | **43.0** | **85.9** | **84.9** | | **1.0** |
| **Plan** | **7.6** | **7.2** | **7.1** | **42.3** | **84.6** | **84.1** | | |
| **Gross Variance to Plan** | **0.1** | **0.0** | **0.0** | **0.7** | **1.3** | **0.8** | | |

## Key Information

Month 2, May, increase in income from prior month due to additional Health Education and Improvement Wales, Non-Contracted activity and Drugs rebate income.

Month 4, July, increase in income from prior month largely relating to year to date recognition of Digital Health and Care Wales income for Digital initiative programmes expenditure £0.5m.

Month 6, September, increase in income from prior month forecast largely relating to Central Income and Workforce Higher Awards income.

Income overachievement of £(0.8)m largely relates to Central Income Non-Contracted Activity income £(1.0)m, Operational Allied Health training and secondment income £(0.5)m and Planned and Specialist Care Bowel Screening income £(0.4)m, offset by underachievement of Dental Income due to reduced activity and termination of Dental practices contracts £1.8m.

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# Detailed Summary

Detailed view of financial performance across the in-month, year-to-date and end-of-year positions. For each period, they explain the core operational and savings performance, quantify key deviations from plan and show performance by Clinical Care Group and Executive Function. They highlight any further mitigating actions required to achieve the reported deficit.



1. Thriving teams



2. Healthier communities



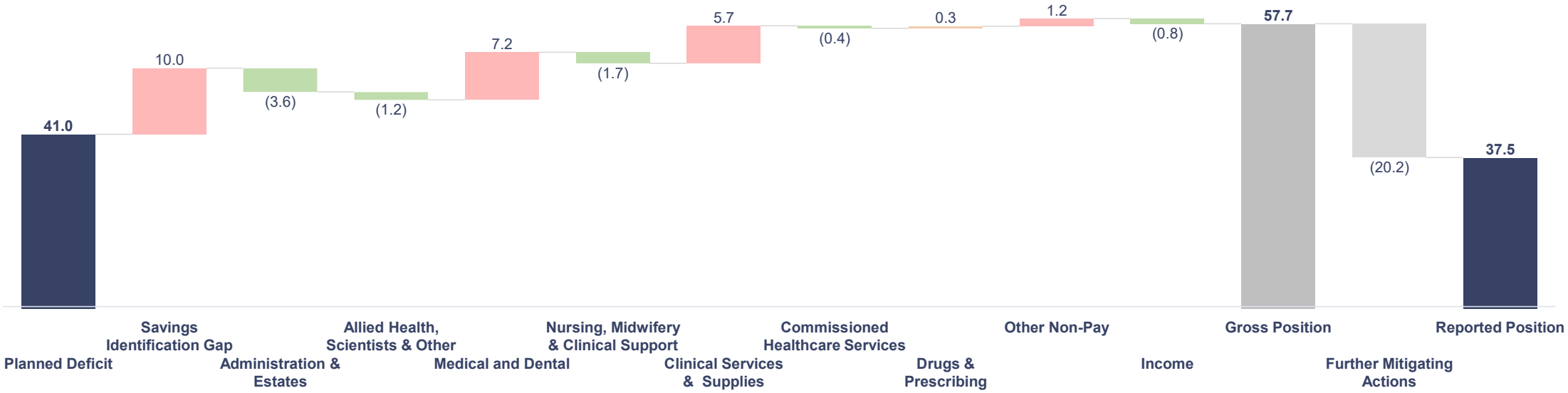
3. Great care



4. Positive futures

# End of Year – Key Drivers vs Plan






## Key Information

**Savings Identification Gap** – Savings identification of £32.8m against savings target of £42.8m, leaving a savings identification gap of £10.0m.

**Administration & Estates** – Pay vacancies mainly within Workforce £(0.8)m, Primary Care £(0.7)m and Public Health £(0.6)m alongside Workforce Health Board wide Improvement Programme relating to Administration and Clerical recruitment restrictions £(0.8)m.

**Medical and Dental** – Community and Integrated Medicine high locum and agency usage to cover rota gaps, sickness and vacancies mainly within Pembrokeshire £2.3m and Carmarthenshire £0.6m. Planned and Specialist Care continuation of dual running of Medical staff within Bronglais Obstetrics, Gynaecology and Paediatrics £1.9m, alongside Pathology £1.4m and Mental Health £1.1m locum usage to cover sickness and vacancies.

**Clinical Services and Supplies** – Theatres, Dermatology, Anaesthetics and Urology outsourcing within Planned and Specialist Care £2.4m, Radiology outsourcing and dual running of services offset by vacancies £2.2m, and Community and Integrated Medicine purchases of Continuous Positive Airway Pressure, insulin pumps, incontinence products and hoist equipment £1.3m.

# End of Year – Key Deviations to Plan



| Key Deviation | | £'m | Key Information |
|---|---|---|---|
| **Planned Deficit** | | **41.0** | **As per plan submitted to Welsh Government** |
| **Savings Delivery Gap** | | 10.0 | Green and Amber savings plans delivering of £32.8m against savings target of £42.8m |
| Overspends | Medical Stabilisation improvements not delivered | 7.2 | C&IM agency usage and dual running to cover vacancies and sickness cover (£3.4m), BGH W&C absence and restricted duties (£1.9m), Pathology agency usage (£1.4m) and MH&LD 4 premium agency (£1.1m) to cover sickness and vacancies. |
| | Continuing Healthcare | 5.9 | Demand increases on Continuing Healthcare packages (£4.5m) and Out of Area Mental Health placements (£1.4m) |
| | Theatre activity and increased outsourcing | 3.6 | Planned and Specialist Care outsourcing of various streams of activity above planned levels |
| | Radiology outsourced services | 2.8 | Double running of Radiology contracts and insourcing of ultrasound services, offset by Radiology vacancies |
| | Primary Care Drugs Price and Concessions | 2.6 | Pharmacy increase in drugs price in line with July Prescribing Audit Report from £8.45 to £8.82 per item. |
| | Estates and Facilities Non Pay | 1.7 | Estates and Facilities building maintenance and repair contracts alongside increase in energy NWSSP forecast |
| | Community & Integrated Medicine Non Pay supplies | 1.3 | Continuous Positive Airway Pressure, insulin pumps, incontinence products, equipment including hoists, alongside building maintenance, security and transportation costs |
| | Long Term Agreements | 1.0 | Non-elective short stay episodes attracting a disproportionate flat rate tariff within Swansea Bay |
| | Band 2/3 banding assumption changes | 0.9 | Increase in national framework assumptions and additional establishment conversion |
| Underspends | Primary Care | (7.6) | Dental contract handback £(5.1)m and General Medical Supplementary Services £(2.6)m. |
| | Administrative vacancies | (3.7) | Workforce Health Board Improvement programme £(0.8)m. Pay vacancies across the majority of services. |
| | Welsh Risk Pool | (3.5) | Welsh Risk Pool risk share reduction in line with latest NWSSP forecast |
| | Clinical fill rates (non-medical) | (2.9) | Vacancies and reduced fill rates within Nursing and Allied Health roles |
| | Income | (2.6) | Central Income £(1.0)m, Operational Allied Health £(0.5)m and Planned and Specialist Care £(0.4)m |
| **Gross Position** | | **57.7** | **Report £37.5m to Welsh Government, with full mitigating actions assumed** |
| Further Mitigating Actions | | (20.2) | Robust plans are yet to be confirmed, but opportunities exceeding the value are being reviewed |
| **Reported Position** | | **37.5** | **Revised to £37.5m following Welsh Risk Pool risk share reduction of £3.5m** |

# End of Year – Key Performance vs Plan



| Clinical Care Groups and Executive Functions (£'m) | Savings Gap to Target | Savings Delivery vs Plan Benefits | Core Operational Variation | Total | Key Information |
|---|---|---|---|---|---|
| **Planned Deficit** | | | | **41.0** | **As per plan submitted to Welsh Government** |
| Chief Operating Officer Management | 0.4 | 0.0 | 0.8 | **1.2** | Savings non delivery plus Voluntary Early Retirement Scheme payments and Physiotherapy First Contact Point pay expenditure. |
| Community and Integrated Medicine | 3.4 | 0.0 | 11.5 | **14.9** | Savings non delivery plus Medical locum agency £3.4m and Nursing bank usage £1.0m to cover sickness and vacancies. Continuing Healthcare packages increase £3.6m and consumables, security, maintenance and transportation costs £2.5m. |
| Mental Health and Learning Disabilities | 3.3 | 0.0 | 1.8 | **5.1** | Savings non delivery plus purchase of outsourced Psychiatric Intensive Care beds £1.4m, Continuing Healthcare packages increase £1.0m, Medical locum agency usage £1.1m offset by Allied Health and Nursing vacancies £(1.6)m. |
| Operational Allied Health & Health Sciences | 3.2 | 0.0 | 1.2 | **4.4** | Savings non delivery plus Radiology services outsourcing and dual running £2.8m offset by Radiology Allied Health vacancies £(2.8)m. Medical agency locum usage within Pathology £1.4m. |
| Planned and Specialist Care | 3.1 | 0.0 | 4.0 | **7.1** | Savings non delivery plus outsourcing of activity in Theatres, Dermatology, Anaesthetics and Urology £3.6m, Children and Women Medical dual running within Bronglais £1.9m and Nursing vacancies due to delay in investment plans £(2.0)m. |
| Primary Care | (0.1) | 0.0 | (8.5) | **(8.6)** | Dental contracts handback offset by income under achievement £(5.1)m, General Medicine Services Supplementary Services underspends £(2.6)m |
| Executive Functions | (3.3) | 0.0 | (4.1) | **(7.4)** | Savings over delivery relating to Workforce pay, VAT recovery and drugs process improvement. Welsh Risk Pool reduction in risk share £(3.5)m, Central Income overachievement £(1.0)m and Workforce Improvement Programme Administration and Clerical recruitment restrictions £(0.8)m. |
| **Sub Total** | **10.0** | **0.0** | **6.7** | **16.7** | |
| **Gross Position** | | | | **57.7** | |
| Further Mitigating Actions | | | | (20.2) | Conversion of opportunities to robust plans required as not yet confirmed |
| **Reported Position** | | | | **37.5** | **Revised following improvement to Welsh Risk Pool risk share £3.5m** |

# End of Year – Key Performance vs Plan Executive



| Executive Function (£'m) | Savings Gap to Target | Savings Delivery vs Plan Benefits | Core Operational Variation | Total | Key Information |
|---|---|---|---|---|---|
| Chief Executive | (0.2) | 0.0 | (0.2) | **(0.4)** | Over-achievement of savings, administrative pay vacancies. |
| Digital | 0.1 | 0.0 | 0.0 | **0.1** | Under-achievement of savings. |
| Estates and Facilities | 2.0 | 0.0 | 1.4 | **3.4** | Under-achievement of savings, building and maintenance expenditure and increase in energy expenditure in line with NWSSP forecast. |
| Executive Allied Health | 0.0 | 0.0 | (0.1) | **(0.1)** | Allied Health pay vacancies. |
| Finance | (0.5) | 0.0 | (0.2) | **(0.7)** | Over-achievement of savings, administrative pay vacancies. |
| Health Board Wide | (3.8) | 0.0 | (5.6) | **(9.4)** | Over-achievement of VAT recovery and drugs process improvement savings. Welsh Risk Pool risk share reduction £(3.5)m, overachievement of income £(1.0)m |
| LTA's | 1.3 | 0.0 | 1.0 | **2.3** | Under-achievement of savings, Swansea Bay emergency activity increase. |
| Medical | (0.1) | 0.0 | 0.0 | **(0.1)** | Over-achievement of savings. |
| Nursing | (0.1) | 0.0 | 0.2 | **0.1** | Over-achievement of savings, offset by increase in legal fees. |
| Pharmacy and Medicines Management | 2.6 | 0.0 | 2.4 | **5.0** | Under-achievement of savings, increase in drugs price, volume and concessions in line with July Prescribing Audit Report from £8.45 to £8.82 per item. |
| Public Health | (0.7) | 0.0 | (1.1) | **(1.8)** | Over-achievement of savings, Administration and Nursing pay vacancies alongside reduction in vaccination programmes uptake. |
| Strategy and Planning | (0.4) | 0.0 | (0.2) | **(0.6)** | Over-achievement of savings, Capital redesign income. |
| Workforce | (3.5) | 0.0 | (1.7) | **(5.2)** | Over-achievement of savings, Administration pay vacancies and Workforce Improvement Programme Administration and Clerical recruitment restrictions |
| **Sub Total** | **(3.3)** | **0.0** | **(4.1)** | **(7.4)** | |

# 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 |
|---|---|---|---|---|---|
| **Planned Deficit** | | | | **0.0** | **No change to Annual Plan Deficit of £41.0m** |
| Chief Operating Officer Management | 0.0 | 0.0 | 0.1 | **0.1** | Increased management administration costs. |
| Community and Integrated Medicine | (1.1) | 0.0 | 0.8 | **(0.3)** | Identified savings relating to Nintedanib drugs, Medical and Nursing. Increase in Continuing Healthcare packages, Nursing agency and enhanced pay, IBD and immunology drugs offset by reduction in Medical variable pay agency. |
| Mental Health and Learning Disabilities | (0.1) | 0.0 | 0.2 | **0.1** | Conversion of pay underspends relating to vacancies to savings, alongside a slight increase in Medical expenditure. |
| Operational Allied Health & Health Sciences | 0.0 | 0.0 | (0.3) | **(0.3)** | Improvement from prior month due to transfer of Children and Young People Weight Management service from Public Health to Operational Allied Health including pay vacancies. |
| Planned and Specialist Care | (0.7) | 0.0 | 0.9 | **0.2** | Conversion of Rheumatology, Ophthalmology and Critical Care drugs savings, previously presented as core underspends. Increases within Medical variable pay, offset by reduction in Oncology drugs expenditure. |
| Primary Care | 0.0 | 0.0 | 0.5 | **0.5** | Dental Orthodontic contract anticipated to continue to the end of the year and General Medical Services increase for Local Supplementary Services. |
| Executive Functions | (0.4) | 0.0 | (3.1) | **(3.5)** | Welsh Risk Pool reduction in risk share £(3.5)m alongside English Provider Services accountancy gain £(0.3)m, offset by Pharmacy drugs price and concessions increase £0.6m and Estates energy forecast increase £0.5m. |
| **Sub Total** | **(2.3)** | **0.0** | **(0.9)** | **(3.2)** | |
| **Gross Position** | | | | **(3.2)** | |
| Further Mitigating Actions | | | | (0.3) | |
| **Reported Position** | | | | **(3.5)** | **Revised to £37.5m following Welsh Risk Pool improvement of £3.5m** |

# Trend – Total Key Performance vs Plan



| Clinical Care Groups and Executive Functions (£'m) | Apr EOY | May EOY | Jun EOY | Jul EOY | Aug EOY | Sep EOY | Key Information |
|---|---|---|---|---|---|---|---|
| **Annual Plan** | **41.0** | **41.0** | **41.0** | **41.0** | **41.0** | **41.0** | **As per plan submitted to Welsh Government** |
| Chief Operating Officer Management | 0.8 | 1.6 | 1.2 | 1.1 | 1.1 | **1.2** | Static, savings under delivery plus Voluntary Early Retirement Scheme payments and Physiotherapy First Contact Point pay. |
| Community and Integrated Medicine | 12.8 | 13.9 | 15.1 | 14.1 | 15.2 | **14.9** | Slight improvement, savings under delivery plus Medical locum agency and Nursing bank usage to cover sickness and vacancies. Continuing Healthcare packages and consumables expenditure. |
| Mental Health and Learning Disabilities | 6.0 | 5.4 | 5.5 | 5.3 | 5.0 | **5.1** | Slight worsening, savings under delivery plus Medical locum usage, Continuing Healthcare packages increase and purchase of outsourced Psychiatric Intensive Care Unit beds |
| Operational Allied Health & Health Sciences | 5.1 | 5.0 | 5.5 | 5.3 | 4.7 | **4.4** | Slight Improvement, Children and Young People Weight Management vacancies transfer from Public Health. Continued savings under delivery and Pathology Medical Locum usage. |
| Planned and Specialist Care | 7.2 | 7.7 | 9.5 | 6.7 | 6.9 | **7.1** | Slight worsening, savings non delivery plus outsourcing of Theatres activity and consumables and Medical dual running. |
| Primary Care | (12.4) | (12.4) | (10.7) | (9.0) | (9.1) | **(8.6)** | Worsening, General Medical Services and Dental increase in programme expenditure. Underspends relating to Dental contract handback £(5.1)m and GMS Supplementary Services £(2.6)m. |
| Executive Functions | 3.1 | (0.3) | (4.9) | (4.1) | (3.9) | **(7.4)** | Improving, Welsh Risk Pool risk share reduction £(3.5)m recognised in September. Other favourable themes include VAT recovery, drugs process improvement, Central Income overachievement and pay vacancies. |
| **Adverse / (Favourable) Variance to Plan** | **22.6** | **20.9** | **21.2** | **19.4** | **19.9** | **16.7** | |
| **Gross Position** | **63.6** | **61.9** | **62.2** | **60.4** | **60.9** | **57.7** | |

# Trend – Total Key Performance vs Plan Executive

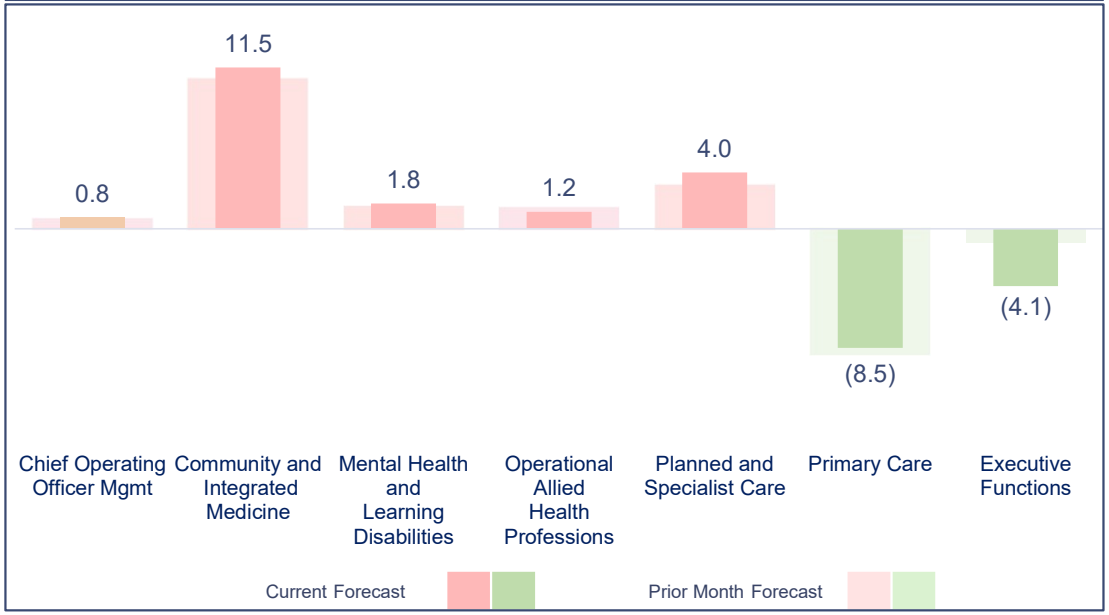


| Executive Functions (£'m) | Apr EOY | May EOY | Jun EOY | Jul EOY | Aug EOY | Sep EOY | Key Information |
|---|---|---|---|---|---|---|---|
| Chief Executive | (0.3) | (0.3) | (0.4) | (0.3) | (0.3) | **(0.4)** | No material change |
| Digital | 0.4 | 0.4 | 0.1 | 0.1 | 0.0 | **0.1** | No material change |
| Estates and Facilities | 3.2 | 3.0 | 3.0 | 2.9 | 2.9 | **3.4** | Worsening, savings under delivery, maintenance costs and increase in energy expenditure in line with NWSSP schedule |
| Executive Allied Health | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **(0.1)** | No material change |
| Finance | (0.3) | (0.6) | (0.4) | (0.5) | (0.6) | **(0.7)** | No material change, administrative pay vacancies |
| Health Board Wide | 0.9 | (1.0) | (4.6) | (5.2) | (5.1) | **(9.4)** | Improving, Welsh Risk Pool risk share reduction £(3.5)m recognised in September. Other themes include VAT recovery, drugs process improvement, Central Income overachievement. |
| LTA's | 4.4 | 4.1 | 3.0 | 2.2 | 2.4 | **2.3** | Improving, Swansea Bay Emergency Activity, offset by Joint Commissioning Committee risk share improvement |
| Medical | (1.1) | (1.1) | (0.4) | (0.2) | (0.2) | **(0.1)** | Deterioration, Value Based Healthcare plans confirmed |
| Nursing | (0.1) | 0.0 | 0.0 | 0.1 | 0.1 | **0.1** | No material change |
| Pharmacy and Medicines Management | 2.0 | 1.9 | 1.9 | 3.6 | 4.8 | **5.0** | Deterioration, savings under delivery and July Prescribing Audit Report increase in drugs price to £8.82 and concessions |
| Public Health | (2.4) | (2.2) | (2.2) | (1.8) | (2.1) | **(1.8)** | Static, pay vacancies and lower vaccination programme uptake |
| Strategy and Planning | (0.4) | (0.6) | (0.5) | (0.5) | (0.6) | **(0.6)** | Static, relating to Capital redesign income. |
| Workforce | (3.2) | (3.9) | (4.4) | (4.5) | (5.2) | **(5.2)** | Improving, Workforce Improvement Programme Administration and Clerical recruitment restrictions £(0.8)m and pay vacancies |
| **Adverse / (Favourable) Variance to Plan** | **3.1** | **(0.3)** | **(4.9)** | **(4.1)** | **(3.9)** | **(7.4)** | |

# End of Year – Core Operational Variation



## Core Operational Variation (£'m)




## Core Operational Variation (£'m)

| Portfolio | Pay | Non-Pay | Income | Total |
|---|---|---|---|---|
| Chief Operating Officer Management | 0.8 | 0.0 | 0.0 | **0.8** |
| Community and Integrated Medicine | 4.8 | 6.9 | (0.2) | **11.5** |
| Mental Health and Learning Disabilities | (0.7) | 2.4 | 0.1 | **1.8** |
| Operational Allied Health and Health Sciences | (1.0) | 2.7 | (0.5) | **1.2** |
| Planned and Specialist Care | 0.8 | 3.6 | (0.4) | **4.0** |
| Primary Care | (0.5) | (9.8) | 1.8 | **(8.5)** |
| Executive Functions | (3.5) | 1.0 | (1.6) | **(4.1)** |
| **Total** | **0.7** | **6.8** | **(0.8)** | **6.7** |

## Key Information

**Community and Integrated Medicine** Medical locum agency £3.4m and Nursing bank usage £1.0m to cover sickness and vacancies, Continuing Healthcare packages increase in monthly average of commissioned care days £3.6m, increase in consumables relating to Continuous Positive Airway Pressure, insulin pumps and equipment including hoists £1.3m and security and building maintenance expenditure.

**Planned & Specialist Care** Theatres, Dermatology, Anaesthetics and Urology activity outsourced £3.6m, Medical dual running within Bronglais £1.9m, Nursing vacancies due to delay in investment plans £(2.0)m.

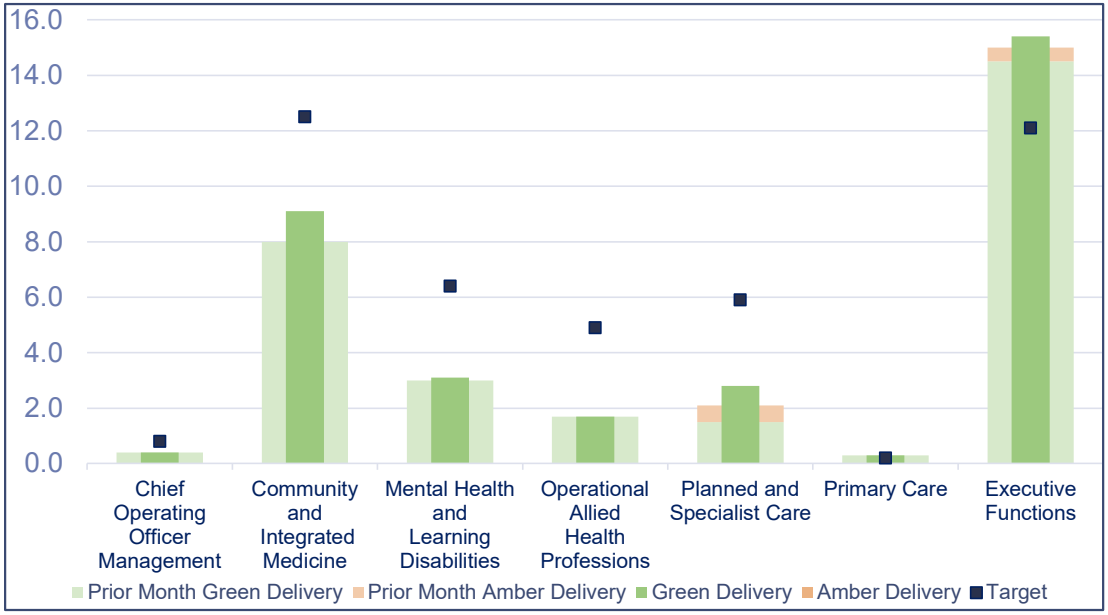
**Primary Care** Dental contracts handback offset by Dental income underachievement £(5.1)m and General Medical Services Supplementary Services underspends £(2.6)m.

**Executive Functions** Welsh Risk Pool reduction in risk share £(3.5)m, Workforce and Public Health vacancies £(2.8)m, Central Income overachievement £(1.0)m, Workforce Improvement Programme Administration and Clerical recruitment restrictions £(0.8)m, offset by Pharmacy increase in drugs price, volume and concessions in line with July Prescribing Audit Report £2.4m, Estates maintenance and increase in energy expenditure £1.4m and Swansea Bay Long Term Agreement Emergency activity increase £1.0m.

# End of Year – Savings Performance Breakdown



## Savings Performance Breakdown (£'m)




## Savings Performance Breakdown (£'m)

| Portfolio | Target | Plan | Delivery | Gap |
|---|---|---|---|---|
| Chief Operating Officer Management | 0.8 | 0.4 | 0.4 | 0.4 |
| Community and Integrated Medicine | 12.5 | 9.1 | 9.1 | 3.4 |
| Mental Health and Learning Disabilities | 6.4 | 3.1 | 3.1 | 3.3 |
| Operational Allied Health and Health Sciences | 4.9 | 1.7 | 1.7 | 3.2 |
| Planned and Specialist Care | 5.9 | 2.8 | 2.8 | 3.1 |
| Primary Care | 0.2 | 0.3 | 0.3 | (0.1) |
| Executive Functions | 12.1 | 15.4 | 15.4 | (3.3) |
| **Grand Total** | **42.8** | **32.8** | **32.8** | **10.0** |

## Key Information

Savings identification is £32.8m, with all savings forecast to fully deliver, leaving a savings under-identification gap of £10.0m against the £42.8m target.

The £10.0m under-identification is primarily attributable to Community and Integrated Medicine £3.4m, Mental Health and Learning Disabilities £3.3m, Operational Allied Health £3.2m, Planned and Specialist Care £3.1m. This is partially offset by £(3.3)m over-identification within Executive Functions, largely relating to Health Board Wide £(3.7)m and Workforce £(3.5)m and However, significant savings under-identfication remain within Executive Functions, notably Pharmacy and Medicines Management £2.7m, Estates and Facilities £2.1m and Long-Term Agreements £1.3m.

Of the schemes identified, £7.8m are recurrent savings with £25.0m being non-recurrent savings.

# End of Year – Saving Delivery Performance



## Savings

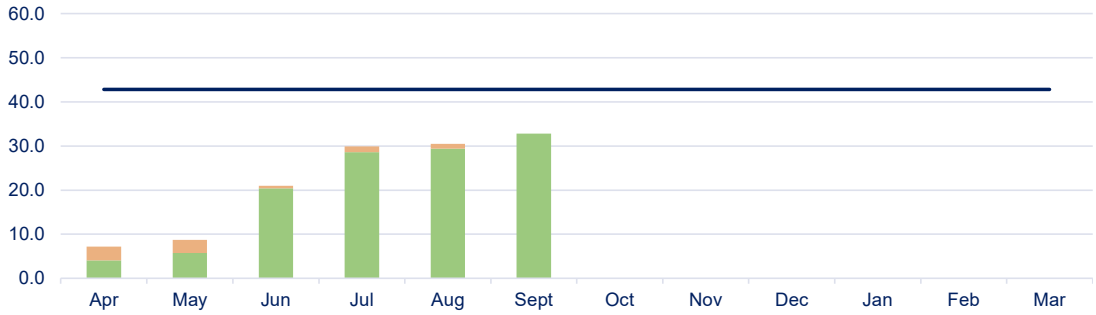
### Savings Target
**£42.8m**
Recurrent = £42.8m
Non-Recurrent = £0.0m

### In-Year Recurrent Gap
**£35.0m**
Target = £42.8m
Delivery = £7.8m

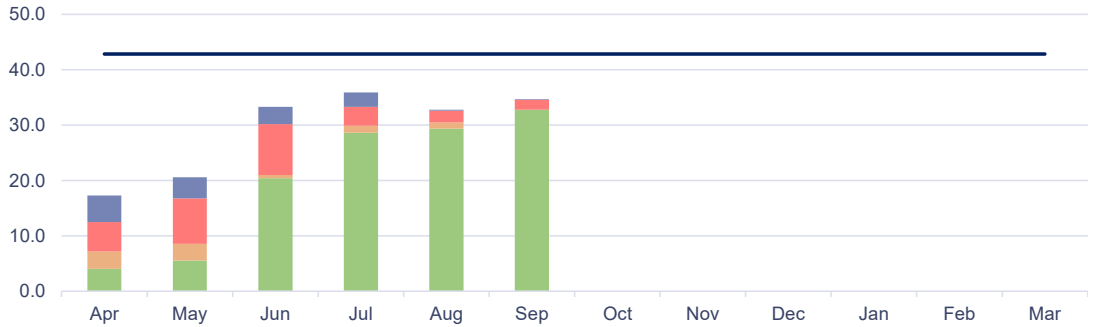
### In-Year Non-Recurrent Gap
**£(25.0)m**
Target = £0.0m
Delivery = £25.0m

### Full Year Recurrent Gap
**£33.9m**
Target = £42.8m
Delivery = £8.9m

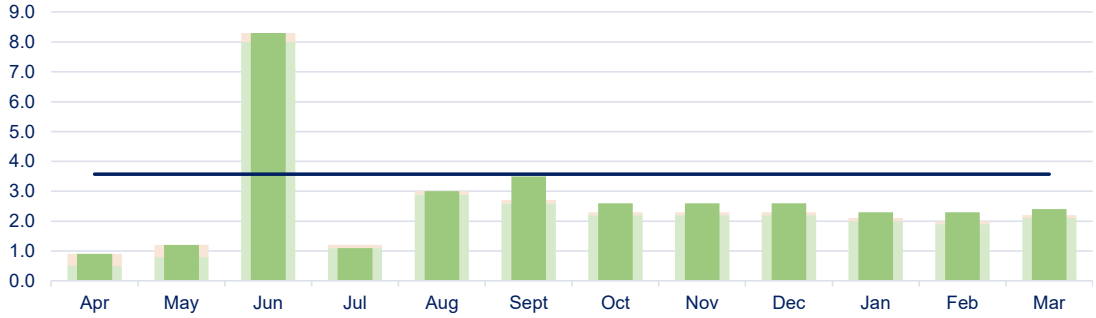
### Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



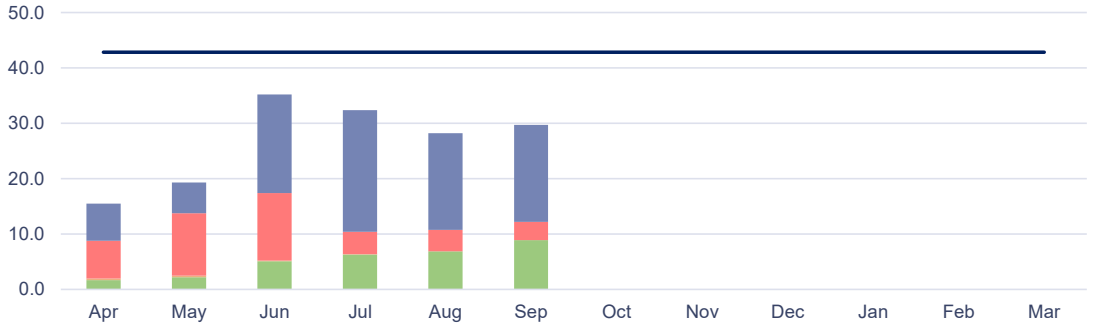

### Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)




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

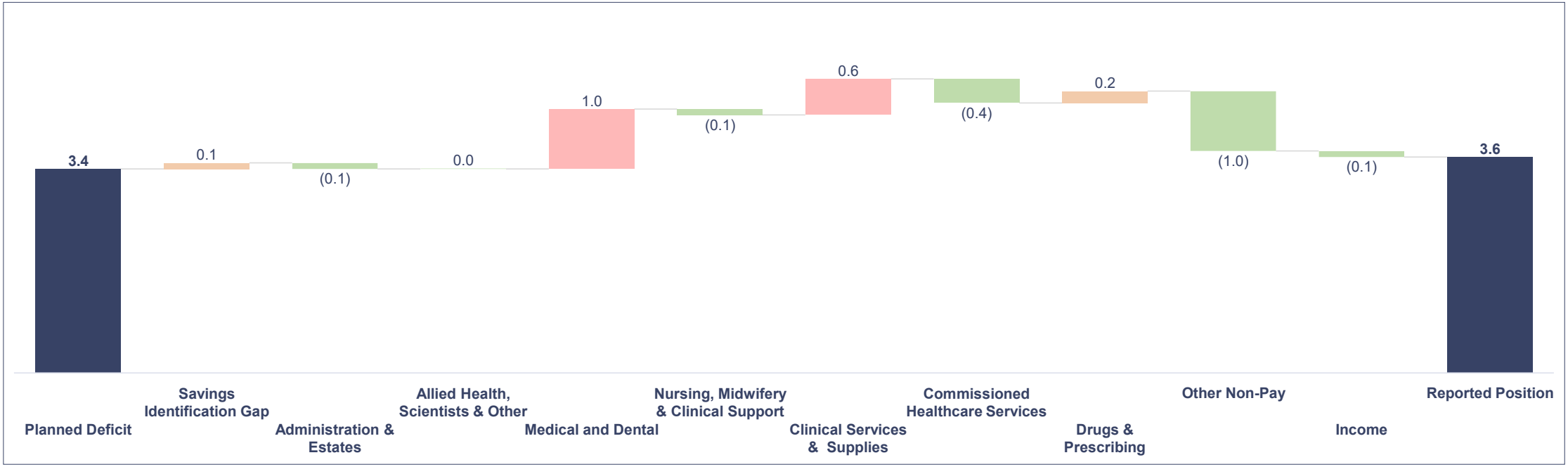



### Monthly Trend of Annual Recurrent Opportunity, Pipeline & Savings Plans (£'m)



# In-Month – Key Drivers vs Plan






## Key Information

**Savings Identification Gap** – Savings identification of £3.5m against savings target of £3.6m, leaving a savings under identification gap of £0.1m.

**Medical and Dental** – Planned and Specialist Care continued locum usage to cover sickness and vacancies, retrospective additional duty claims, dual running of staff in Bronglais £0.5m and Community and Integrated Medicine continued locum usage to cover sickness and vacancies, alongside retrospective payments £0.4m mainly within Carmarthenshire and Pembrokeshire.

**Clinical Services &Supplies** – Theatre loan kits and implants purchases in Planned and Specialist Care £0.3m, and Radiology outsourcing of services within Operational Allied Health £0.2m.

**Commissioned Healthcare Services** – Primary Care Dental contracts handback £(0.6)m and General Medical Services supplementary services underspend £(0.2)m, offset by Continuing Healthcare packages within Community and Integrated Medicine and Mental Health £0.4m alongside purchase of outsourced Mental Health Psychiatric Intensive Care unit beds £0.2m.

**Other Non-Pay** – Recognition of year to date reduction in Welsh Risk Pool risk share £(1.8)m, offset by increase in year to date energy expenditure within Estates and Facilities in line with latest NWSSP forecast £0.2m, alongside maintenance expenditure within Community and Integrated Medicine £0.1m, and Workforce Higher Awards contract expenditure £0.1m.

# In-Month – Key Deviations to Plan



| Key Deviation | | £'m | Key Information |
|---|---|---|---|
| **Planned Deficit** | | **3.4** | **As per plan submitted to Welsh Government** |
| **Savings Delivery Gap** | | 0.2 | Green and Amber savings plans delivering of £3.4m against savings target of £3.6m |
| Overspends | Medical Stabilisation improvements not delivered | 1.0 | Agency usage to cover vacancies and sickness within Community and Integrated Medicine £0.4m, Cancer and Scheduled Care £0.3m and Children and Women £0.2m, alongside retrospective payments |
| | Primacy Care Drugs Price and Concessions | 0.6 | Pharmacy and Medicines Management increase in drugs price, concessions and volume in line with latest Prescribing Audit Report. Increase in price from £8.45 per item to £8.74 per item. |
| | Continuing Healthcare and outsourced beds | 0.6 | Demand increases on Continuing Healthcare packages within Community and Integrated Medicine and Mental Health, and purchase of outsourced Mental Health Psychiatric Intensive Care Unit beds |
| | Clinical Services and Supplies | 0.5 | Planned Care theatre loan kits and implants purchases alongside outsourcing of activity £0.3m, Radiology outsourced services £0.2m, insulin pumps, cardiac and diabetic consumable purchases £0.1m |
| | Estates and Facilities Non Pay | 0.2 | Estates and Facilities maintenance expenditure and repairs alongside year to date increase in energy expenditure in line with latest NWSSP forecast. |
| Underspends | Welsh Risk Pool risk share year to date reduction | (1.8) | Recognition of year to date Welsh Risk Pool risk share reduction in risk share percentages and forecast in line with latest NWSSP schedule. |
| | Primary Care | (1.1) | Dental contracts handback £(0.6)m, General Medical Services supplementary services underspend £(0.2)m and delay in Primary Care cluster project plans £(0.2)m |
| **Reported Position** | | **3.6** | |

# In-Month – Key Performance vs Plan



| Clinical Care Groups and Executive Functions (£'m) | Savings Gap to Target | Savings Delivery vs Plan Benefits | Core Operational Variation | Total | Key Information |
|---|---|---|---|---|---|
| **Annual Plan** | | | | **3.4** | **As per plan submitted to Welsh Government** |
| Chief Operating Officer Management | 0.1 | 0.0 | 0.0 | **0.1** | Savings non delivery. |
| Community and Integrated Medicine | 0.1 | 0.0 | 1.3 | **1.4** | Medical locum agency usage to cover sickness and vacancies, alongside retrospective payments £0.4m, increase in Continuing Healthcare packages £0.4m and Nursing enhanced rates and agency £0.3m. |
| Mental Health and Learning Disabilities | 0.1 | 0.0 | 0.2 | **0.3** | Savings non delivery plus increase in Continuing Health Care packages and purchase of outsourced Psychiatric Intensive Care Unit beds. |
| Operational Allied Health & Health Sciences | 0.2 | 0.0 | 0.1 | **0.3** | Savings non delivery plus outsourcing of Radiology services £0.1m. |
| Planned and Specialist Care | 0.2 | 0.0 | 0.6 | **0.8** | Savings non delivery plus Medical locum agency usage including dual running of staff and retrospective payments £0.5m, Theatre loan kits and implants £0.3m offset by Theatres Nursing investment vacancies £(0.4)m. |
| Primary Care | 0.0 | 0.0 | (1.0) | **(1.0)** | Dental contracts handback £(0.6)m, General Medical Services supplementary services £(0.2)m, delay in cluster projects £(0.2)m |
| Executive Functions | (0.6) | 0.0 | (1.1) | **(1.7)** | Savings over-delivery relating to VAT recovery, English Provider Services accountancy gain, Injury Cost Recovery income, and Workforce pay savings. Recognition of year to date Welsh Risk Pool risk share reduction £(1.8)m, offset by increase in drugs volume, concessions and price £0.6m. |
| **Sub Total** | **0.1** | **0.0** | **0.1** | **0.2** | |
| **Gross Position** | | | | **3.6** | |

# In-Month – Key Performance vs Plan Executive



| Executive Function (£'m) | Savings Gap to Target | Savings Delivery vs Plan Benefits | Core Operational Variation | Total | Key Information |
|---|---|---|---|---|---|
| Chief Executive | 0.0 | 0.0 | 0.0 | **0.0** | No material deviation to plan |
| Digital | 0.0 | 0.0 | 0.1 | **0.1** | No material deviation to plan |
| Estates and Facilities | 0.2 | 0.0 | 0.2 | **0.4** | Under-achieved savings, building and maintenance expenditure alongside increase in year to date energy expenditure in line with NWSSP schedule |
| Executive Allied Health | 0.0 | 0.0 | 0.0 | **0.0** | No material deviation to plan |
| Finance | (0.1) | 0.0 | 0.0 | **(0.1)** | Over-achieved savings |
| Health Board Wide | (0.7) | 0.0 | (1.9) | **(2.6)** | Over-achieved savings relating to VAT recovery, English Provider Services accountancy gain and Injury Cost Recovery income. Recognition of year to date Welsh Risk Pool risk share reduction £(1.8)m |
| LTA's | 0.1 | 0.0 | 0.1 | **0.2** | Under-achieved savings, Swansea Bay emergency activity increase |
| Medical | 0.0 | 0.0 | 0.1 | **0.1** | No material deviation to plan |
| Nursing | 0.0 | 0.0 | 0.0 | **0.0** | No material deviation to plan |
| Pharmacy and Medicines Management | 0.2 | 0.0 | 0.5 | **0.7** | Under-achieved savings, increase in drugs volume, concessions and price from £8.45 to £8.74 per item in line with June Prescribing Audit Report. |
| Public Health | 0.0 | 0.0 | (0.1) | **(0.1)** | Pay vacancies across the service within Admin and Nursing |
| Strategy and Planning | 0.0 | 0.0 | 0.0 | **0.0** | No material deviation to plan |
| Workforce | (0.3) | 0.0 | (0.1) | **(0.4)** | Over-achieved savings, alongside Admin pay vacancies |
| **Sub Total** | **(0.6)** | **0.0** | **(1.1)** | **(1.7)** | |

# 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 Annual Plan Deficit** |
| Chief Operating Officer Management | 0.1 | 0.0 | 0.1 | **0.2** | Less savings identified and increase in non-pay costs relating to Hospital Sterilisation and Decontamination Unit and Transport. |
| Community and Integrated Medicine | (0.4) | 0.0 | 0.4 | **0.0** | Additional savings identified relating to delay in Clinical Streaming Hub investment and respiratory drugs loss of exclusivity, offset by increase in Nursing enhanced rates and agency. |
| Mental Health and Learning Disabilities | (0.1) | 0.0 | 0.1 | **0.0** | Additional pay savings identified previously classified as core operational underspends. Increase in Continuing Healthcare packages. |
| Operational Allied Health & Health Sciences | 0.0 | 0.0 | 0.0 | **0.0** | No material deviation to prior month |
| Planned and Specialist Care | (0.1) | 0.0 | 0.4 | **0.3** | Additional savings identified in-month, increase in Medical variable pay expenditure and retrospective payments and increase in Theatres loan kits and implants expenditure. |
| Primary Care | 0.0 | 0.0 | 0.6 | **0.6** | Primary Care year to date reduction in General Medical Services contract expenditure in prior month, with increased expenditure in-month. |
| Executive Functions | 0.0 | 0.0 | (2.1) | **(2.1)** | Recognition of year to date Welsh Risk Pool risk share reduction £(1.8)m, Pharmacy drugs price and concessions year to date increase in prior month £(0.4)m, offset by increase in year to date energy £0.2m. |
| **Sub Total** | **(0.5)** | **0.0** | **(0.5)** | **(1.0)** | |
| **Gross Position** | | | | **(1.0)** | |

# Trend – Total Key Performance vs Plan



| Clinical Care Groups and Executive Functions (£'m) | Apr | May | Jun | Jul | Aug | Sep | Year to Date | Key Information |
|---|---|---|---|---|---|---|---|---|
| **Annual Plan** | **3.4** | **3.4** | **3.4** | **3.4** | **3.4** | **3.4** | **20.5** | **As per plan submitted to Welsh Government** |
| Chief Operating Officer Management | 0.1 | 0.5 | 0.1 | 0.0 | (0.1) | 0.1 | **0.8** | Static, one-off Voluntary Early Retirement Scheme payments in May |
| Community and Integrated Medicine | 1.0 | 1.2 | 1.6 | 1.3 | 1.4 | 1.4 | **7.9** | Static, Medical and Nursing variable and agency to cover sickness and Continuing Healthcare packages |
| Mental Health and Learning Disabilities | 0.4 | 0.5 | 0.3 | 0.5 | 0.3 | 0.3 | **2.5** | Static, demand for outsourced Psychiatric Intensive Care Unit and Continuing Healthcare packages |
| Operational Allied Health & Health Sciences | 0.3 | 0.4 | 0.5 | 0.4 | 0.3 | 0.3 | **2.1** | Static, savings non delivery plus Medical agency usage within Pathology to cover vacancies and Radiology outsourcing |
| Planned and Specialist Care | 0.6 | 0.8 | 1.3 | 0.8 | 0.5 | 0.8 | **4.6** | Worsening, savings non delivery plus Medical retrospective payments and sickness cover and Theatre loan kits and implants |
| Primary Care | (0.5) | (0.9) | (0.9) | (0.7) | (1.6) | (1.0) | **(5.7)** | Delay in General Medical Services Global Sum expenditure in prior month. Dental contracts handback |
| Executive Functions | 0.2 | 0.1 | (1.2) | (0.6) | 0.4 | (1.7) | **(2.8)** | Improving due to recognition of year to date Welsh Risk Pool risk share reduction in-month £(1.8)m and Pharmacy recognition of increase drugs price and concessions in prior month £(0.4)m |
| **Adverse / (Favourable) Variance to Plan** | **2.1** | **2.6** | **1.7** | **1.7** | **1.2** | **0.2** | **9.4** | |
| **Gross Position** | **5.5** | **6.0** | **5.1** | **5.1** | **4.6** | **3.6** | **29.9** | |

# Trend – Total Key Performance vs Plan Executive

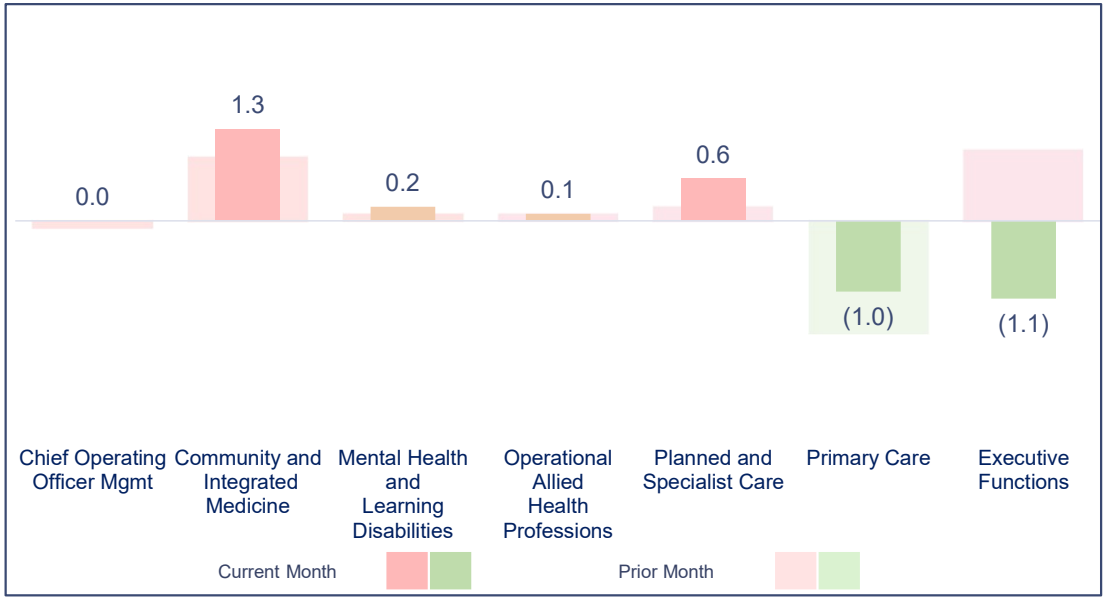


| Executive Functions (£'m) | Apr | May | Jun | Jul | Aug | Sep | Year to Date | Key Information |
|---|---|---|---|---|---|---|---|---|
| Chief Executive | (0.1) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **(0.3)** | Static |
| Digital | 0.0 | 0.1 | 0.0 | 0.2 | 0.2 | 0.1 | **0.6** | Static, Digital initiatives programmes expenditure |
| Estates and Facilities | 0.3 | 0.3 | 0.4 | 0.1 | 0.1 | 0.4 | **1.8** | Worsening, recognition of year to date increase in energy due to global factors in line with latest NWSSP forecast |
| Executive Allied Health | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **0.0** | Static |
| Finance | 0.0 | 0.0 | (0.1) | 0.0 | (0.1) | (0.1) | **(0.3)** | Static |
| Health Board Wide | 0.2 | (0.1) | (1.1) | (0.8) | (0.7) | (2.6) | **(5.2)** | Improving, recognition of year to date Welsh Risk Pool risk share reduction in-month £(1.8)m. VAT recovery year to date saving in June, alongside Controlled Drugs Stock Review. |
| LTA's | 0.3 | 0.4 | 0.5 | 0.1 | 0.1 | 0.2 | **1.6** | Static, Swansea Bay emergency activity offset by reduction in Joint Commissioning Committee risk share |
| Medical | (0.1) | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | **(0.1)** | Static |
| Nursing | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **0.0** | Static |
| Pharmacy and Medicines Management | 0.1 | 0.1 | (0.1) | 0.4 | 1.3 | 0.7 | **2.6** | Improving, prior month year to date increase in drugs price and concessions in line with Prescribing Audit Report |
| Public Health | (0.1) | (0.3) | (0.2) | (0.1) | (0.1) | (0.1) | **(0.8)** | Static |
| Strategy and Planning | (0.1) | (0.1) | (0.1) | 0.0 | (0.1) | 0.0 | **(0.5)** | Static |
| Workforce | (0.3) | (0.3) | (0.5) | (0.5) | (0.3) | (0.4) | **(2.2)** | Static, additional Admin pay vacancies |
| **Adverse / (Favourable) Variance to Plan** | **0.2** | **0.1** | **(1.2)** | **(0.6)** | **0.4** | **(1.7)** | **(2.8)** | |

# In-Month – Core Operational Variation



## Core Operational Variation (£'m)




## Core Operational Variation (£'m)

| Clinical Care Group | Pay | Non-Pay | Income | Total |
|---|---|---|---|---|
| Chief Operating Officer Management | 0.0 | 0.0 | 0.0 | **0.0** |
| Community and Integrated Medicine | 0.8 | 0.5 | 0.0 | **1.3** |
| Mental Health and Learning Disabilities | 0.0 | 0.2 | 0.0 | **0.2** |
| Operational Allied Health and Health Sciences | (0.2) | 0.3 | 0.0 | **0.1** |
| Planned and Specialist Care | 0.3 | 0.2 | 0.1 | **0.6** |
| Primary Care | 0.0 | (1.1) | 0.1 | **(1.0)** |
| Executive Functions | (0.2) | (0.7) | (0.2) | **(1.1)** |
| **Total** | **0.7** | **(0.6)** | **0.0** | **0.1** |

## Key Information

**Community and Integrated Medicine** – Medical Agency locum usage to cover vacancies and sickness £0.4m, Nursing enhanced payment rates and agency usage £0.3m, and Continuing Healthcare packages volume increase £0.4m.

**Planned and Specialist Care** – Medical locum agency usage including dual running of staff and retrospective payments £0.5m, Theatre loan kits and implants £0.3m offset by Theatres Nursing investment vacancies £(0.4)m.

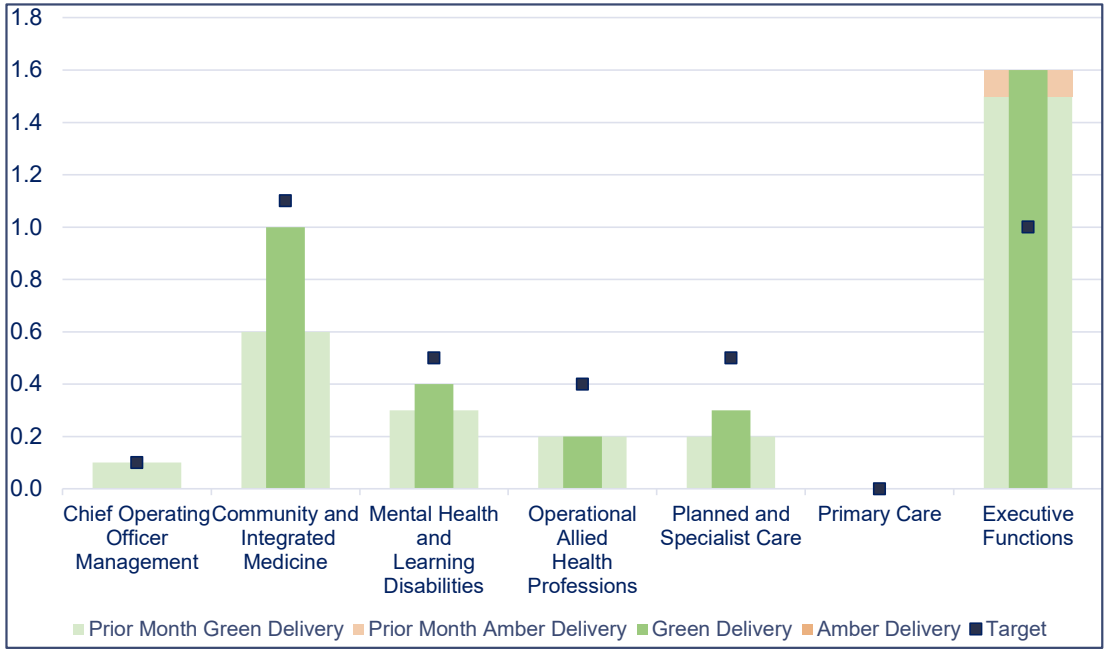
**Primary Care** – Dental contracts handback £(0.6)m, General Medical Services supplementary services underspend £(0.2)m and delay in Primary Care cluster project plans £(0.2)m

**Executive Functions** – Recognition of year to date Welsh Risk Pool risk share reduction in-month £(1.8)m, offset by Pharmacy and Medicines Management increase in drugs volume, concessions and price from £8.45 to £8.74 per item in line with June Prescribing Audit Report £0.6m, Estates and Facilities increase in energy expenditure in line with NWSSP schedule £0.2m.

# 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 | 0.0 | 0.0 | 0.1 |
| Community and Integrated Medicine | 1.1 | 1.0 | 1.0 | 0.1 |
| Mental Health and Learning Disabilities | 0.5 | 0.4 | 0.4 | 0.1 |
| Operational Allied Health and Health Sciences | 0.4 | 0.2 | 0.2 | 0.2 |
| Planned and Specialist Care | 0.5 | 0.3 | 0.3 | 0.2 |
| Primary Care | 0.0 | 0.0 | 0.0 | 0.0 |
| Executive Functions | 1.0 | 1.6 | 1.6 | (0.6) |
| **Grand Total** | **3.6** | **3.5** | **3.5** | **0.1** |

## Key Information

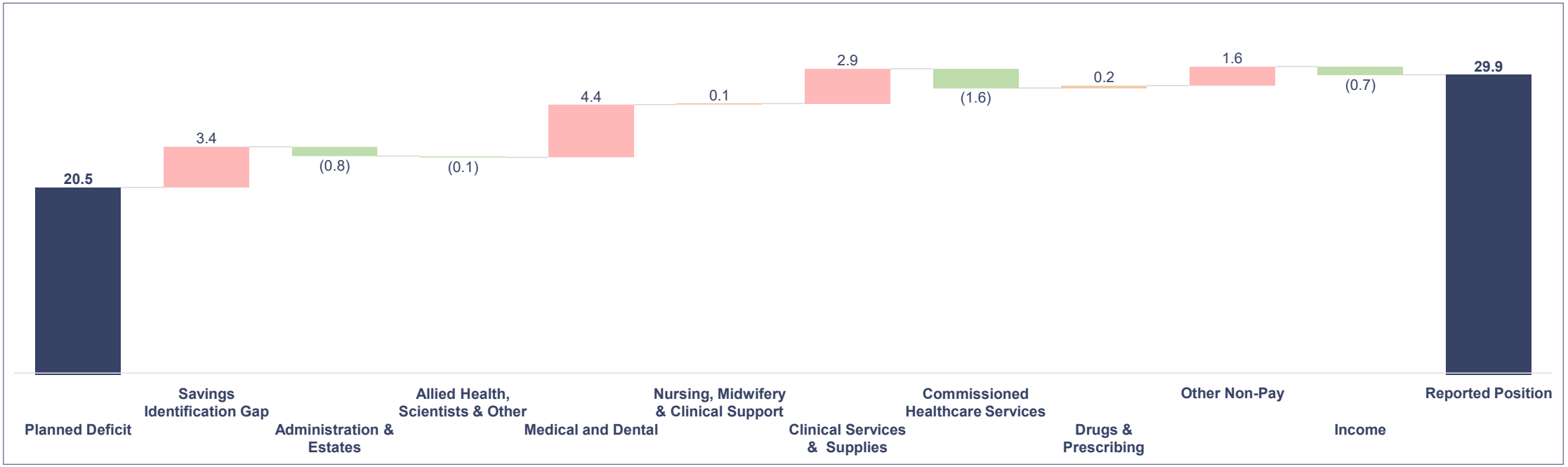
Overall, savings identification and delivery of £3.5m has been achieved in Month 6, resulting in a £0.1m under-delivery against the £3.6m target, with variations across Clinical Care Groups.

£0.1m under-identification of savings largely relates to Operational Allied Health £0.2m, Planned and Specialist Care £0.2m, offset by over-identification within Executive Functions £(0.6)m. Executive Functions includes over-identification within Health Board Wide £(0.7)m and Workforce £(0.3)m, offset by under-identification within Pharmacy and Medicines Management £0.2m and Estates and Facilities £0.2m.

Increase in savings identification from prior month largely relates to English Provider Services accountancy gain £0.3m and Clinical Streaming Hub delay in investments expenditure within Community and Integrated Medicine £0.2m.

# Year to Date – Key Drivers vs Plan






## Key Information

**Savings Identification gap** – Savings delivery of £18.0m achieved against a target of £21.4m leaving a savings delivery gap of £3.4m.

**Medical and Dental** – Community and Integrated Medicine continued locum usage to cover sickness and vacancies £1.9m, Planned and Specialist Care continued locum usage to cover sickness and vacancies alongside dual running and rate card usage £1.8m, and Mental Health Medical agency usage £0.5m.

**Clinical Services & Supplies** – Theatre activity insourcing and consumable purchases including loan kits and implants, alongside Dermatology and Urology outsourcing within Planned and Specialist Care £1.4m, outsourcing of Radiology services within Operational Allied Health £1.1m and purchase of Cardiac and Diabetic consumables within Community and Integrated Medicine £0.6m.

**Commissioned Healthcare Services** – Primary Care Dental contract handbacks £(3.6)m and General Medical Services underspend £(1.8)m, offset by increase in Continuing Healthcare packages within Mental Health and Community and Integrated Medicine £2.3m, Swansea Bay emergency activity increase £0.9m and Planned and Specialist Care outsourcing of Ophthalmology activity £0.8m.

**Other Non-Pay** – Digital initiative programmes contract expenditure £0.9m, increase in Estates maintenance and energy contract expenditure in line with NWSSP schedule £0.8m, alongside building maintenance and repairs, patient security and transportation expenditure within Community and Integrated Medicine £0.6m, offset by Welsh Risk Pool risk share year to date reduction £(1.8)m.

# Year to Date – Key Deviations to Plan



| Key Deviation | | £'m | Key Information |
|---|---|---|---|
| **Planned Deficit** | | **20.5** | **As per plan submitted to Welsh Government** |
| **Savings Delivery Gap** | | 3.4 | Green and Amber savings plans delivering of £18.0m against savings target of £21.4m |
| **Overspends** | Medical Stabilisation improvements not delivered | 4.4 | C&IM agency usage to cover vacancies and sickness (£1.9m), BGH W&C absence and restricted duties (£1.0m), Anaesthetist rate card extended (£0.8m), and MH&LD 4 premium agency (£0.5m). |
| | Continuing Healthcare and outsourced beds | 3.1 | Demand increases on CHC packages (£2.3m), Out of Area Mental Health placements (£0.8m) |
| | Clinical Services and Supplies | 2.0 | Radiology outsourced services £1.1m, insulin pumps, cardiac and diabetic consumable purchases £0.6m |
| | Theatre activity and increased outsourcing | 1.7 | Planned and Specialist Care activity and consumables increase, alongside outsourcing of services |
| | Pharmacy Drugs Price and Concessions | 1.5 | Pharmacy and Medicines Management increase in drugs price, concessions and volume in line with June Prescribing Audit Report. Increase in price from £8.45 per item to £8.74 per item. |
| | Digital Non Pay contracts | 0.9 | Digital initiative programmes contract expenditure |
| | Swansea Bay Long Term Agreement | 0.9 | Non-elective short stay episodes attracting a disproportionate flat rate tariff |
| | Estates and Facilities Non Pay | 0.8 | Building maintenance and repairs, alongside energy expenditure increase in line with NWSSP schedule |
| **Underspends** | Primary Care | (5.3) | Dental contracts handback £(3.6)m, General Medical Services supplementary services underspend £(1.8)m and delay in cluster project plans £(0.8)m, offset by Dental income underachievement £0.9m |
| | Welsh Risk Pool risk share reduction | (1.8) | Recognition of year to date Welsh Risk Pool risk share reduction in risk share percentages and forecast in line with NWSSP schedule in September. |
| | Income | (1.5) | Central Income £(0.4)m, Capital Design recharge income £(0.2)m, Velindre drugs rebates £(0.2)m, alongside various income streams within Planned and Specialist Care and Operational Allied Health. |
| | Administrative vacancies | (0.7) | Across many services, mainly within Primary Care £(0.3)m, Digital £(0.2)m, Workforce £(0.2)m and Public Health £(0.2)m. Continued commitment to convert underspends to savings. |
| **Reported Position** | | **29.9** | |

# Year to Date – Key Performance vs Plan



| Clinical Care Groups and Executive Functions (£'m) | Savings Gap to Target | Savings Delivery vs Plan Benefits | Core Operational Variation | Total | Key Information |
|---|---|---|---|---|---|
| **Planned Deficit** | | | | **20.5** | **As per plan submitted to Welsh Government** |
| Chief Operating Officer Management | 0.1 | 0.0 | 0.7 | **0.8** | Voluntary Early Retirement Scheme payments. |
| Community and Integrated Medicine | 2.0 | 0.0 | 5.9 | **7.9** | Savings non delivery plus Medical agency locum to cover sickness and vacancies £1.9m, Continuing Healthcare packages volume increase £1.6m, Nursing agency £0.7m, Cardiac and Diabetic consumables £0.6m. |
| Mental Health and Learning Disabilities | 0.9 | 0.0 | 1.6 | **2.5** | Savings non delivery plus purchase of outsourced Psychiatric Intensive Care Unit beds £0.8m, Continuing Healthcare packages volume increase £0.7m and Medical agency usage £0.5m. |
| Operational Allied Health & Health Sciences | 1.7 | 0.0 | 0.4 | **2.1** | Savings non delivery plus Medical agency usage within Pathology to cover vacancies £0.7m, Radiology outsourcing of services £1.1m, offset by Radiology vacancies due to delayed recruitment £(1.1)m. |
| Planned and Specialist Care | 1.9 | 0.0 | 2.7 | **4.6** | Savings non delivery plus Medical agency locum, dual running and rate card usage £1.8m, outsourcing of activity within Ophthalmology, Theatres, Dermatology and Urology £1.7m, offset by Nursing vacancies £(0.8)m. |
| Primary Care | (0.2) | 0.0 | (5.5) | **(5.7)** | Dental contracts handback £(3.6)m, General Medical Services supplementary services £(1.8)m, cluster project plans delay £(0.8)m |
| Executive Functions | (3.0) | 0.0 | 0.2 | **(2.8)** | Savings over-delivery plus Pharmacy drugs price and concessions £1.5m, Digital initiative programmes £0.9m, Swansea Bay emergency activity £0.9m, Estates maintenance and energy £0.8m, offset by Welsh Risk Pool reduction £(1.8)m, pay vacancies and income overachievement £(1.8)m. |
| **Sub Total** | **3.4** | **0.0** | **6.0** | **9.4** | |
| **Gross Position** | | | | **29.9** | |

# Year to Date – Key Performance vs Plan Executive

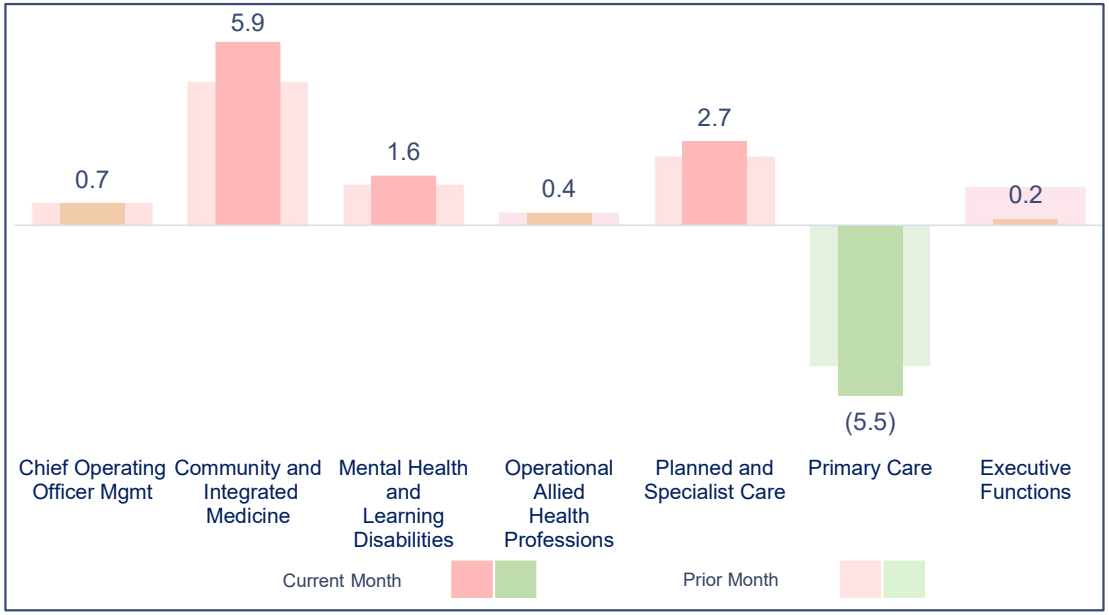


| Executive Function (£'m) | Savings Gap to Target | Savings Delivery vs Plan Benefits | Core Operational Variation | Total | Key Information |
|---|---|---|---|---|---|
| Chief Executive | (0.2) | 0.0 | (0.1) | **(0.3)** | Savings over-delivery |
| Digital | 0.1 | 0.0 | 0.5 | **0.6** | Increase in Digital initiative programmes contract expenditure |
| Estates and Facilities | 1.0 | 0.0 | 0.8 | **1.8** | Savings non delivery plus maintenance, repairs and energy expenditure |
| Executive Allied Health | 0.0 | 0.0 | 0.0 | **0.0** | No material deviation to plan |
| Finance | (0.2) | 0.0 | (0.1) | **(0.3)** | Savings over-delivery |
| Health Board Wide | (2.5) | 0.0 | (2.7) | **(5.2)** | VAT recovery and drugs review saving, Welsh Risk Pool risk share year to date reduction £(1.8)m and Central Income over achievement £(0.4)m |
| LTA's | 0.7 | 0.0 | 0.9 | **1.6** | Savings non delivery plus Swansea Bay Emergency Activity increase |
| Medical | (0.1) | 0.0 | 0.0 | **(0.1)** | Savings over-delivery |
| Nursing | (0.1) | 0.0 | 0.1 | **0.0** | Savings over-delivery |
| Pharmacy and Medicines Management | 1.0 | 0.0 | 1.6 | **2.6** | Under delivery of savings, drugs price, volume and concessions increases |
| Public Health | (0.5) | 0.0 | (0.3) | **(0.8)** | Pay underspends recognised as savings and lower vaccination uptake |
| Strategy and Planning | (0.2) | 0.0 | (0.3) | **(0.5)** | Savings over-delivery, plus Capital Design recharge income overachieved |
| Workforce | (2.0) | 0.0 | (0.2) | **(2.2)** | Savings over-delivery relating to pay vacancies |
| **Sub Total** | **(3.0)** | **0.0** | **0.2** | **(2.8)** | |

# 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 | 0.7 | 0.0 | 0.0 | **0.7** |
| Community and Integrated Medicine | 2.9 | 3.1 | (0.1) | **5.9** |
| Mental Health and Learning Disabilities | 0.0 | 1.5 | 0.1 | **1.6** |
| Operational Allied Health and Health Sciences | (0.4) | 1.1 | (0.3) | **0.4** |
| Planned and Specialist Care | 1.3 | 1.6 | (0.2) | **2.7** |
| Primary Care | (0.2) | (6.2) | 0.9 | **(5.5)** |
| Executive Functions | (0.8) | 2.0 | (1.0) | **0.2** |
| **Total** | **3.5** | **3.1** | **(0.6)** | **6.0** |

## Key Information

**Community and Integrated Medicine** Medical agency locum to cover sickness and vacancies £1.9m, Continuing Healthcare packages volume increase £1.6m, Nursing bank and agency usage £0.7m and Cardiac and Diabetic consumable purchases £0.6m.

**Mental Health** Purchase of outsourced Psychiatric Intensive Care Unit beds £0.8m and Continuing Healthcare packages volume increase £0.7m.

**Planned and Specialist Care** Medical locum and agency usage including dual running and rate card usage £1.8m, outsourcing of activity within Ophthalmology, Theatres, Dermatology and Urology £1.7m, offset by Nursing vacancies due to delayed recruitment for Theatres investment £(0.8)m.

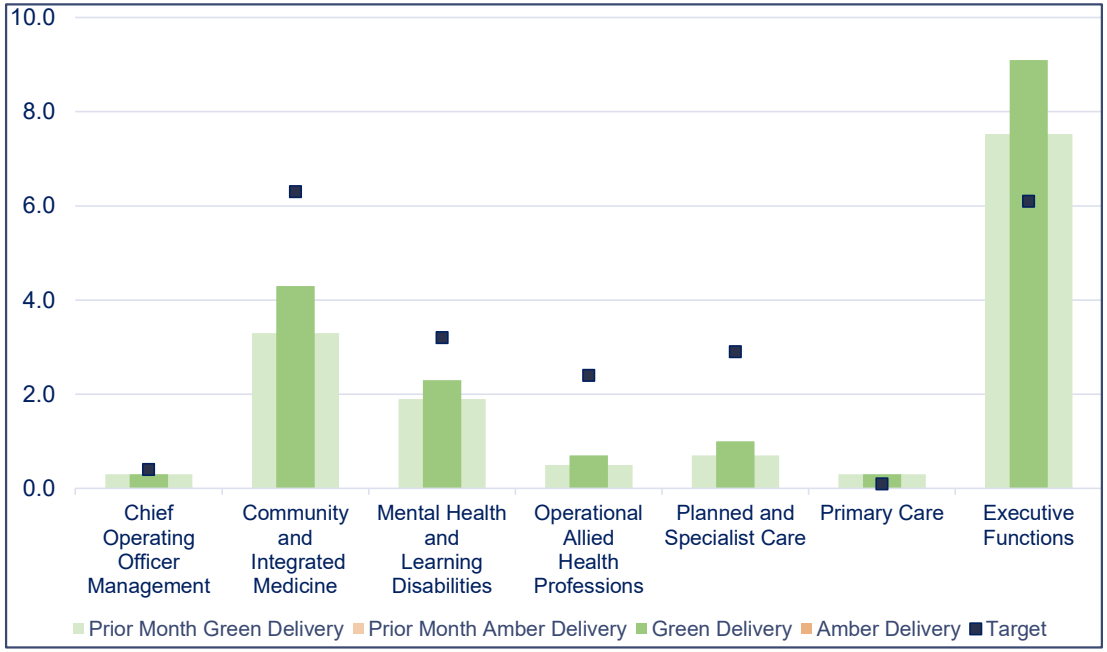
**Primary Care** Dental contracts handback £(3.6)m, General Medical supplementary services £(1.8)m, cluster project plans delay £(0.8)m, offset by underachieved Dental income £0.9m.

**Executive Functions** Pharmacy drugs price, volume and concessions £1.5m, Digital initiative programmes £0.9m, Swansea Bay emergency activity £0.9m, Estates maintenance and energy contracts £0.8m, offset by pay vacancies and income overachievement across various service areas £(1.8)m and Welsh Risk Pool risk share year to date reduction £(1.8)m.

# Year to Date – Savings Performance Breakdown



## Savings Delivery vs Target (£'m)




## Savings Performance Breakdown (£'m)

| Clinical Care Group | Target | Plan | Delivery | Gap |
|---|---|---|---|---|
| Chief Operating Officer Management | 0.4 | 0.3 | 0.3 | 0.1 |
| Community and Integrated Medicine | 6.3 | 4.3 | 4.3 | 2.0 |
| Mental Health and Learning Disabilities | 3.2 | 2.3 | 2.3 | 0.9 |
| Operational Allied Health and Health Sciences | 2.4 | 0.7 | 0.7 | 1.7 |
| Planned and Specialist Care | 2.9 | 1.0 | 1.0 | 1.9 |
| Primary Care | 0.1 | 0.3 | 0.3 | (0.2) |
| Executive Functions | 6.1 | 9.1 | 9.1 | (3.0) |
| **Grand Total** | **21.4** | **18.0** | **18.0** | **3.4** |

## Key Information

Overall savings identification and delivery of £18.0m, resulting in a £3.4m savings under-identification gap against £21.4m target, with variations across Clinical Care Groups.

Under-identification within Community and Integrated Medicine £2.0m, Planned and Specialist Care £1.9m, Operational Allied Health £1.7m, Mental Health £0.9m, offset by over-identification within Executive Functions £(3.0)m. Executive Functions includes over-identification within Health Board Wide £(2.4)m, Workforce £(2.0)m and Public Health £(0.5)m, offset by under-identification within Estates and Facilities £1.0m, Pharmacy and Medicines Management £1.0m and Long Term Agreements £0.7m.

The identified savings are mainly non-recurrent £14.9m, with only £3.1m being identified as recurrent savings. Increase in savings identification from prior month largely relates to English Provider Services accountancy gain £0.3m and Clinical Streaming Hub delay in investments expenditure within Community and Integrated Medicine £0.2m.

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Hywel Dda
University Health Board

# Appendices

The following appendices provide the detailed analysis supporting the main summary report. They include workforce trends and establishment information, revenue performance against plan, and the latest year-end savings position, providing additional context for the key findings, risks and proposed actions presented in the preceding slides.



1. Thriving teams



2. Healthier communities



3. Great care



4. Positive futures

# Capital Performance



Capital

## Total Capital Performance

**£38.6m**

Annual Plan **£38.6m**

## All Wales Capital

**£30.5m**

Annual Plan **£30.5m**

## Discretionary Capital

**£8.1m**

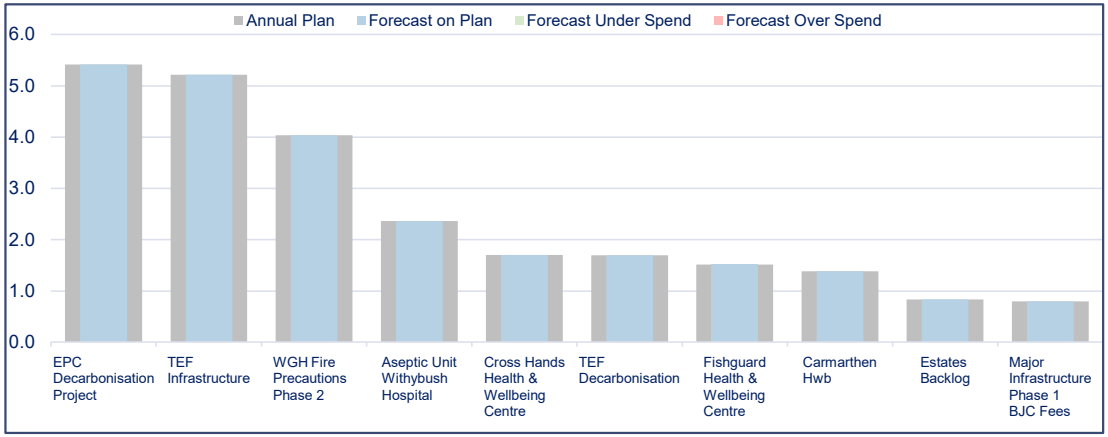
Annual Plan **£8.1m**

## IFRS 16

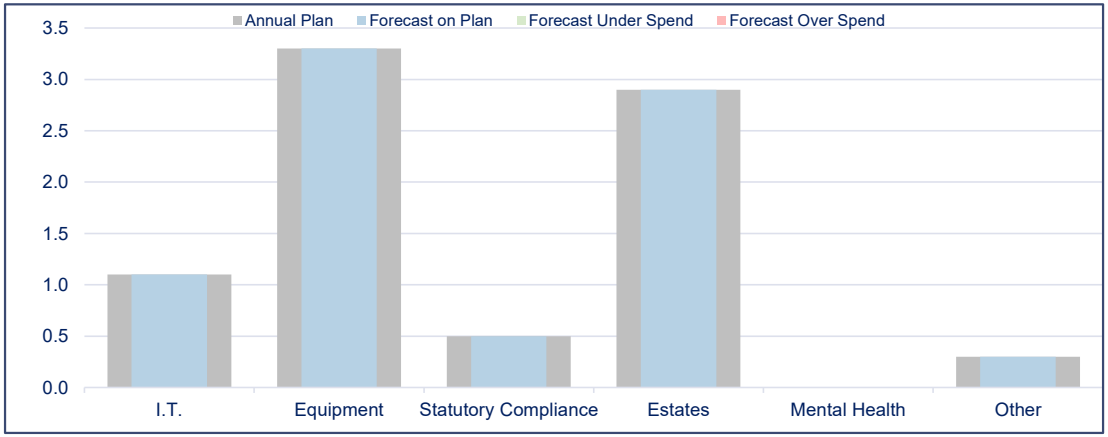
**£0.0m**

Capital Resource Limit **£0.0m**

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




### Discretionary Capital Programme Category Summary (£'m)




### Key Information

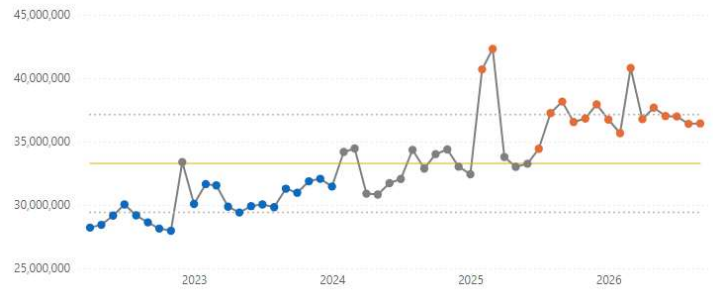
Delivery against the capital programme is currently assessed as minimal risk. A number of individual capital schemes have medium risks flagged against them; however, these are not expected currently to present a risk to overall delivery of the capital programme.

The Capital Programme is comprised of £30.5m All Wales Capital Programme funding and £8.1m discretionary funds. The discretionary value represents the net after adjustments to the gross allocation of £11.2m for contributions to Targeted Estates Fund, the ongoing payback for Picton Terrace, and adjustments relating to prior year outturn.

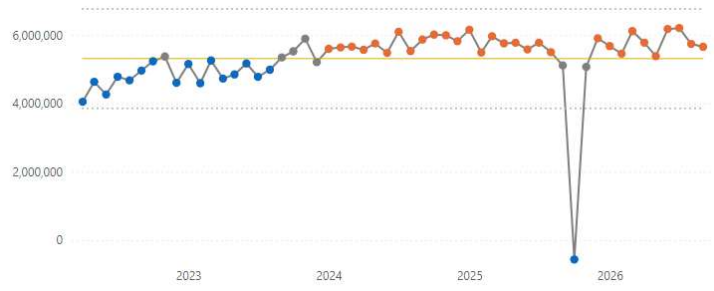
# Trend Analysis – Non-Pay and Income



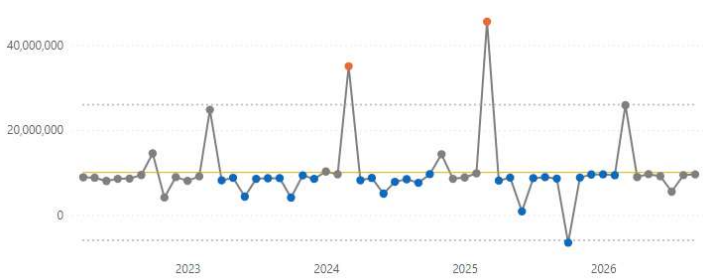
## Commissioned Healthcare Services (£)



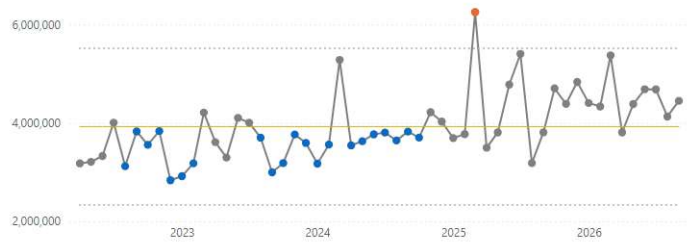

## Secondary Care Drugs (£)



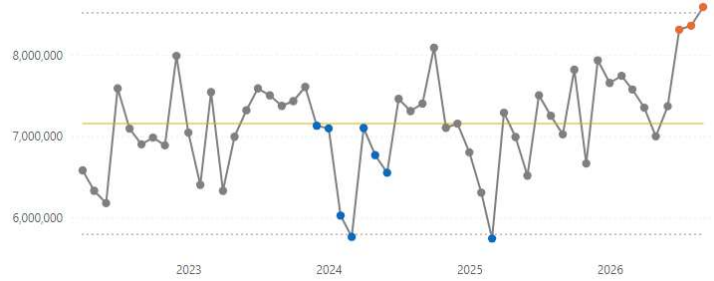

## Other Non-Pay (£)




## Clinical Services and Supplies (£)




## Primary Care Prescribing (£)




## Income (£)




## Key Information

**Secondary Care Drugs** – Reduction in drugs expenditure from prior month within Community and Integrated Medicine Prince Philip General Medicine.

**Other Non Pay** – Increase in expenditure from prior month due to increase in year to date energy expenditure in line with NWSSP schedule £0.2m.

**Clinical Services and Supplies** – Increase in theatre loan kits and implants purchases within Planned and Specialist Care £0.3m.

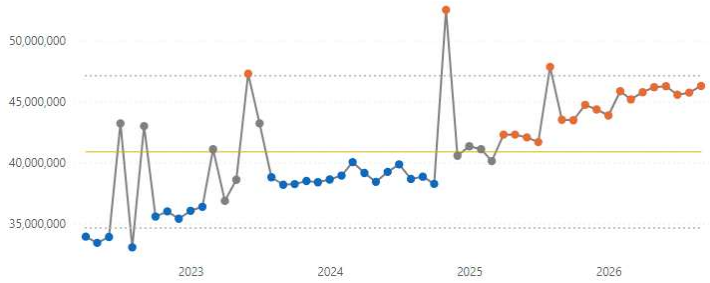
**Primary Care Prescribing** – Increase in drugs price concessions from Month 3 in line with Prescribing Audit Report. Increase of 7p per item from prior month, alongside increase in prescribing days.

**Income** – Reduction in Digital income due to year to date recognition in prior months, alongside reduction in Capital Design recharge income.

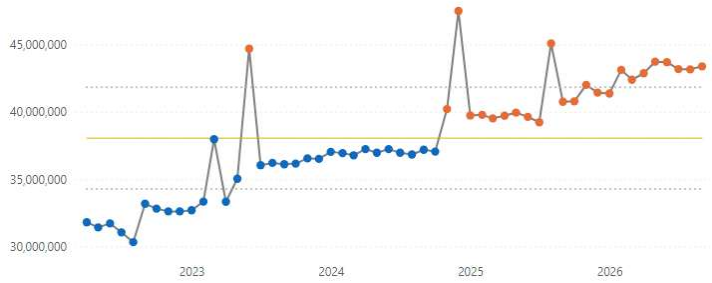
# Trend Analysis – Pay Agenda for Change



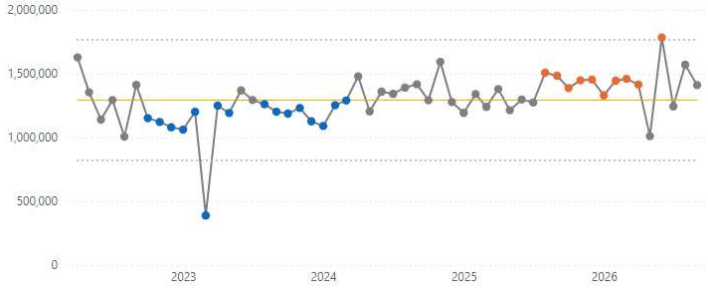
## Total (£)




## Substantive (£)



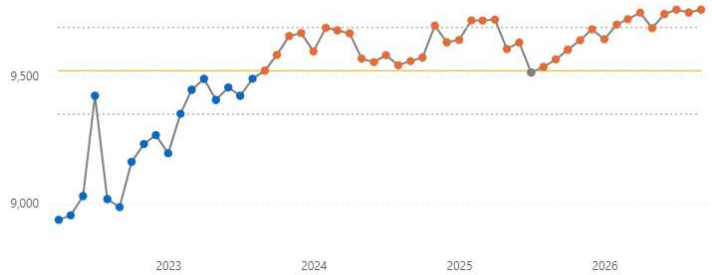

## Bank (£)



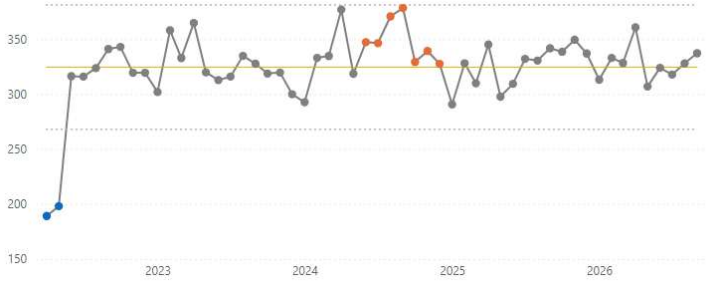

## Total (WTE)




## Substantive (WTE)




## Bank (WTE)




## Key Information

**Bank WTE and £** – Bank WTE deviated by 12 WTE from the mean usage, largely relating to Nursing and Healthcare Support Workers within Community and Integrated Medicine and Planned and Specialist Care.

**Substantive WTE** – Workforce levels are 196 WTE higher than the same period last year, with the increase largely relating to Nursing and Midwifery. Despite this growth, staffing pressures remain due to ongoing vacancies and sickness absence.

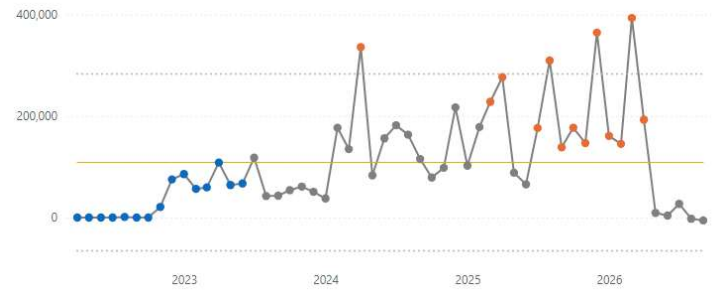
# Trend Analysis – Pay Agenda for Change



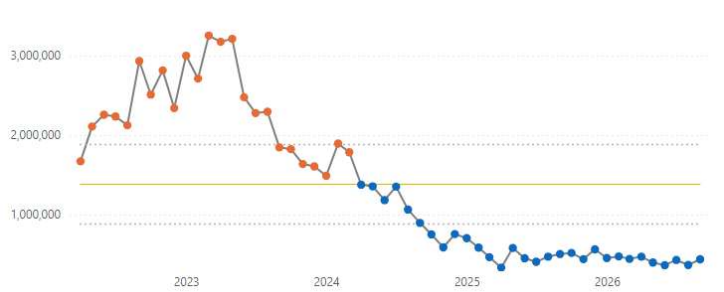
## Overtime (£)



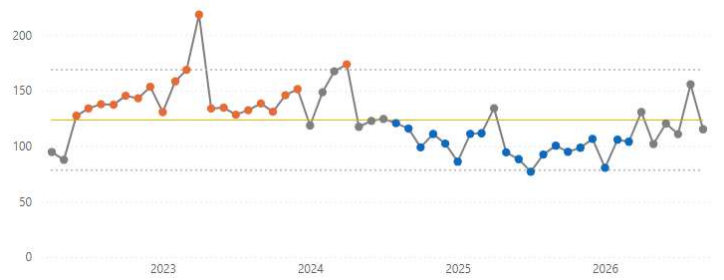

## WLI (£)



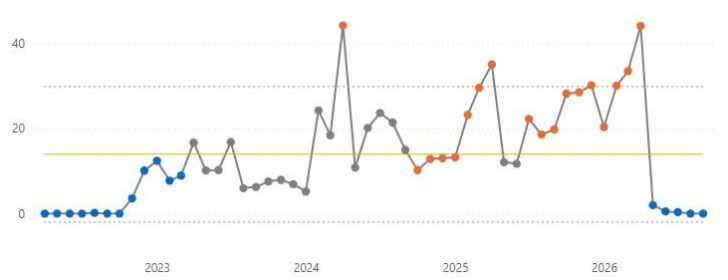

## Agency (£)



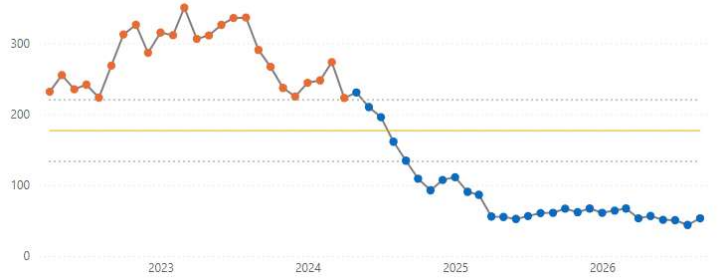

## Overtime (WTE)




## WLI (WTE)




## Agency (WTE)




## Key Information

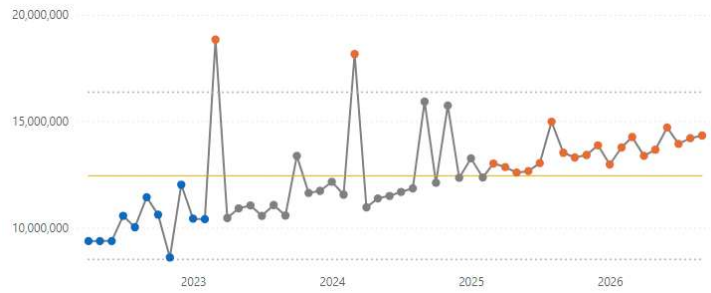
**Overtime £ and WTE** – Overtime expenditure has increased compared with last year, mainly within Community and Integrated Medicine and Planned and Specialist Care, driven by vacancies and high sickness levels. Although overtime usage in 2026/27 is higher than in 2025/26, it remains close to the mean, with no concerns flagged by the SPC charts. The WTE trend also reflects the continued use of overtime to cover sickness related staffing gaps.

**Waiting List Initiative £ and WTE** – Reduction from prior year due to significantly less Waiting List Initiative activity being undertaken within Planned and Specialist Care this year.

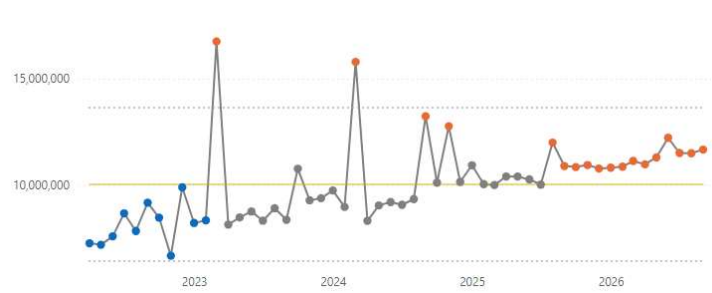
# Trend Analysis – Pay Medical and Dental



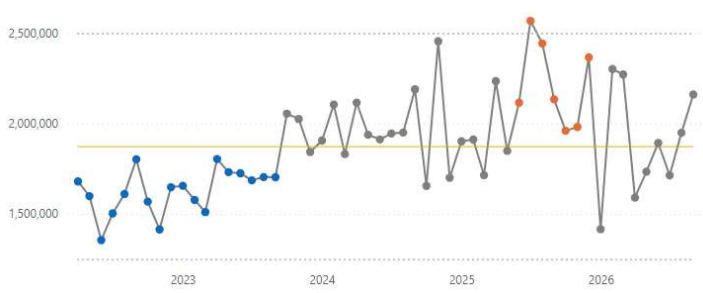
## Total (£)



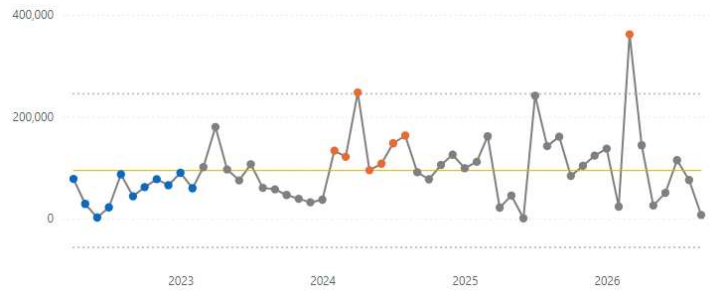

## Substantive (£)



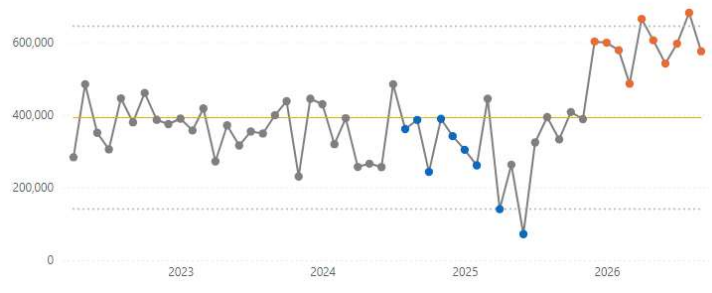

## Additional Hours (£)



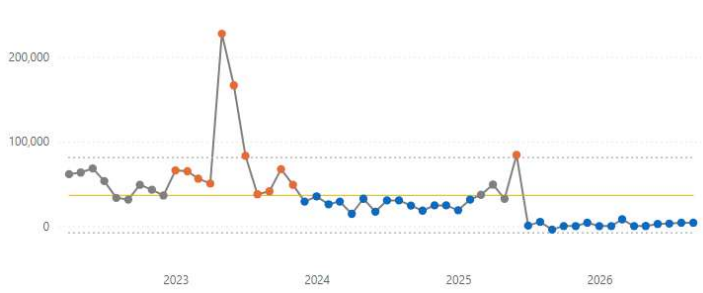

## WLI (£)




## On Contract Agency Premium (£)




## Off Contract Agency Premium (£)




## Key Information

**Total £** – Increase in Medical expenditure within Planned and Specialist Care relating to retrospective additional duty hours claims £0.2m and Carmarthenshire Integrated System increased locum usage to cover sickness and vacancies, alongside retrospective payments £0.1m.

**Additional Hours £** – Increase in Medical additional duty hours expenditure within Planned and Specialist Care due to retrospective claims within Anaesthetics and Orthopaedics £0.2m.

**Waiting List Initiative £** – Reduction in Waiting List Initiative payments from prior month within Planned and Specialist Care, due to lower activity within Elective Recovery £(0.1)m.

**On Contract Agency Premium £** – Reduction in agency expenditure from prior month largely within Pembrokeshire and Ceredigion General Medicine £(0.1)m.

| 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%** | **2,662** | **2,334** | **(271)** | **276** | **50** | **53** |
| **Community and Integrated Medicine** | **103.2%** | **1,915** | **1,668** | **(199)** | **201** | **45** | **46** |
| Carmarthenshire Integrated System | 103.5% | 1,152 | 1,017 | (92) | 123 | 12 | 42 |
| Ceredigion Integrated System | 107.5% | 327 | 266 | (57) | 44 | 17 | 4 |
| Pembrokeshire Integrated System | 99.4% | 436 | 385 | (50) | 34 | 16 | - |
| **Mental Health and Learning Disabilities** | **104.7%** | **287** | **236** | **(38)** | **50** | **1** | **13** |
| **Planned and Specialist Care** | **96.6%** | **460** | **430** | **(34)** | **25** | **4** | **(6)** |
| Cancer and Scheduled Care | 94.6% | 169 | 153 | (9) | 11 | 4 | 5 |
| Children, Women and Family Health | 97.6% | 291 | 277 | (25) | 14 | - | (11) |
| **Grand Total** | **102.2%** | **2,662** | **2,334** | **(271)** | **276** | **50** | **53** |

| All Other Staffing Levels (WTE) Excluding Medical and Ward Nursing & HCSWs | Total Fill Rate | Total WTE | Substantive WTE | Substantive WTE Vacancy | Variable WTE | Agency (Premium) WTE | Total Over/(Under) Staffed |
|---|---|---|---|---|---|---|---|
| **Chief Executive** | **90.6%** | **90** | **90** | **(5)** | **-** | **-** | **(5)** |
| **Chief Operating Officer** | **93.7%** | **5,260** | **5,140** | **(509)** | **115** | **2** | **(388)** |
| Chief Operating Officer Management | 81.6% | 132 | 123 | (5) | 8 | - | 3 |
| Community and Integrated Medicine | 97.0% | 1,409 | 1,370 | (169) | 36 | 2 | (130) |
| Mental Health and Learning Disabilities | 90.3% | 915 | 904 | (104) | 11 | - | (92) |
| Operational Allied Health and Health Sciences | 97.2% | 1,119 | 1,093 | (85) | 26 | - | (59) |
| Planned and Specialist Care | 95.0% | 1,483 | 1,455 | (110) | 27 | - | (82) |
| Primary Care | 87.2% | 202 | 195 | (36) | 7 | - | (28) |
| **Executive Director of Allied Health Professions and Health Sciences** | **95.2%** | **901** | **837** | **(83)** | **64** | **-** | **(19)** |
| **Executive Director of Finance** | **89.9%** | **439** | **432** | **(37)** | **6** | **-** | **(31)** |
| **Executive Director of Nursing, Quality and Patient Experience** | **90.9%** | **177** | **177** | **(14)** | **-** | **-** | **(13)** |
| **Executive Director of Public Health** | **87.6%** | **142** | **142** | **(32)** | **-** | **-** | **(31)** |
| **Executive Director of Strategy and Planning** | **93.9%** | **49** | **49** | **(1)** | **-** | **-** | **(1)** |
| **Executive Director of Workforce and Organisational Development** | **74.6%** | **222** | **221** | **(74)** | **1** | **-** | **(72)** |
| **Executive Medical Director** | **87.0%** | **320** | **318** | **(39)** | **2** | **-** | **(37)** |
| **Grand Total** | **92.7%** | **7,600** | **7,406** | **(794)** | **188** | **2** | **(597)** |

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



| Clinical Care Group and Executive Functions (£'k) | Pay | | | | Non-Pay | | | | Income | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | Administration and Estates | Allied Health, Scientists and Other | Medical and Dental | Nursing, Midwifery and Clinical Support | Clinical Services and Supplies | Commissioned Healthcare Services | Drugs and Prescribing | Other Non-Pay | Income | |
| **Chief Executive** | **(17)** | | | | | **0** | | **(23)** | **0** | **(40)** |
| **Chief Operating Officer** | **121** | **(24)** | **971** | **(127)** | **610** | **(432)** | **(346)** | **293** | **185** | **1,250** |
| Chief Operating Officer Management | (5) | 13 | (18) | 10 | 23 | 9 | | 15 | (3) | **44** |
| Community and Integrated Medicine | 91 | 44 | 368 | 261 | 109 | 358 | (53) | 97 | 43 | **1,318** |
| Mental Health and Learning Disabilities | 2 | (52) | 106 | (30) | (9) | 235 | (18) | 5 | 30 | **270** |
| Operational Allied Health and Health Sciences | (3) | (137) | (42) | 49 | 163 | (26) | 25 | 91 | (30) | **90** |
| Planned and Specialist Care | 103 | 80 | 526 | (388) | 328 | 136 | (292) | 19 | 40 | **551** |
| Primary Care | (66) | 28 | 30 | (30) | (4) | (1,144) | (8) | 66 | 105 | **(1,023)** |
| **Executive Director of Allied Health Professions and Health Sciences** | **45** | **(27)** | | **(3)** | **0** | **1** | **0** | **255** | **(21)** | **249** |
| Estates and Facilities | 32 | | | (3) | 0 | | 0 | 255 | (21) | **263** |
| Executive Allied Health Professions and Health Sciences | 13 | (27) | | | | 1 | | | | **(14)** |
| **Executive Director of Finance** | **(9)** | **(3)** | **11** | **4** | **2** | **14** | | **4** | **40** | **61** |
| Digital | (4) | (3) | 11 | 4 | 2 | 17 | | 19 | 40 | **85** |
| Finance | (5) | | | | | (3) | | (16) | 0 | **(24)** |
| **Executive Director of Nursing, Quality and Patient Experience** | **(20)** | **(11)** | | **10** | **(0)** | **7** | | **19** | **6** | **10** |
| **Executive Director of Public Health** | **(63)** | **11** | **(9)** | **(42)** | **4** | **2** | **(10)** | **4** | **2** | **(100)** |
| **Executive Director of Strategy and Planning** | **(16)** | **(0)** | **9** | | | **89** | **0** | **(26)** | **15** | **71** |
| LTAs with other NHS Providers | 2 | | | | | 89 | 0 | (0) | | **91** |
| Strategy and Planning | (18) | (0) | 9 | | | (0) | | (25) | 15 | **(20)** |
| **Executive Director of Workforce and Organisational Development** | **(100)** | **(3)** | | **(8)** | **0** | **10** | **(3)** | **149** | **(127)** | **(82)** |
| **Executive Medical Director** | **(33)** | **38** | **63** | **16** | **(5)** | **(36)** | **572** | **37** | **(34)** | **618** |
| Medical | (28) | 10 | 63 | 19 | 7 | | | (19) | 17 | **69** |
| Pharmacy and Medicines Management | (5) | 28 | | (3) | (12) | (36) | 572 | 56 | (51) | **549** |
| **Health Board Wide** | **2** | **(5)** | **(27)** | **5** | **(17)** | **(17)** | **(51)** | **(1,665)** | **(102)** | **(1,876)** |
| **Planned Deficit** | | | | | | | | **3,417** | | **3,417** |
| **Savings Identification** | | | | | | | | **36** | | **36** |
| **Grand Total** | **(89)** | **(25)** | **1,018** | **(145)** | **593** | **(362)** | **163** | **2,498** | **(36)** | **3,615** |

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



| Clinical Care Group and Executive Functions (£'k) | Pay | | | | Non-Pay | | | | Income | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | Administration and Estates | Allied Health, Scientists and Other | Medical and Dental | Nursing, Midwifery and Clinical Support | Clinical Services and Supplies | Commissioned Healthcare Services | Drugs and Prescribing | Other Non-Pay | Income | |
| **Chief Executive** | **(32)** | | | | | **0** | | **(66)** | **(0)** | **(99)** |
| **Chief Operating Officer** | **(1)** | **(289)** | **4,469** | **39** | **2,963** | **(2,375)** | **(913)** | **1,503** | **326** | **5,722** |
| Chief Operating Officer Management | 135 | 219 | (49) | 372 | 67 | 11 | 0 | (71) | (8) | **675** |
| Community and Integrated Medicine | 35 | 204 | 1,891 | 696 | 646 | 1,598 | 281 | 640 | (57) | **5,933** |
| Mental Health and Learning Disabilities | (3) | (129) | 478 | (325) | (4) | 1,476 | (53) | 65 | 48 | **1,554** |
| Operational Allied Health and Health Sciences | (9) | (919) | 229 | 224 | 960 | (78) | (241) | 478 | (289) | **355** |
| Planned and Specialist Care | 139 | 196 | 1,757 | (754) | 1,426 | 830 | (952) | 300 | (215) | **2,727** |
| Primary Care | (297) | 139 | 163 | (175) | (132) | (6,211) | 52 | 90 | 848 | **(5,522)** |
| **Executive Director of Allied Health Professions and Health Sciences** | **54** | **(62)** | | **(9)** | **24** | **4** | **4** | **813** | **(9)** | **820** |
| Estates and Facilities | (21) | | | (9) | 24 | | 4 | 812 | (9) | **801** |
| Executive Allied Health Professions and Health Sciences | 76 | (62) | | | | 4 | | 0 | | **18** |
| **Executive Director of Finance** | **(273)** | **(5)** | **13** | **66** | **2** | **(185)** | **0** | **893** | **7** | **517** |
| Digital | (258) | (5) | 13 | 66 | 2 | (167) | | 911 | 6 | **568** |
| Finance | (16) | | | | | (18) | 0 | (18) | 1 | **(51)** |
| **Executive Director of Nursing, Quality and Patient Experience** | **(95)** | **(12)** | | **0** | **(1)** | **63** | | **82** | **17** | **55** |
| **Executive Director of Public Health** | **(202)** | **90** | **3** | **(107)** | **29** | **(35)** | **(223)** | **162** | **7** | **(277)** |
| **Executive Director of Strategy and Planning** | **(9)** | **(0)** | **54** | | | **891** | **0** | **(173)** | **(198)** | **565** |
| LTAs with other NHS Providers | 15 | | | | | 893 | 0 | (3) | | **905** |
| Strategy and Planning | (23) | (0) | 54 | | | (2) | | (170) | (198) | **(341)** |
| **Executive Director of Workforce and Organisational Development** | **(164)** | **(11)** | | **(7)** | **8** | **63** | **(17)** | **56** | **(133)** | **(205)** |
| **Executive Medical Director** | **(78)** | **169** | **99** | **107** | **(67)** | **(4)** | **1,532** | **12** | **(223)** | **1,549** |
| Medical | (66) | 15 | 97 | 106 | 25 | | 0 | (201) | (6) | **(30)** |
| Pharmacy and Medicines Management | (12) | 155 | 2 | 2 | (92) | (4) | 1,532 | 213 | (216) | **1,579** |
| **Health Board Wide** | **(2)** | **(9)** | **(285)** | **11** | **(20)** | **(67)** | **(166)** | **(1,627)** | **(465)** | **(2,629)** |
| **Planned Deficit** | | | | | | | | **20,500** | | **20,500** |
| **Savings Identification** | | | | | | | | **3,360** | | **3,360** |
| **Grand Total** | **(802)** | **(128)** | **4,353** | **99** | **2,938** | **(1,645)** | **217** | **25,517** | **(671)** | **29,878** |

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



| Clinical Care Group and Executive Functions (£'k) | Pay | | | | Non-Pay | | | | Income | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | Administration and Estates | Allied Health, Scientists and Other | Medical and Dental | Nursing, Midwifery and Clinical Support | Clinical Services and Supplies | Commissioned Healthcare Services | Drugs and Prescribing | Other Non-Pay | Income | |
| **Chief Executive** | **(150)** | | | | | **0** | | **(10)** | **1** | **(159)** |
| **Chief Operating Officer** | **(536)** | **(881)** | **7,253** | **(1,680)** | **5,786** | **(1,565)** | **(1,125)** | **2,665** | **823** | **10,740** |
| Chief Operating Officer Management | 122 | 401 | (156) | 417 | 231 | 21 | 0 | (230) | (6) | **801** |
| Community and Integrated Medicine | (34) | 405 | 3,404 | 1,029 | 1,269 | 3,585 | 880 | 1,153 | (167) | **11,524** |
| Mental Health and Learning Disabilities | (120) | (638) | 1,079 | (1,069) | (4) | 2,365 | (76) | 110 | 112 | **1,759** |
| Operational Allied Health and Health Sciences | (32) | (1,645) | 405 | 320 | 2,199 | (231) | (343) | 1,012 | (498) | **1,187** |
| Planned and Specialist Care | 234 | 285 | 2,229 | (1,963) | 2,379 | 2,063 | (1,487) | 672 | (385) | **4,027** |
| Primary Care | (706) | 311 | 292 | (414) | (288) | (9,367) | (99) | (53) | 1,768 | **(8,557)** |
| **Executive Director of Allied Health Professions and Health Sciences** | **(158)** | **(226)** | | **(19)** | **10** | **8** | **5** | **1,681** | **3** | **1,303** |
| Estates and Facilities | (312) | | | (19) | 10 | | 5 | 1,680 | 3 | **1,366** |
| Executive Allied Health Professions and Health Sciences | 154 | (226) | | | | 8 | | 1 | | **(63)** |
| **Executive Director of Finance** | **(226)** | **(7)** | **8** | **166** | **7** | **(37)** | **0** | **(60)** | **(32)** | **(180)** |
| Digital | (148) | (7) | 8 | 166 | 7 | 0 | | (6) | (33) | **(12)** |
| Finance | (78) | | | | | (37) | 0 | (55) | 1 | **(168)** |
| **Executive Director of Nursing, Quality and Patient Experience** | **(61)** | **(77)** | | **21** | **(2)** | **120** | | **165** | **33** | **200** |
| **Executive Director of Public Health** | **(593)** | **155** | **(28)** | **(357)** | **59** | **(22)** | **(549)** | **205** | **16** | **(1,117)** |
| **Executive Director of Strategy and Planning** | **(103)** | **(0)** | **116** | | | **949** | **0** | **11** | **(225)** | **748** |
| LTAs with other NHS Providers | 28 | | | | | 954 | 0 | (6) | | **976** |
| Strategy and Planning | (131) | (0) | 116 | | | (5) | | 17 | (225) | **(228)** |
| **Executive Director of Workforce and Organisational Development** | **(1,598)** | **(30)** | **0** | **6** | **12** | **126** | **(33)** | **(116)** | **(47)** | **(1,682)** |
| **Executive Medical Director** | **(232)** | **(119)** | **275** | **180** | **(136)** | **(45)** | **2,583** | **225** | **(327)** | **2,405** |
| Medical | (189) | 70 | 274 | 217 | 46 | | 0 | (355) | (93) | **(31)** |
| Pharmacy and Medicines Management | (43) | (188) | 2 | (37) | (182) | (45) | 2,583 | 580 | (234) | **2,436** |
| **Health Board Wide** | **6** | **(17)** | **(449)** | **11** | **(19)** | **0** | **(560)** | **(3,535)** | **(1,029)** | **(5,593)** |
| **Planned Deficit** | | | | | | | | **41,000** | | **41,000** |
| **Savings Identification** | | | | | | | | **10,003** | | **10,003** |
| **Grand Total** | **(3,652)** | **(1,202)** | **7,175** | **(1,672)** | **5,717** | **(466)** | **321** | **52,232** | **(785)** | **57,668** |

# End of Year – Savings Detail (£'k)



| Clinical Care Group and Executive Functions (£'k) | Annual Savings Target | In-Year Identified Plans | In-Year Recurrent Delivery | In-Year Non Recurrent Delivery | In-Year Total Forecast Delivery | In-Year Forecast Shortfall | In-Year % Saving vs Budget | Recurrent Forecast Delivery | Recurrent Forecast Shortfall | Recurrent % Saving vs Budget |
|---|---|---|---|---|---|---|---|---|---|---|
| **Chief Executive** | **(25)** | **166** | **0** | **166** | **166** | **(191)** | **4.9%** | **0** | **(25)** | **0.0%** |
| **Chief Operating Officer** | **30,675** | **17,414** | **2,486** | **14,929** | **17,414** | **13,261** | **2.6%** | **3,473** | **27,202** | **0.5%** |
| Chief Operating Officer Management | 749 | 436 | 0 | 436 | 436 | 313 | 3.4% | 0 | 749 | 0.0% |
| Community and Integrated Medicine | 12,524 | 9,093 | 1,427 | 7,665 | 9,093 | 3,431 | 3.7% | 1,737 | 10,787 | 0.7% |
| Mental Health and Learning Disabilities | 6,441 | 3,146 | 52 | 3,093 | 3,146 | 3,295 | 3.0% | 52 | 6,389 | 0.1% |
| Operational Allied Health and Health Sciences | 4,848 | 1,680 | 22 | 1,658 | 1,680 | 3,169 | 2.1% | 29 | 4,820 | 0.0% |
| Planned and Specialist Care | 5,890 | 2,804 | 985 | 1,820 | 2,804 | 3,086 | 1.3% | 1,655 | 4,235 | 0.8% |
| Primary Care | 223 | 256 | 0 | 256 | 256 | (33) | 2.3% | 0 | 223 | 0.0% |
| **Executive Director Of Allied Health Professions and Health Sciences** | **2,715** | **692** | **509** | **184** | **692** | **2,023** | **1.4%** | **535** | **2,180** | **1.1%** |
| Estates and Facilities | 2,705 | 648 | 509 | 140 | 648 | 2,057 | 1.3% | 535 | 2,170 | 1.1% |
| Executive Allied Health Professions and Health Sciences | 10 | 44 | 0 | 44 | 44 | (34) | 19.2% | 0 | 10 | 0.0% |
| **Executive Director Of Finance** | **238** | **672** | **414** | **257** | **672** | **(433)** | **2.9%** | **467** | **(229)** | **2.0%** |
| Digital | 373 | 315 | 295 | 20 | 315 | 58 | 1.8% | 348 | 24 | 2.0% |
| Finance | (134) | 357 | 119 | 238 | 357 | (491) | 6.0% | 119 | (253) | 2.0% |
| **Executive Director Of Nursing, Quality and Patient Experience** | **0** | **130** | **0** | **130** | **130** | **(130)** | **1.4%** | **0** | **0** | **0.0%** |
| **Executive Director Of Public Health** | **131** | **834** | **0** | **834** | **834** | **(703)** | **12.7%** | **0** | **131** | **0.0%** |
| **Executive Director Of Strategy and Planning** | **2,035** | **1,114** | **74** | **1,040** | **1,114** | **921** | **1.8%** | **74** | **1,961** | **0.1%** |
| LTAs With Other NHS Providers | 1,961 | 655 | 0 | 655 | 655 | 1,306 | 1.2% | 0 | 1,961 | 0.0% |
| Strategy and Planning | 74 | 459 | 74 | 385 | 459 | (385) | 12.3% | 74 | 0 | 2.0% |
| **Executive Director Of Workforce and Organisational Development** | **(481)** | **3,039** | **302** | **2,737** | **3,039** | **(3,520)** | **20.0%** | **302** | **(783)** | **2.0%** |
| **Executive Medical Director** | **5,952** | **3,429** | **2,520** | **909** | **3,429** | **2,523** | **3.4%** | **2,520** | **3,432** | **2.5%** |
| Medical | 72 | 202 | 75 | 127 | 202 | (130) | 4.5% | 75 | (3) | 1.7% |
| Pharmacy and Medicines Management | 5,880 | 3,228 | 2,445 | 783 | 3,228 | 2,652 | 3.4% | 2,445 | 3,435 | 2.6% |
| **Health Board Wide** | **1,560** | **5,307** | **1,529** | **3,778** | **5,307** | **(3,747)** | **14.6%** | **1,546** | **14** | **4.3%** |
| **Grand Total** | **42,800** | **32,797** | **7,833** | **24,964** | **32,797** | **10,003** | **3.4%** | **8,918** | **33,882** | **0.9%** |

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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

Ein cyf/Our ref: CEO.21879

Gofynnwch am/Please ask for: Kelly Sursona

Dyddiad/Date: 13 October 2026

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

By e-mail to: dsdghsceynhswce@gov.wales

Dear Jacqueline,

**2026/27 Financial Position – Month 6 Reporting and actions for the next 6 weeks**

Following our Accountability Meeting on 16 September, I agreed that I would write to you with an update on our progress on finance by 13 October.

As you will be aware, the Health Board is addressing an extraordinary number of pressures against our financial position, alongside a challenging context of our performance within urgent and emergency care. Our response is therefore one which has sought to balance our budget responsibilities with the need to maintain the delivery of care to our population.

The principal drivers to our financial position are:

- **Savings delivery and maturity:** A material gap of £10m remains against the £42.8m annual savings requirement. The identified schemes are weighted heavily towards non-recurrent benefits, which support the current year but do not correct the underlying cost base.

- **Workforce and premium staffing:** Continued reliance on medical locums, agency, bank and additional hours to cover vacancies, sickness and service fragility remains a major contributor. These pressures are most pronounced in Community and Integrated Medicine, Planned and Specialist Care, Mental Health and Learning Disabilities, and Pathology.

- **Commissioned and externally provided care:** Increased acuity and cost in Continuing Healthcare and out-of-area placements, alongside outsourced psychiatric intensive care capacity and wider commissioned activity, continue to create expenditure above plan.

- **Clinical capacity, outsourcing and dual running:** Radiology, theatre and specialty outsourcing, and medical dual-running arrangements have added cost while the Health Board protects access, safety and continuity of care.

- **Prescribing, medicines and other operational pressures:** Drug price and concessionary cost increases, estates maintenance, national energy prices, clinical supplies and emergency activity commissioned from neighbouring organisations have added further pressure.

These pressures are partially offset by favourable movements in Primary Care contract expenditure, central income, vacancies and other corporate areas. Those improvements are recognised in the revised forecast, but they are not sufficient to offset the wider savings, workforce and operational pressures.

I am grateful to the work which has been facilitated through Welsh Government and colleagues in NHS Wales Shared Services Partnership through the Welsh Risk Pool. We have recognised the improvement in their forecast position in our year to date and forecast position. That has resulted in an improvement to our planned position for the year from £41m in Month 5 to £37.5m in Month 6. As a Board, we recognise this as being our revised plan for the remainder of the financial year.

Our gross forecast before required mitigating actions in Month 5 was £60.9m. On a like-for-like basis, this would therefore translate into a position of £57.4m following the recognition of the Welsh Risk Pool position. Regrettably, the gross forecast has slightly deteriorated to £57.7m in our reported Month 6 position.

While further savings were identified during Month 6, at £2.3m, this was offset by a deterioration in our expenditure profile for the remainder of the year of £2.6m. We recognise this is unacceptable, and are acting to improve upon this position with urgency.

## Actions

I am grateful for the support which has been provided by Jeremy Griffiths into the organisation since our Accountability Meeting, recognising that we are in the process of recruiting into a Chief Delivery Officer to support me with improving our position for the remainder of the year.

We are putting in place a Delivery Control Centre in order to support a more focused response to tracking the delivery of our actions, alongside a Workforce Cell led by our Clinical Executives and supported by Workforce and Finance colleagues to both scrutinise and approve all variable pay requests, and review the impact of applying tighter processes.

The Executive Team has strengthened the organisation’s recovery response, with a clear focus on improving the in-year position where it is safe, deliverable and sustainable to do so, while reducing the recurrent deficit carried into 2027/28. A clear distinction is being maintained between identified opportunity, approved action and

evidenced delivery, so that reported improvements are supported by appropriate assurance.

| Programme | Purpose and assurance |
|---|---|
| **Workforce Improvement Programme** | A coordinated set of workstreams covering recruitment restrictions, establishment control, sickness absence, rostering and job planning, variable pay and medical workforce stabilisation. Reconciled workforce and financial baselines, named leads and delivery trajectories are being used to strengthen accountability. |
| **Enhanced grip and control assessments** | Clinical Care Groups and Executive Functions are completing evidence-based self-assessments across financial, workforce and procurement controls. Gaps must be converted into named actions, timescales and monitoring arrangements, with escalation where local resolution is not sufficient. |
| **Executive oversight and internal escalation** | The Executive Team is increasing scrutiny of expenditure, savings maturity, run-rate and corrective actions. Material pressures are being tracked through internal escalation, with clearer ownership and rapid intervention when trajectories are missed. |
| **Targeted operational action** | The recovery programme is focusing on controllable and variable areas of spend, including premium staffing, commissioned care and packages, prescribing, procurement, non-pay commitments and the conversion of savings opportunities into robust plans. |

There remains a route to delivering our planned position, though I recognise that the delivery window is diminishing. The next six weeks will be critical. At our public Board meeting on 26 November, the Board will scrutinise the impact and outcomes of our actions. If the impact is insufficient, I recognise that I will need to write to you in early December with our assessment of the implications on our forecast.

The actions we are targeting are as follows:

| **Gross forecast at Month 6** | **57.7** | **Lead** |
|---|---|---|
| Operational improvements recorded since Month 6 reporting: Planned and specialist care | 0.5 | Andrew Carruthers |
| Productivity: Planned and specialist care | 1.0 | Andrew Carruthers |
| Commissioning: Swansea Bay | 2.0 | Lee Davies |
| Commissioning: Anticipated improvement in the JCC position after forecasts are confirmed | 0.6 | Lee Davies |
| Prescribing: Accelerating delivery | 1.0 | Mark Henwood |
| Procurement: Choices and options | 0.5 | Huw Thomas |
| Central finance: DHCW VAT rebate benefit | 0.4 | Huw Thomas |
| **Workforce cell** | | |
| Medical: Advance scrutiny of all variable pay and robust adherence to rules and controls | 1.9 | Mark Henwood |

| | | |
|---|---|---|
| Nursing: Newly registered onboarding and reduced variable pay | 1.8 | Sharon Daniel |
| Nursing: Improved roster management | 1.6 | Sharon Daniel |
| Nursing: Fill rate impact | 1.2 | Sharon Daniel |
| Admin and clerical: Recruitment freeze and Financial Control Group controls | 1.0 | Lisa Gostling |
| Estates and ancillary: Control measures | 0.4 | James Severs |
| Further mitigations required – target further variable pay, particularly medical workforce, maximise productivity gains and optimise bed utilisation in collaboration with partners | 6.3 | |
| **Required plan position** | **37.5** | |

This plan would result in a minimum 44% reduction in our anticipated spend for the second half of the financial year in Nursing and Healthcare Support Worker variable pay expenditure and a 15% reduction in our anticipated spend for Medical and Dental variable pay.

The delivery of these savings would result in a significant change for the organisation. It would represent an expenditure run rate which would take us below our historic deficit position, and consequently require significant service changes across the organisation in a short period of time.

**Risks**

There is a risk that the delivery of robust controls, particularly within Medical and Dental, will result in the Health Board being unable to fill on-call rotas, resulting in urgent service change requirements over the coming six weeks. I will remain in regular dialogue with NHS Performance and Improvement and Welsh Government when these issues arise.

The most significant risk the Health Board is managing remains our urgent and emergency care performance. This represents a significant clinical, operational and financial risk. Maintaining flow and safe care through our system remains a priority.

Financially, the delivery of the improvements needed to deliver our plan represents an unprecedented challenge to the organisation. We are committed to this work, but I remain in a position without sufficient assurance that this is deliverable. Within this context, there are two areas in particular for which I would be grateful for further discussions:

1. Planned care recovery funding. While our planned care recovery funding has been committed to the schemes we need to deliver in order to achieve our RTT position, there remains some opportunity to pause expenditure should Welsh Government require cash cover for the risks in any shortfall arising from delivery against our plan. This would clearly have implications for Welsh Government's commitment to RTT recovery, but remains a material area of expenditure for

which options remain in order to secure the cash needed for any shortfall in our local delivery of financial improvements.

2. Dental ringfence underspend. We have consistently sought to maximise the benefit arising from the dental ringfence. However, robust performance management of our primary care dental practitioners alongside limited capacity within the market has often let to an underspend against our position. We remain in that position this year. Following a reassessment of our position over Month 6, we anticipate that we will underspend £5.1m against our ringfence. While we understand the policy imperative to withdraw this funding, that would result in a deterioration in our forecast. We have paused further commitments against the dental allocation pending a discussion with Welsh Government officials given the material impact of this for the Health Board this year.

**Conclusion**

I recognise the seriousness of the emerging position and its potential implications for the Health Board's statutory financial duties and escalation arrangements. I welcome the continued constructive engagement with Welsh Government and NHS Wales Performance and Improvement as we implement and assure the recovery programme.

We will provide a further formal update following completion of the next forecast review and the relevant Board governance, including confirmation of any revised forecast, delivery against agreed actions, and any support or decisions required.

Yours sincerely,



**Prof Phil Kloer**
**Prif Weithredwr / Chief Executive**

Cc:
Neil Wooding (Chair)
HDUHB Executive Team

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

# Financial Plan 2027/30

## Approach, Principles and Assumptions

### Finance and Performance Committee Update

### October 2026



1. Thriving teams



2. Healthier communities



3. Great care



4. Positive futures

# Contents


A Background and Context

B Approach, components and assumptions

C Key Milestones

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# A. Background and Context

Sets the financial baseline, Welsh Government expectations and the trajectory required to return to breakeven.



1. Thriving teams



2. Healthier communities



3. Great care

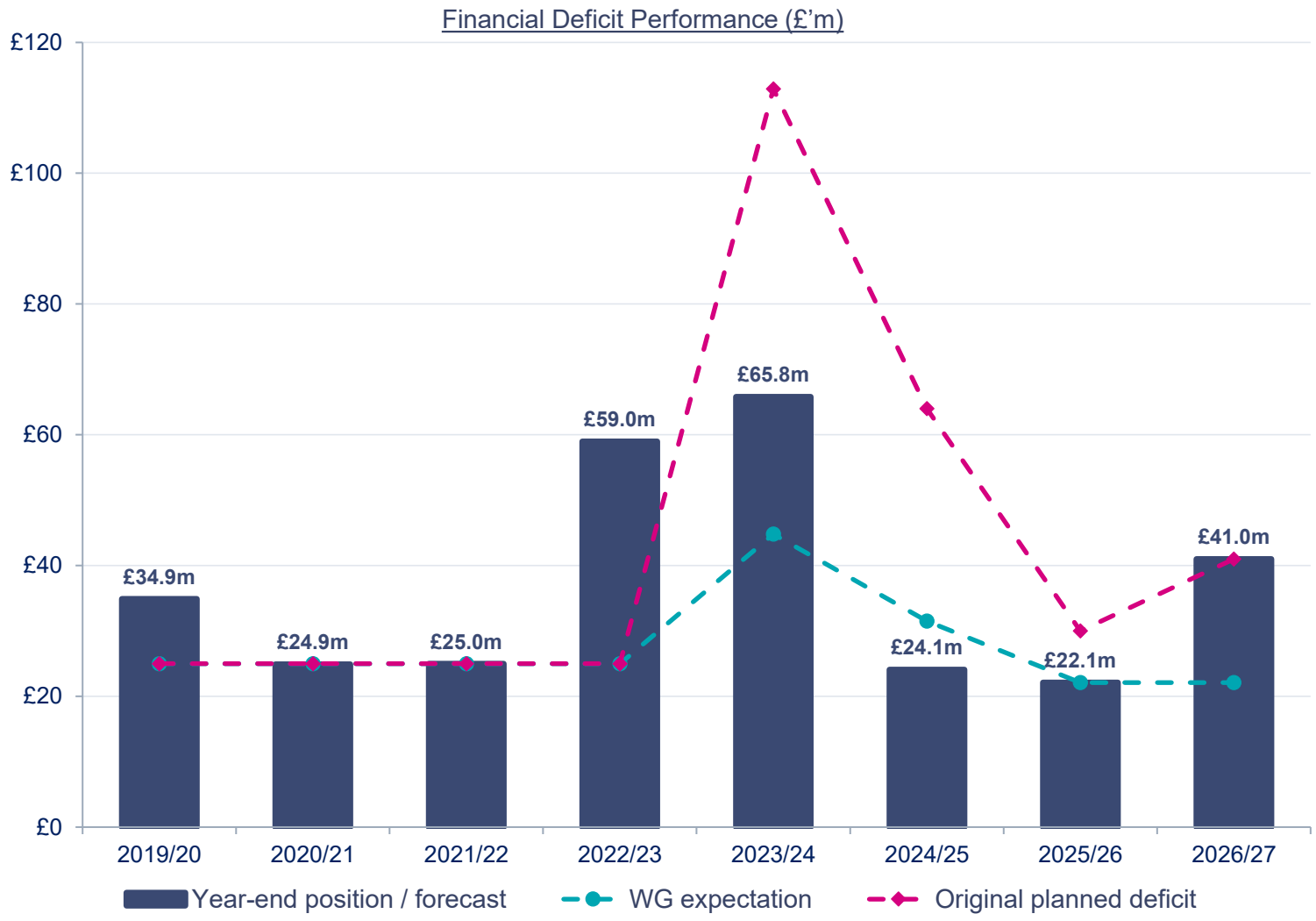


4. Positive futures

# Financial deficit performance



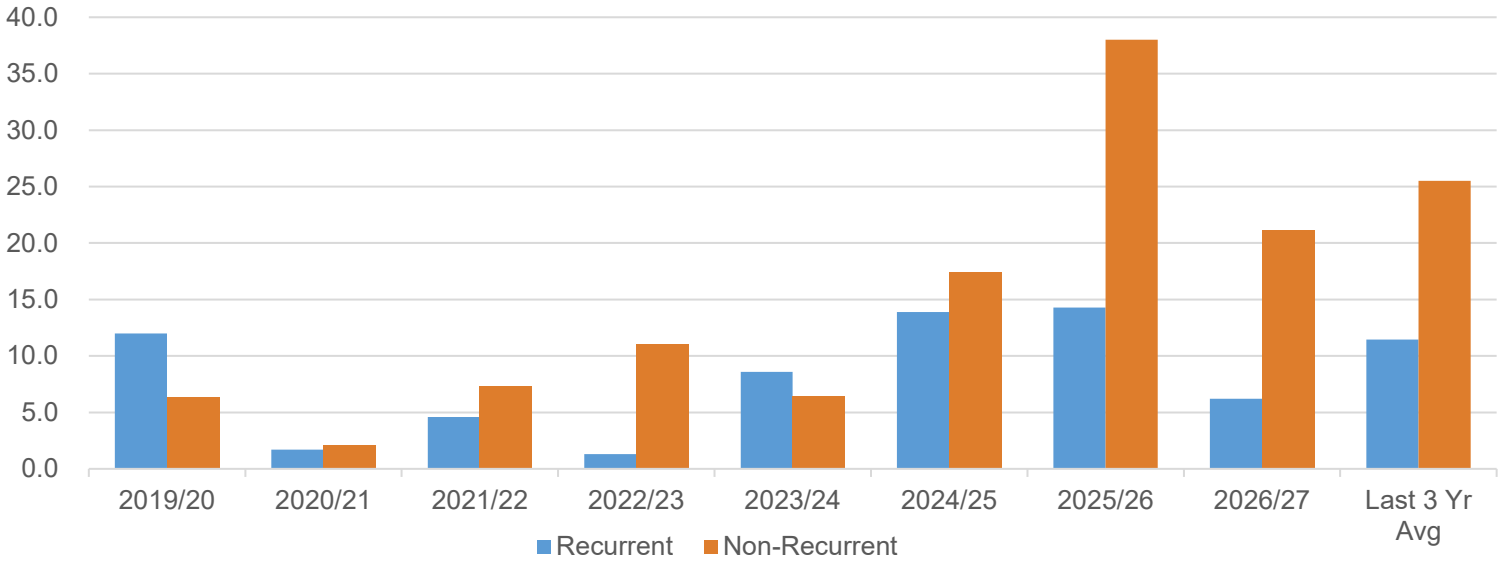
- The Health Board has an **annual plan deficit of £41.0m for 2026/27**. However, **Welsh Governments expectations are for a deficit of £22.1m, being target control total;**
- Given the scale of the challenge to bridge to a break-even position, the Health Board submitted an Annual Plan for 2026/27 and 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 delivering savings in the post-pandemic era, 2024/25 and 2025/26 have reversed this trend with a reframed approach to internal escalation and accountability;
- The Health Board is proposing to submit a Three-Year Financial Plan for 2027-30.

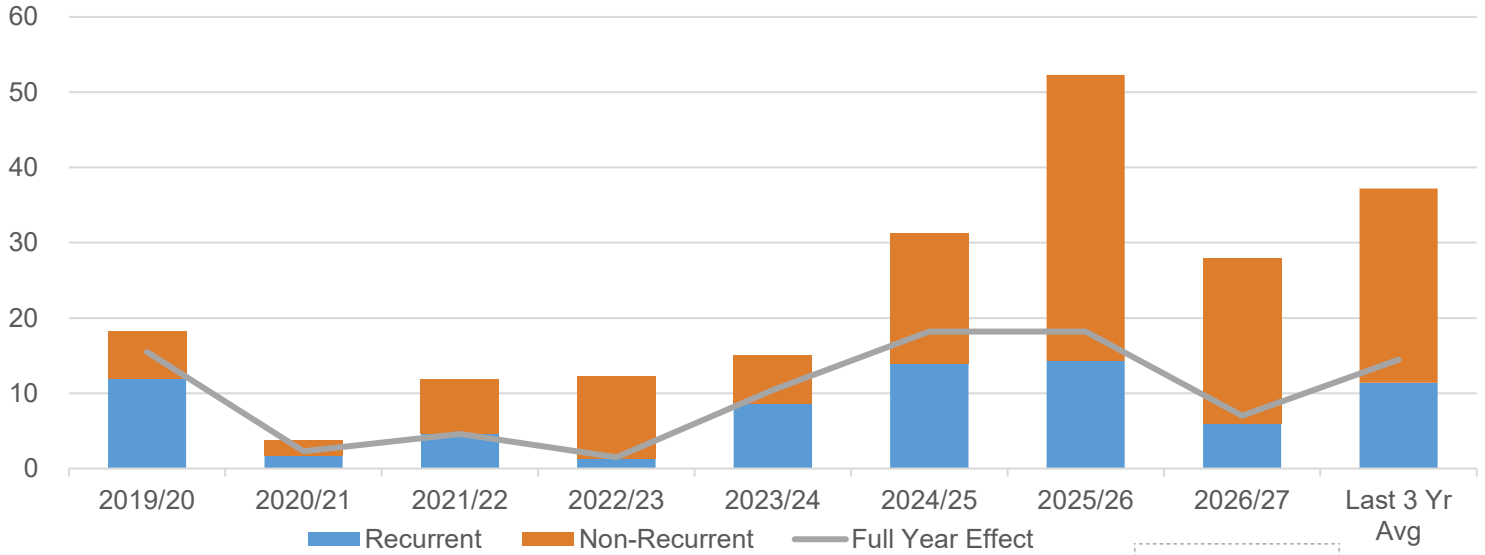



**Note:** The 2026/27 position stated as at Month 5 Monthly Monitoring Return submission to Welsh Government. A mid-year a ng undertaken for review within the September 2026 Board meeting.

# Savings Deliverability Assessment (£'m)






- **Note:** 2026/27 savings reflect the Month 5 reporting position. The three-year average covers 2024/25 to 2026/27.
- There remains a historic and continuing **over-reliance on non-recurrent savings.** In no year has the full-year effect of recurrent schemes matched total savings delivery.
- In 2026/27, **non-recurrent** savings represent **73% of total delivery**.
- The 2026/27 target was to carry forward any residual savings from the ambitious two-year savings target of 2024/25 and 2025/26, and increase by 2.0% of non-ring fenced budgets
- Savings performance improved in 2024/25 and 2025/26 but **plateaued in 2026/27**, resulting in the £42.8m target not being met. Delivery continues to rely partly on underspends, with **limited progress in securing additional recurrent** savings.

# Financial Roadmap Assessment 2026-27 (Year 0)



The underlying assessment is identified at the start of a new financial year together with an assessment of the inflation, demographics, allocation funding and savings. The 2026/27 financial plan is summarised as follows, and when factoring in extraordinary items, demonstrates a marginal improvement compared to the 2025/26 outturn:

| 2026/27 Financial Plan Assessment | Recurrent £'m | Non-Rec £'m | Total £'m |
|---|---|---|---|
| **Underlying deficit carried forward** | 53.7 | - | **53.7** |
| Macro-economic inflation price modelling | 10.8 | - | **10.8** |
| Contractual or unavoidable (incl. Welsh Risk Pool) | 19.7 | - | **19.7** |
| Demographic prevalence modelling | 12.2 | 0.2 | **12.4** |
| Welsh Government allocation funding | (12.8) | | **(12.8)** |
| **Gross expenditure plan** | **83.6** | **0.2** | **83.8** |
| Savings target | (42.8) | | **(42.8)** |
| **Planned financial deficit** | **40.8** | **0.2** | **41.0** |
| Welsh Risk Pool additional element | (12.6) | - | **(12.6)** |
| Accountancy gains that are one-off in nature | (7.1) | - | **(7.1)** |
| **Adjusted planned financial deficit excluding extraordinary items** | **21.1** | **0.2** | **21.3** |
| **2025/26 outturn position** | **22.1** | **-** | **22.1** |

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# B. Approach, components and assumptions

Defines the planning components, appraisal approach and governance required to support key decisions and savings. Establishes the budget-setting principles and assumptions for workforce, inflation, growth, funding and cost pressures.



1. Thriving teams



2. Healthier communities



3. Great care



4. Positive futures

# Principle Components and Approach



As a framework approach to identifying components that would require a financial appraisal with the planning cycle, the following key elements are defined, and an assessment will be undertaken to provide clarity for decision-making through the Planning Steering Group, Executive Team and Board. Timelines and organisation communication will be aligned to that coordinated by the Planning function.



| Macro-Economic Price Inflation | National Investments | Pre-Committed Investments | Volume and Mix Growth Modelling | In-Year Assessment | FYE Assessment | Investment Decisions | Savings Plans |
|---|---|---|---|---|---|---|---|
| Macro-Inflationary items modelled based on latest economic / market conditions; highly likely to manifest and largely unavoidable. These items are pre-defined. A prior year review of funding assumptions verses actual costs will also be undertaken to adjust budgets up/ down as appropriate. | New National All-Wales investments approved through national governance processes. Would be difficult to avoid investment as contradictory to approvals already given and Once for Wales ethos. Specific approval and business case will need to be evidenced. | Local investments approved through in-year governance processes. Local choice to endorse or unwind decision. | Assessments to be undertaken against specific cost areas that are susceptible to social and health volume and mix growth demographics. A prior year review of funding assumptions verses actual costs will also be undertaken to highlight areas for action. | Assessment of the key in-year operational driver changes to the deficit. Check and challenge reviews will be undertaken to ensure consistency and appropriateness. Local choice to endorse or take mitigating action to change current practice. | Assessment of the full year effect of the key operational drivers. Check and challenge reviews will be undertaken to ensure consistency, appropriateness and realism of delivery of further steps up or down. Local choice linked to decision regarding appropriateness of in-year assessment. | Local investments approved through the current planning cycle. Local choice to endorse or unwind decision. Collated through the planning cycle led by the Planning function and in addition to existing expenditure. | Opportunities for service changes (house-keeping and transformational) to mitigate the existing, and any additional, increases in expenditure, and to erode the pre-existing deficit. Savings schemes to follow the BRAG definitions for assessing deliverability. |

Proposed priority order of approval of income or expenditure – all need Executive Team and Board ratification

Approval of opportunities and savings requirements to offset any impacts of Income or Expenditure changes

# Key Principles



- **Budgets will be delegated** from the Accountable Officer (CEO) **to Delegated Officers** (Executive Directors) and their immediate **Deputies** (Executive Function Leads and Clinical Care Group Directors);
- **Consolidation of budgets** will be **undertaken for key areas** to align holistic oversight with appropriate Delegated Officers;
- The **Workforce** plan to be **within existing budgets** only, or specifically included within investment decisions;
- Resourcing requirements for **25A and 25B wards** are to be conducted by **Corporate Nursing Team only**;
- **Only assured** (Green and Amber) **savings plans will be included** within the final planning submission, any residual gap to the total savings requirement will be highlighted as a remaining total of pipeline schemes;
- 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 an in-year break-even position for 2029/30 (Year 3);
- **Clinical Care Group/Executive Function savings targets** will be the minimum of the national efficiency target expectation, **plus** any residual recurrent savings gap from the savings requirement set in 2026/27.

# Key Focus Areas for Budget Setting



- **In-year cost pressures and underlying assessment of positions** – a decision is required whether the material in-year cost pressures will be recognised in budget setting, these are including and not exclusively linked to the finance risks identified on a separate slide, such as medical pay, continuing healthcare and prior elective care savings not being maintained in non-pay. To obtain clarity on the existing realistic run rates, an informed review of underlying positions are required;
- **Establishment control review** – workforce improvement programme to update cost centre and band discrepancies within existing budgets (actual vs budget misalignments), cleansing of under and over established areas and accommodating accurate mix changes to be made through the annual spine point rightsizing exercise, and removing any budgets that have historically not be achieved thus reducing the recurrent deficit and removing the continued underspend non-recurrent savings;
- **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;
- **Profiling of budgets** – ensuring budgets are appropriately phased to align with spend profile and seasonality.

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# C. Key Milestones

Sets out the deadlines and responsibilities for developing, approving and submitting the financial plan



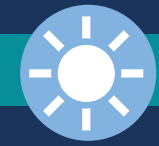
1. Thriving teams



2. Healthier communities



3. Great care



4. Positive futures

# Key Milestone Deadlines

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Item | Deadline | Delivery Owner |
|---|---|---|
| Executive Team sign-off of financial approach and assumptions | 21/10/2026 | Formal Executive Team |
| F&PC sign-off of financial approach and assumptions | 27/10/2026 | Huw Thomas and Andrew Spratt |
| Macro-economic, growth modelling and cost driver assessment first draft | 17/11/2026 | Finance Team and Budget Holders |
| First Draft – Executive Team review of Financial Plan before F&PC | 09/12/2026 | Huw Thomas and Executive Leads |
| First Draft – Finance Plan presented to F&PC for assurance review | 15/12/2026 | Huw Thomas and Executive Leads |
| Welsh Government (WG) core funding uplift confirmed | Dec 2026 | Welsh Government |
| Financial Recovery meetings, focusing on Plans and Savings | Jan/Feb 2027 | Lead Exec, Service Lead, Finance, Exec Reps |
| Second Draft – Executive Team review of Financial Plan before F&PC | 03/02/2027 | Huw Thomas and Executive Leads |
| Accountable Officer Letter to be submitted to WG | 12/02/2027 | Chief Executive – Accountable Officer |
| Second Draft – Financial Plan presented to F&PC for assurance review | 23/02/2027 | Huw Thomas and Executive Leads |
| Internal accountability letters issued to delegated officers | 02/03/2027 | Phil Kloer and Finance Team. 31/03/27 deadline to sign |
| Profiling or mix changes of budgets confirmed by delegated officers (must comply with budgeting principles rules) | 12/03/2027 | Delegated officers |
| Final Draft Annual Plan presented to Board for approval | 25/03/2027 | Executive Team |
| Annual Plan and supporting templates submitted to WG | 31/03/2027 | Lee Davies |

4.2

**11:45, 5 Mins**

# 4.2 - FINANCIAL ROUTE MAP VERBAL UPDATE

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

For assurance

4.3 **11:50, 5 Mins**

# 4.3 - PROCUREMENT SCRUTINY

***Gemma Deverill (NWSSP - Procurement)***

For assurance

### Attachments

4.3 Procurement Scrutiny October 2026.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | **27 OCTOBER 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:

Outcome of the following procurement exercises which have been undertaken on behalf of Hywel Dda University Health Board (HDdUHB). In line with Welsh Government approval procedures, the Health Board is required to approve the following new contract, as it has a cumulative contract value in excess of £1m over the term of the contract for HDdUHB.

## Cefndir / Background

1. Procurement Outcomes:

a) Energy Performance Contract (EPC) Phase 2

| Duration of Contract | Supplier | Current (Phase One) Annual Contract Value (Ex VAT) | Proposed (Phase Two) Annual Value of New Contract (Ex VAT) | Maximum Anticipated (Phase Two) Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 July 2027 – 30 June 2029 | Vital Energi Utilities Ltd | £3,075,000.00 | £4,075,000.00 | £9,500,000.00 |

b) Contract Change Notice for Insourcing and Outsourcing Clinical Procedures

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 December 2026 – 31 March 2027 | ID Medical Ltd | £960,000.00 | £1,440,000.00 | £1,440,000.00 |
| 01 December 2026 – 31 March 2027 | Circle Healthcare Group | £797,262.50 | £1,195,893.75 | £1,195,893.75 |
| 01 December 2026 – 31 March 2027 | ID Medical Ltd | £3,500,000.00 | £5,520,000.00 | £5,520,000.00 |

c) Defibrillator Replacement Programme

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 January 2027 – 31 December 2036 | TBC - This will be confirmed post FPC and will be included within the Board report. | N/A | TBC | £3,500,000.00 |

d) All Wales Wound Management Renewal

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 February 2027 – 31 January 2031, with an option to extend for a further two (2) years to 31 January 2033 | Multiple (Framework creation) | N/A | £207,153.62 | £1,242,921.72, inclusive of optional extension |

e) Endoscopy Equipment Replacement

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| One off requirement | Olympus | N/A | £1,361,305.80 including VAT | £1,361,305.80 including VAT |

f) Patient Engagement Platform

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 January 2027 to 30 November 2032 with an option to extend to 30 November 2034 | TBC – Following completion of standstill period | £152,432.00 | TBC – Following completion of standstill period | TBC – Following completion of standstill period |

g) Community Information System (WCCIS)

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 January 2027 to 30 September 2034 with an option to extend to 30 September 2037 | TBC - This will be confirmed post FPC and will be included within the Board report. | TBC | TBC | TBC |

h) Contract Change Notice for Electronic Patient Flow Management System (eFlow) and Electronic Patient Observation System (eObs)

| Duration of Contract | Supplier | Original Total Contract Value (Ex VAT) | CCN Value (Ex VAT) | New Total Value (Ex VAT) |
|---|---|---|---|---|
| 01 December 2027 to 06 February 2030 with an option to extend to 06 February 2032 | Alcidion UK Limited | £5,039,856.00 Including the extension period | £18,700.00 | £5,058,556.00 |

i) Tier 2 Substance Misuse Service

| Duration of Contract | Supplier | Current Annual Contract Value (Ex VAT) | Proposed Annual Value of New Contract (Ex VAT) | Proposed Total Value of New Contract (Ex VAT) |
|---|---|---|---|---|
| 01 April 2027 to 31 March 2030 with an option to extend to 31 March 2032 | TBC - This will be confirmed post FPC and will be included within the Board report. | £227,423.00 | 3288,063.00 | £1,440.315.00 |

## Asesiad / Assessment

1. Procurement Outcomes:

a) Energy Performance Contract (EPC) Phase 2

Approval is sought to progress Phase 2 of the Health Board's Energy Performance Contract with Vital Energi via the existing compliant Refit 4 Framework call-off arrangement.

Vital Energi was appointed through a competitive tender process in 2024 by the All-Wales Utilities Sourcing team for a multi-phase programme of decarbonisation works. Phase One (1) (£7.5m) remains on track, being delivered on time and within budget.

Phase 2 will deliver significant energy efficiency and carbon reduction measures, including Light Emitting Diode (LED) lighting upgrades across seven sites, a major solar carport installation at Prince Philip Hospital (PPH), and a range of smaller energy-saving initiatives.

The scheme is forecast to deliver annual savings of £718k and reduce emissions by 962 tonnes $CO_2e$ per annum, with an estimated payback period of 13.3 years. Subject to Health Board approvals and Welsh Government funding, works are expected to commence in Summer 2027.

b) Contract Change Notice for Insourcing and Outsourcing Clinical Procedures

Following additional Welsh Government funding to support referral to treatment (RTT), the Planned and Specialist Clinical Care Group wish to increase its current contract value via a change control notice (CCN) for the following specialities:

- Insourcing Dermatology
- Outsourcing Trauma and Orthopaedic Procedures
- Insourcing Theatre Staff

Insourcing and outsourcing clinical procedures provide additional capacity to see and treat more patients within Welsh Government set targets of 104 weeks. Following competitive mini competition exercises, HDdUHB has several contracts in place until 31 March 2027; however, to maximise throughput, additional value is required at 50% of the initial contract value.

In Dermatology, this would support an additional 700 referrals, and for Trauma and Orthopaedics, this will support a total of 127 patients across the total contract value. The Insourcing Theatre Staff contract will support additional capacity across Ophthalmology, ENT, and Urology.

The proposed change remains within the original scope and purpose of the contract and will support ongoing RTT delivery.

Including the CCN values, the total contract values will be:

| Speciality | Initial Contract Value (exc VAT) | CCN Value (exc VAT) | New Total Contract Value (exc VAT) |
|---|---|---|---|
| Insourcing Dermatology | £960,000.00 | £480,000.00 | £1,440,000.00 |
| Outsourcing Trauma and Orthopaedic Procedures | £797,262.50 | £398,631.25 | £1,195,893.75 |
| Insourcing Theatre Staff | £3,500,000.00 | £1,750,000.00 | £5,520,000.00 |

c) Defibrillator Replacement Programme

HDdUHB is seeking to award a contract for the replacement of its fleet of defibrillators, including the provision of ongoing maintenance, consumables and accessories. Defibrillators are critical life-saving devices used in the treatment of cardiac arrest and form a key element of the Resuscitation Council UK's Chain of Survival, supporting the timely delivery of emergency care to patients across the Health Board.

The replacement programme will be delivered over a four-year period as capital funding becomes available, or until the fleet of Automated External Defibrillators (AEDs) and full defibrillators has been fully replaced, whichever occurs sooner. To support long-term operational resilience and provide certainty of whole-life costs, the procurement also includes ten years of maintenance, consumables and accessories, enabling the total cost of ownership to be established and managed from the outset.

A mini-competition exercise is currently being undertaken through NHS Supply Chain's External Defibrillation Devices and Related Services and Accessories Framework. Confirmation of the recommended supplier(s) and contract award value will be included within the Board report following completion of the procurement process.

The proposed contract term is from 1 January 2027 to 31 December 2036, with no option to extend. The contract duration reflects the expected operational lifespan of the equipment and ensures continuity of maintenance and consumable support throughout the asset lifecycle, whilst providing value for money and reducing procurement and operational risk.

d) All Wales Wound Management Renewal

The All Wales (AW) contract for wound management expires on 31 January 2027. The AW Sourcing Team seek approval to award a multi-lot framework for four (4) years, with an option to extend for a further two (2) years.

The contract will extend its scope to merge Topical Negative Pressure (TNP) into the wound management framework, providing a single framework for wound care products, therapies, and

technologies. Whilst Lots 1-99 will be sole-supplier, Lot 100 for TNP will be a multi-supplier award due to the technology available in the marketplace.

Product, therapies, and technologies available on the framework include the following:

- Dressings, including foam dressings
- Absorbents
- Bandages
- Wound gel
- Negative pressure

Wound care products are currently supplied via NWSSP's distribution stores in Bridgend and direct. The products, therapies, and technologies awarded under this framework will support Tissue Viability (TV) to formalise a wound care formulary, with standardised products available to nursing teams, both acute and community.

The contract term will be from 01 March 2027 to 31 January 2031, with an option to extend to 31 January 2033.

e) Endoscopy Equipment Replacement

HDdUHB's Capital Team has approved funding for the replacement of endoscopy equipment. Approval is sought to undertake a direct award for the replacement of the existing Fujifilm endoscopy platform at Prince Philip Hospital (PPH).

This investment forms part of the Health Board's longer-term strategy for endoscopy equipment standardisation, lifecycle management and service sustainability. The proposed replacement will establish a single Olympus endoscopy platform across the PPH unit, improving interoperability between equipment, streamlining clinical workflows, enhancing patient throughput, reducing scope turnaround times and strengthening operational and workforce resilience.

A direct award to Olympus is proposed, as the majority of endoscopy equipment currently deployed within the PPH unit is already Olympus-based. Standardising on a single manufacturer platform will maximise compatibility between endoscopes, processors, ancillary equipment and associated digital systems, while reducing the operational complexity and inefficiencies associated with supporting multiple platforms. This approach will also support equipment utilisation, staff training and maintenance arrangements across the service.

The existing Fujifilm equipment removed from PPH will be redeployed to Glangwili General Hospital (GGH) and Bronglais General Hospital (BGH), replacing equipment that is older, approaching end of life and increasingly vulnerable to failure. This will maximise the value derived from the Health Board's capital investment, extend the operational life of existing assets and reduce the risk of service disruption across the endoscopy network.

This procurement represents a one-off capital purchase of equipment with no ongoing commitment beyond standard maintenance and support arrangement. The proposed approach delivers best overall value by supporting standardisation across the service, avoiding unnecessary duplication of equipment platforms, reducing training requirements and improving operational efficiency across the Health Board's endoscopy services.

f) Patient Engagement Platform

The HDdUHB Digital Directorate is seeking to procure a replacement Digital Personal Health Record Platform / Patient Engagement Platform (PEP) ahead of the expiry of the current contract in November 2027. The appointed supplier will deliver a secure, scalable and patient-centred digital platform that supports the Health Board's digital transformation objectives whilst ensuring continuity of service for patients and clinical teams.

The PEP provides patients with secure online access to their health information by bringing together relevant information from hospitals, primary care and specialist services into a single platform. This reduces fragmentation of information, improves continuity of care and supports greater patient involvement in managing their own health and wellbeing. The platform also supports the Health Board's objectives by improving patient engagement, streamlining communication and enhancing operational efficiency through improved access to timely information. Continued provision of this service is therefore essential to the delivery of safe and effective care, with any interruption presenting significant clinical, operational and legal risks. The platform forms a key component of the Health Board's ambition to deliver digital-first healthcare services, improve patient involvement in care decisions, reduce avoidable outpatient activity and support more efficient models of service delivery. By providing secure access to health information, care pathways and digital support tools, the solution enables patients to take a more active role in managing their health, reduces unnecessary travel and supports improved communication between patients and healthcare professionals.

In addition, the platform supports preventative healthcare and population health objectives through the use of patient-reported outcome measures, patient-reported experience measures and other digital engagement tools. These capabilities support earlier identification of at-risk individuals, facilitate timely intervention and contribute to wider initiatives, such as Making Every Contact Count. By placing the individual at the centre of their care, the platform also supports efforts to reduce health inequalities and improve long-term health outcomes.

Given the volume of patient data held within the system and the complexity of migration and implementation activities, a significant mobilisation and transition period will be required should a new supplier be appointed. This underpins the proposed procurement timetable, with contract award anticipated in January 2027 and implementation completed ahead of the current contract expiry in November 2027. The new solution will provide patients with a single point of access to view, manage and better understand their health information, whilst supporting the Health Board's strategic objectives for digital transformation, patient empowerment, clinical safety and quality improvement.

A mini-competition was undertaken through the NHS London Procurement Partnership (LPP) Clinical Digital Health Solutions (CDHS) Framework under Lot 5 - Patient Support System Solutions. Three bids were received and evaluated against technical, social value and commercial criteria, followed by supplier demonstrations to validate system functionality and delivery capability.

Following completion of the evaluation process, a recommendation is made to award the contract to the highest-ranked bidder for an initial term of five years, with the option to extend for up to a further 24 months if required. The Board report will be updated to reflect the final procurement outcome and recommended supplier following completion of the standstill process.

The proposed contract duration reflects the strategic importance of the platform, the significant implementation and migration requirements associated with transitioning patient data and

services, and the need to maximise the long-term benefits and value derived from the Health Board's digital investment whilst maintaining continuity of service for patients and clinicians.

g) Community Information System (WCCIS)

HDdUHB Digital Directorate is seeking to procure a replacement Community Information System (formerly known as the Welsh Community Care Information System (WCCIS)), as the current solution will reach end of life in September 2027. The existing platform is based on legacy technology that no longer fully aligns with NHS Wales' future digital architecture, interoperability ambitions, or the evolving requirements of integrated health and social care services.

The procurement presents a critical opportunity not only to maintain service continuity, but also to support the continued digital transformation of community and social care services. The proposed solution will enable health boards and local authorities to securely share care records and optimise service delivery for citizens across Wales, supporting the strategic objectives of the Social Services and Well-being (Wales) Act and wider integrated care agendas. It will also provide an opportunity for services currently reliant on paper-based processes to transition to electronic clinical records, supporting safer, faster and more accurate access to information. The new platform will support a significant number of clinical, operational and administrative users across community health and social care services and will hold substantial volumes of patient and citizen data. As a result, it will form a critical component of the wider NHS Wales digital ecosystem and represents a strategically important asset requiring high levels of resilience, security, interoperability and supplier capability.

Given the scale and complexity of implementation, including system configuration, data migration, integration with existing infrastructure, user acceptance testing, staff training and Digital Services assurance requirements, a significant mobilisation and transition period will be required to support safe and effective deployment.

An Open Tender exercise is currently underway, with the outcome expected prior to contract award. The Board report will be updated to reflect the final procurement outcome and recommended supplier following completion of the evaluation process.

Subject to the outcome of the tender, it is anticipated that a recommendation will be made to award the contract for an initial term of seven years and nine months, with the option to extend for up to a further three years. The proposed contract duration reflects the strategic importance of the system, the significant implementation and transition costs involved, and the need to realise long-term benefits and value from the investment while maintaining continuity of service delivery. The contract term is also intended to provide supplier stability, maximise the return on implementation and transformation investment, and minimise operational disruption associated with replacing a business-critical system.

h) Contract Change Notice for eFlow and eObs

Following the successful implementation of the Miya Electronic Patient Flow (eFlow) and Electronic Patient Observation (eObs) platforms under the existing contract with Alcidion UK Limited, approval is sought to execute a Contract Change Notice (CCN) to provide contextual launch functionality between Miya and the Welsh Clinical Portal (WCP).

The proposed enhancement will enable authorised users to launch directly from a patient's record within Miya into the corresponding record within WCP, improving access to clinical information and supporting more efficient clinical workflows. The functionality will strengthen

interoperability between existing digital systems, reduce the need for duplicate navigation and information retrieval activities, and provide clinicians with a more seamless and integrated user experience.

The proposed change remains within the original scope and intent of the contract and represents a logical enhancement of the existing Miya platform. It will further support operational efficiency, clinical decision-making and the delivery of safe, effective patient care across Hywel Dda University Health Board.

The value of the CCN is £18,700.00 (ex. VAT), increasing the total contract value from £5,039,856.00 (ex. VAT) to £5,058,556.00 (ex. VAT). The supplier has confirmed a fixed-price proposal covering technical validation, configuration, testing, deployment and initial post-deployment support, providing cost certainty and minimising implementation risk.

The proposed enhancement represents a low-cost investment in comparison to the overall contract value and will maximise the benefits realised from the Health Board's existing investment in the Miya platform by improving integration with core national digital systems.

i) Tier 2 Substance Misuse Service

HDdUHB, on behalf of the Hywel Dda Area Planning Board and partner organisations, has undertaken an above-threshold Open Tender exercise for the provision of an Integrated Tier 2 Substance Misuse Service across Carmarthenshire, Ceredigion and Pembrokeshire. The service supports prevention, early intervention, treatment, recovery and criminal justice pathways for individuals affected by drug and alcohol misuse and is a key component of the regional substance misuse strategy.

The procurement sought a fully managed service model covering Adult Substance Misuse Services, Children and Young People Substance Misuse Prevention, Early Intervention and Treatment Services, and Criminal Justice Substance Misuse Services. The contract will support the delivery of person-centred, trauma-informed services aligned to Welsh Government policy objectives, whilst ensuring consistent access to specialist support across the Hywel Dda region.

An Open Tender exercise was undertaken, with two compliant bids received and evaluated against published technical, social value and commercial criteria. Evaluation was undertaken by a multidisciplinary panel comprising representatives from Hywel Dda University Health Board, Local Authorities, the Area Planning Board, Probation Services and Dyfed Powys Police, with governance and procurement support provided by NWSSP Procurement Services.

The evaluation process has identified a preferred bidder that achieved the highest overall score and demonstrated the strongest combination of quality, social value and commercial value. At the time of submission, the procurement remains subject to the completion of the mandatory standstill period. The Board paper will therefore be updated to reflect the outcome of the standstill process and the recommended supplier prior to award.

Subject to the successful conclusion of the standstill period and completion of governance approvals, it is proposed that the contract is awarded for an initial term of three years, with the option to extend for a further two years in minimum increments of 12 months. The proposed contract duration reflects the importance of maintaining continuity of critical substance misuse services, whilst providing sufficient stability to support long-term service delivery, workforce planning and partnership working across the region.

## Argymhelliad / Recommendation

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

- **APPROVE** the award of the Energy Performance Contract (EPC) Phase 2 contract from the 01 July 2027 to the 30 June 2029 with an option to extend to 30 September 2032 at a maximum anticipated total contract value of £9,500,000.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government.
- **APPROVE** the Contract Change Notice for Insourcing and Outsourcing contracts increasing the total contract value to £8,155,893.75 ex VAT across three (3) contracts. This Contract Change Notice will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Defibrillator Replacement Programme from 01 January 2027 to 31 December 2036 total contract value of £3,500,000.00 ex VAT. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the All-Wales Wound Management framework from 01 February 2027 to 31 January 2031, with an option to extend for a further two (2) years to 31 January 2033 with total contract value of £1,242,921.72 ex VAT. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Endoscopy Equipment Replacement with total contract value of £1,361,305.80 for a one-off Capital purchase. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Patient Engagement Platform contract from the 01 January 2027 to the 30 November 2032 with an option to extend to 30 November 2034. The contract value will be confirmed within the November Board report following completion of the standstill period. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government.
- **APPROVE** the award of the Community Information System (WCCIS) replacement from the 01 January 2027 to the 30 September 2034 with an option to extend to 30 September 2037. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government.
- **APPROVE** the award of a Contract Change to the Electronic Patient Flow Management System (eFlow) and Electronic Patient Observation System (eObs) contract from 1 December 2026 to 6 February 2030, with an option to extend to 6 February 2032. This contract will have onwards submission to Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership).
- **APPROVE** the award of the Tier 2 Substance Misuse contract from the 01 April 2027 to the 31 March 2030, with an option to extend to 31 March 2032, at an anticipated total contract value of £1,440,315.00 ex VAT. This contract will have onwards submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government.

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 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 |

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| | those that are capital and digital in nature), projects, and proposed investment decisions on behalf of the Board.<br>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, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | Not Applicable |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 9. All HDdUHB Well-being Objectives apply |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | 7. All Apply |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | Not Applicable |
| Rhestr Termau:<br>Glossary of Terms: | Contained within the body of the report |

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| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | Not Applicable |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Not Applicable |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Not Applicable |
| **Gweithlu:<br>Workforce:** | Not Applicable |
| **Tegwch Iechyd:<br>Health Equity:** | Not Applicable |
| **Risg:<br>Risk:** | Not Applicable |
| **Cyfreithiol:<br>Legal:** | Not Applicable |
| **Enw Da:<br>Reputational:** | Not Applicable |
| **Gyfrinachedd:<br>Privacy:** | Not Applicable |
| **Cydraddoldeb:<br>Equality:** | Not Applicable |

4.4

**11:55, 5 Mins**

# 4.4 - PLANNING GOALS UPDATE REPORT Q2 2026-27

***Angharad Lloyd-Probert (Hywel Dda UHB - Senior Project Manager)***

For assurance

## Attachments

4.4 Planning Goals Update Report Oct 2026.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD: DATE OF MEETING:** | 27 October 2026 |
| **TEITL YR ADRODDIAD: TITLE OF REPORT:** | Planning Goals 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

The Health Board approved the 2026/27 Annual Plan in March 2026, based on requirements specified in the NHS Wales Planning Framework 2026/29 and against the Escalation Framework, which was subsequently submitted to Welsh Government on 31 March 2026. Since submission, Welsh Government (WG) has issued further communication that noted the plan was unacceptable and unsupportable given the expected financial outturn for 2026/27.

For 2026/27, **Planning Goal 6** has been aligned to the Finance and Performance Committee (FPC), namely:

Planning Goal 6: Safe, timely, high-quality care which covers the following previous Planning Objectives. To note **Planning Objective 2** (Financial Roadmap) has not been carried forward for 2026-27, therefore there is no specific defined Finance Planning Goal for 2026-27.

- **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 Goals, for onward assurance to the Board through the Board Assurance Framework.

### Cefndir / Background

Planning Goals
One key aspect of the Annual Plan remains our Planning Goals (previously referred to as Planning Objectives).

Of the eight Planning Goals, one is aligned to this Committee:

- Planning Goal 6: Safe, timely, high-quality care

**Asesiad / Assessment**

The Planning Goals remain a key element of the Annual Plan for 2026/27. The current status of the Planning Goal aligned to this Committee are:

| Planning Goal | Executive Lead | Status and Key Outcomes |
|---|---|---|
| Planning Goal 6: Safe, timely, high-quality care | Chief Operating Officer | Planning Objective 3: Status On Track<br><br>**Pillar 1 – Pre-Hospital & Community**<br>• Progress has been made on the implementation planning for 7-Day Clinical Streaming Hubs**,** including workforce planning, recruitment preparation and implementation arrangements across counties. Go Live is planned for 30 November 2026<br>• Development of the Call Before Convey model has continued, including SOP development, pathway mapping and engagement with WAST. The pilot went live on 28 September 2026, ongoing evaluation points are scheduled in.<br>• The Community Falls Programme has progressed through development of the iSTUMBLE digital pathway, care home engagement and redesign of falls response pathways to better align with community-based alternatives to conveyance.<br>• The operational implementation of redirection policy has commenced, currently the development of a DoS and engagement with Primary Care are the focus<br>**Pillar 2 – Front Door & First 72 Hours**<br>• A dedicated Pillar 2 Recovery Programme has been established with weekly delivery meetings, clear executive sponsorship and a focused programme of work around front-door flow and the first 72 hours of care.<br>• Significant progress has been made on the Ambulance Handover 45 Programme, including:<br>  ○ Development of a Health Board and WAST implementation plan.<br>  ○ Drafting of Ambulance Handover and Call Before Convey SOPs.<br>  ○ Establishment of operational governance and monitoring arrangements.<br>  ○ Progression of local site action plans |

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| | | • The Withybush 7-Day SDEC Programme has progressed through consultation, workforce planning and recruitment preparations, with implementation delivery plans now established. Optimal SDEC service will go live in December 2026<br>• Work has commenced on developing a First 72 hours plan, which focuses on:<br>  ○ Senior clinical decision-making.<br>  ○ Front-door medical models.<br>  ○ Acute frailty pathways.<br>  ○ ED redirection policies.<br>  ○ Therapy and diagnostic support models.<br>**Pillar 3 – Ward-Based Flow & Discharge**<br>• The Business Case for Carmarthenshire Integrated Care Home project has been approved by Welsh Government and project work has started to implement by December 2026.<br>• The Preventing Deconditioning Programme (DEWI) has expanded across 38 wards with associated training, data collection and development of supporting tools and resources.<br>• Criteria Led Discharge, Red2Green, board round improvement and discharge optimisation have continued to progress as key components of the wider flow and discharge agenda.<br>• The programme has strengthened regional collaboration through the West Wales Optimal Flow and Discharge Delivery Group, supporting a coordinated approach to discharge, delayed pathways and hospital flow improvement.<br>**Overall Programme Position**<br>• Governance, accountability, reporting and executive sponsorship for each Pillar have been clarified as part of a refreshed 3 Pillars Programme Group approach.<br>• Multiple priority workstreams are now operating with formal programme management arrangements.<br>• Key implementation activity is underway across Ambulance Handover 45, Clinical Streaming Hubs, SDEC, Falls, Acute Frailty, Optimal Flow, Red2Green, Criteria Led Discharge and Deconditioning. |

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| | | Planning Objective 4 (Diagnostics)<br>USC Radiology Investigations – under 7 days.<br><br>**Overall status: Stable –** Funded capacity does not meet an increased demand. Recovery funding used to provide some capacity; however, will not result in diagnostics under 7 days.<br><br>**Activities completed in reporting period**<br>**Mobile CT Van** – July 26-Sept 26 – 1352 USC and follow up cancer patients scanned.<br>**Task and finish group workstream**, 3 themes: Data Quality, Capacity Validation, D&C trajectory tools – completed Sept 26<br><br>**Activities planned for next milestone and reporting period**<br>**Mobile CT Van –** plan to scan 1500 USC patients<br>**Funding –** Oct 26 – £2.8m received of WG funding – original ask £4.1m (8 week waits and improve cancer performance). The funding will provide improved performance in Q3 but not Q4, unless further funding received<br><br>**Risks to delivery:** If WG funding does not continue into Q4, the planned cancer improvement may not be sustained**.** Recruitment of key clinical posts – shortages in both radiographers, sonographers and radiologists. OCP posts have been advertised (Oct 26) aim to be in post at end of Q4. Reliance on locum positions in NOUS.<br><br>**Over 8 weeks for a radiology diagnostic**<br>**Status On Track**<br><br>**Activities completed in reporting period**<br>MRI van – July-September 26 – 1641 patients in Q2<br>USS Insourcing to continue –1026 patients in Q2<br>Task and finish group workstream, 3 themes: Data Quality, Capacity Validation, D&C trajectory tools – completed Sept 26<br><br>**Activities planned for next milestone and reporting period**<br>MRI van – plan to scan 4041 patients in Q3.<br>CT Van – plan to scan 2000 patients in Q3.<br>USS Insourcing to continue – plan to scan 2400 patients in Q3<br>Funding - If Planned Care delivery and sustainability WG funding is agreed, capacity will increase to meet demand and backlog. |

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| | | **Risks to delivery:** If further WG funding is not secured, this will run out at the end of December 26 and we will not meet zero 8 weeks in MRI and NOUS by 31 March 27.<br>Recruitment of key clinical posts - shortages in radiographers, sonographers and radiologists. OCP posts have been advertised (Oct 26) aim to be in post at end of Q4. Reliance on locum positions in NOUS**.**<br><br>**Planning Objective 4 (Cancer)**<br><br>**Single Cancer Pathway**<br>**Forecast Trajectory 2026/27 Per Tumour Site (In-year recovery funding )**<br>• August 26 performance **61.9%** above predicted trajectory<br>• The trajectories have been revised to reflect in year recovery allocation awarded for 8 week diagnostic recovery for radiology. Confirmation of funding allocation of £12,849,721; of which £3,743,985 was allocated for diagnostics, despite original bid being circ £15m, the Health Board has supported continuing with the plans to improve cancer performance.<br><br>Q2 Focus on early urology and lower GI improvements; secure MRI access; optimise tracking.<br>**Progress**<br>• **Outsourcing of CT scanning capacity will continue until June 2026**, providing on average an additional 338 scans per month. The arrangement began on 5 January 26. This is to continue until end December 26.<br>• **New prostate clinic** introduced as of 3 June 26, which will fast track high risk patients following MRI & LATP to CT TAP. This clinic will streamline pathway and reduce MDT delays. |

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| | | Planning Objective 5<br>**On Track**:<br><br>**Open Access Demonstrator Projects – Status On Track**<br>• All four demonstrator projects have progressed from planning into implementation preparation and testing phases.<br>• CAMHS OAAT remains on track for pilot implementation in November 2026.<br>• Primary Care and Perinatal teams have progressed pathway development, stakeholder engagement and workforce training.<br>• Peer Support and Lived Experience workforce development has been supported through a successful co-production day, helping to shape implementation priorities and future service design.<br>• Shared governance arrangements continue to support learning, evaluation and alignment across the programme.<br><br>**111 Option 2 – Status On Track**<br>• Planning is underway to commence rollout of the revised 111 Press 2 Mental Health access pathway in Pembrokeshire within the next three months.<br>• Work will be undertaken with Primary Care partners to revisit the proposed pathway changes, building on previous stakeholder engagement activity.<br>• Continued stakeholder engagement will support pathway implementation, address outstanding concerns and ensure awareness of the revised access model across the locality.<br>• Ceredigion operational teams will continue to work closely with Primary Care partners to further embed and strengthen the pathway, ensuring consistent implementation, improved collaboration, and sustainable service delivery across the locality.<br><br>**Psychological Therapies – Status In progress**<br><br>• RTT compliance reduced, as a direct result of planning for the transition from AA to MEDIO, to 56.7%. Improvements have been sighted for next month's reporting to |

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| | | return to the continued progress towards the Q2 target of 63%.<br>• Referral and discharge activity remains balanced, preventing further waiting list growth.<br>• A 34% reduction in the overall waiting list has been sustained, with improvements across a range of therapy modalities.<br>• Recruitment of NQN in place to support all group activity releasing resources for 1:1 HI interventions<br>• Trauma-Focused DBT provision has increased treatment capacity and supports recovery.<br>**Risk:**<br>• Full transition from AA to MEDIO is expected from 1 October 26. Residual risks remain relating to contingency arrangements; however, collaboration between digital services and MEDIO are limiting potential risks.<br>• Current modelling suggests a residual backlog of patients waiting up to two years may remain without further intervention; however, the service has seen a 10.6% reduction in these numbers since April 26.<br><br>**Patient Flow – Improving Mental Health Inpatient Flow and Reducing Out of Area Beds – Status In progress**<br><br>• 72 Hour crisis admission pathway working group started in July 26<br>• Aim to establish a consistent, clinically robust pathway and clear standards<br>• Focus on improving assessment, treatment, discharge planning, and patient flow<br>• Emphasis on multi-disciplinary, multi-agency working and continuity across services<br>• Vanguard work supporting improvements in patient flow and reducing out of area placements<br><br>**Neurodevelopmental (ND) – Status On Track**<br><br>• School cluster pilot is enabling multiple assessments to be completed more efficiently in areas with the highest referral rates. |

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| | | • Benefits realisation work underway to quantify improvements resulting from the introduction of AI scribe package.<br>• Forging closer working relationships with Community Paediatrics, education and Local Authority in order to provide training, supervision and consultation. Current project includes a co-ordinated response to Inset day training for teachers and ALNCo's working alongside colleagues from education, CAMHS and School In-Reach teams.<br>• Additional WG funding has secured a further outsourcing contract for 300 assessments to be completed by the end of November 2026.<br>**Risks / Challenges**<br>Demand continues to outstrip capacity. Additional funding received in 2026/27 will not bring about the eradication of over 3 year waits without further system change<br><br>**Learning Disabilities (LD) – Status On Track**<br><br>• Finalise OCP for LD Service Redesign and begin recruitment – The briefing paper has been signed off by Workforce. The implementation meeting planned for August 26 did not take place and has now been rescheduled for 8 October 26, to progress implementation with affected staff and commence recruitment to vacant posts.<br>• Start HEF digitisation rollout planning – Service Planning will meet with NHS Performance & Improvement colleagues to discuss the current trajectory and agree the inclusion and exclusion criteria.<br>• Confirm GP register validation and AHC support arrangements – Ongoing work to strengthen GP register validation and improve AHC uptake, Targeted support to practices, alongside coordinated education, and awareness for people with learning disabilities, families, carers, and PHC teams.<br>• Compliance with Paul Ridd Learning Disability Awareness Training remains high, with MH&LD CCG achieving 98.12% compliance, compared to the Health Board position of 95.14% against Q2 trajectory of 95% Health Board Wide**.** |

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| | | **Suicide & Self Harm – Safe Discharge, Ligature Safety, Multi Agency Prevention - Status On Track**<br><br>Safe Discharge<br>• Performance against the 72-hour discharge follow-up standard was 83% in June 2026, exceeding the Welsh Government target of 80%.<br>• Compliance continues to be monitored weekly and reported to WG monthly.<br>• Despite reporting challenges associated with exceptional cases, the service achieved the national performance target during the reporting period.<br>Ligature Safety<br>Adult Mental Health Wards:<br>• Ligature awareness training compliance has exceeded the Quarter 2 trajectory target of 40%, with 80.92% of inpatient staff having completed the training as of July 2026.<br>Older Adult Mental Health:<br>• All Ward Managers and Ward Sisters have completed ligature awareness training (100%) and are registered on ESR.<br>• Compliance amongst the registered nursing workforce is 100% across Bryngolau, Enlli and St Non's wards. Overall ward compliance currently stands at 29% for Bryngolau Ward, 67% for Enlli Ward and 64% for St Non's Ward, with the remaining gap relating predominantly to Nursing Support Workers. |

## Argymhelliad / Recommendation

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

| **Amcanion: (rhaid cwblhau)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | Seek assurance on delivery against all Planning Goals aligned to the Committee in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering and scrutinising the plans, including the medium term financial plans, and savings plans, that are developed and implemented, supporting and endorsing these as appropriate |

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| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | Not applicable |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | 6. Safe, Timely, High Quality Care |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 9. All HDdUHB Well-being Objectives apply |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | 7. All Apply |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | 3 Year Plan and Annual Plan 2026-27 |
| Rhestr Termau:<br>Glossary of Terms: | AHC – Annual Health Check<br>AI – Artificial Intelligence<br>ALNCo – Additional Learning Needs Co-ordinator |

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| | CAMHA OAAT – Child and Adolescent Mental Health Services One-At-A-Time therapy<br>CT – Computerised Tomography<br>CT TAP – CT Thoraco-Abdomino-Pelvic scan<br>D&C – Demand and Capacity<br>DBT – Dialectical Behaviour Therapy<br>DoS – Directory of Services<br>ED – Emergency Department<br>ESR – Electronic Staff Record<br>HEF – Health Equalities Framework<br>HI – High Intensity<br>LATP – Local Anaesthetic Transperineal biopsy<br>MDT – Multi Disciplinary Team<br>MH&LD CCG – Mental Health & Learning Disabilities Clinical Care Group<br>MRI – Magnetic Resonance Imaging<br>NOUS – Non Obstetric Ultrasound<br>NQN – Newly Qualified Nurse<br>OCP – Organisational Change Process<br>PHC – Primary Health Care<br>RTT – Referral To Treatment<br>SDEC – Same Day Emergency Care<br>SOP – Standard Operating Procedure<br>USC – Unscheduled Care<br>USS – Ultrasound Scan<br>WAST – Welsh Ambulance Services University NHS Trust |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | Not applicable |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Any financial impacts and considerations are identified in the report |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Any issues are identified in the report |
| **Gweithlu:<br>Workforce:** | Any issues are identified in the report |
| **Tegwch Iechyd:<br>Health Equity:** | 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. |
| **Risg:<br>Risk:** | Any issues are identified in the report |
| **Cyfreithiol:<br>Legal:** | Any financial impacts and considerations are identified in the report |
| **Enw Da:<br>Reputational:** | Any issues are identified in the report |
| **Gyfrinachedd:<br>Privacy:** | Not applicable |
| **Cydraddoldeb:<br>Equality:** | Not applicable |

5

**12:00, 0 Mins**

# 5 - PERFORMANCE

5.1

**12:00, 5 Mins**

# 5.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT

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

For assurance

### Attachments

5.1 IPAR - M6 FPC Oct 2026.pdf

5.1 M6 October 2026 IPAR Overview.pdf

5.1 M6 Internal Escalation Update - October 2026.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

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|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | **27 OCTOBER 2026** |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Performance and Internal Escalation Update for Hywel Dda University Health Board – Month 6 2026/27 |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Huw Thomas, Director of Finance<br>In association with all Executive Leads |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Huw Thomas, Executive Director of Finance |

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

**ADRODDIAD SCAA**
**SBAR REPORT**

## Sefyllfa / Situation

This report relates to the month 6, 2026/27 Integrated Performance Assurance Report (IPAR) and the month 6 Internal Escalation Update.

**Integrated Performance Assurance Report (IPAR) – month 6 2026/27**
The IPAR summarises progress against a range of national and local performance measures. The IPAR consists of this SBAR and the following supporting documents:

- IPAR overview – includes a summary, data, issues and actions for the Health Board's key performance improvement measures. Appendix A of the overview gives an indication of the metric types i.e. targeted intervention, performance framework, annual plan etc.
- IPAR dashboard – provides statistical process control (SPC) charts for each of our performance measures. Ahead of the committee meeting, the dashboard will also be made available via our internet site.

The health board is in further discussion with Welsh Government and the National Performance and Improvement Team to revise our annual plan trajectories. Once agreed and formalised, they will be included within the IPAR.

Ambulance Handovers: New national methodology applied from 1 September 2026 for 15- and 45-minute handovers:

- All handover measures will be based on the Welsh health board where the patient is taken to.
- All handovers will be included, not just patients taken by ambulance to an emergency department.
- Conveyances by taxi, air ambulance, and any non-conveying vehicle type will be excluded.
- Verified data from Welsh Ambulance Service Trust is an additional month behind.

**Internal escalation update: October 2026**
This document outlines the escalation levels for each clinical care group and executive function across the health board against our seven improvement domains.

## Cefndir / Background

Welsh Government published the 2026/27 NHS Wales Performance Framework in February 2026. Following the health board's recent Accountability and Oversight meeting with Welsh Government, our 2026/27 trajectories are being reviewed. The revised trajectories will be included in the IPAR as soon as they are finalised.

The Our Improving Together Framework was approved by Board in March 2025. It sets out our approach to embedding performance improvement through our organisation. The framework's ultimate aim is to improve outcomes for our patients, staff and population.

## Asesiad / Assessment

### Performance overview

The key metric summary table below has been revised to reflect changes to the 2026/27 performance framework, ministerial priorities and other 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 |
|---|---|---|---|---|---|---|---|
| % sickness absence rate of staff | 6.20% | Sep 2026 | 6.85% | n/a | n/a | n/a | Alert |
| Patients spending > 12 hours in A&E/MIU Hywel Dda | 0 | Sep 2026 | 1,649 | Usual | Missing target | n/a | Alert |
| % patients spending <4 hours in A&E/MIU Hywel Dda | 95% | Sep 2026 | 66.8% | Usual | Missing target | n/a | Alert |
| Pts waiting 14 wks+ for specified therapy (Exc. Audiology) | 0 | Sep 2026 | 4,255 | Concerning | Missing target | n/a | Alert |
| Pts waiting 8 wks+ for specified diagnostic | 0 | Sep 2026 | 7,903 | Concerning | Missing target | n/a | Alert |
| Ambulance handover > 4 hours Hywel Dda | 0 | Sep 2026 | 236 | Improving | Missing target | n/a | Alert |
| Ambulance handovers > 1 hour Hywel Dda | 0 | Sep 2026 | 796 | Improving | Missing target | n/a | Alert |
| Ambulance handover > 45 minutes Hywel Dda | 0 | Aug 2026 | 833 | Improving | Missing target | n/a | Alert |
| Number of Pathways of Care delayed discharges | n/a | Sep 2026 | 222 | Usual | n/a | n/a | Alert |
| Total days delayed for Pathways of Care delayed discharges | n/a | Sep 2026 | 8,063 | Improving | n/a | n/a | Alert |
| C. difficile: Number of confirmed cases (in-month) | 5 | Sep 2026 | 15 | Usual | Hit and miss | n/a | Alert |
| Waits over 52 weeks: new outpatient appointment | 0 | Sep 2026 | 625 | Improving | Missing target | n/a | Alert |
| Patients waiting 104 weeks+ RTT | 0 | Sep 2026 | 862 | Improving | Missing target | n/a | Alert |
| Patients waiting over 52 weeks RTT | 0 | Sep 2026 | 13,765 | Concerning | Missing target | n/a | Alert |
| % uptake of RSV vacc - 75+ years | 70% | Aug 2026 | 41.0% | n/a | n/a | n/a | Alert |
| Median time ambulance emergency category calls | 8 | Aug 2026 | 11 | n/a | n/a | n/a | Alert |
| Median time ambulance arrest category calls | 8 | Aug 2026 | 9 | n/a | n/a | n/a | Alert |
| % pts on single cancer pathway within 62 days | 75% | Aug 2026 | 62% | Improving | Missing target | n/a | Alert |
| % adult psychological therapy waits <26 weeks | 80% | Aug 2026 | 58.0% | Concerning | Missing target | n/a | Alert |
| Financial in month deficit | n/a | Sep 2026 | £3,615,000 | Concerning | n/a | Trajectory missed by over 5% | Alert |
| % child neurodevelopment assess waits <26 weeks | 80% | Aug 2026 | 26.0% | Improving | Missing target | n/a | Advise |
| S. aureus (MSSA) BSI: Number of laboratory confirmed cases (in-month) | 8 | Sep 2026 | 7 | Usual | Hit and miss | n/a | Advise |
| Patients waiting 26 weeks+ new outpatient | 0 | Sep 2026 | 7,153 | Improving | Missing target | n/a | Advise |
| % R1 eyecare patients waiting within 25% delay to target date | 95% | Aug 2026 | 46.5% | Improving | Missing target | Trajectory missed by over 5% | Advise |
| % of children who are up to date with scheduled vaccinations by age 5 | 95% | Jun 2026 | 88.4% | Usual | Missing target | n/a | Advise |
| % of children receiving HPV by age 15 | 90% | Jun 2026 | 79.2% | n/a | n/a | n/a | Advise |
| % uptake of flu vacc - 65+ years | 75% | Mar 2026 | 71.0% | n/a | n/a | n/a | Advise |
| Pts 12yrs+ with diabetes receiving all 8 NICE care processes | 50% | Sep 2026 | 46.2% | Improving | Missing target | n/a | Advise |
| Follow-up appts - delayed >100% | 11387 | Sep 2026 | 13,725 | Improving | Missing target | n/a | Advise |
| E. coli BSI: Number of hospital onset cases (in-month) | 5 | Sep 2026 | 0 | Usual | Hit and miss | n/a | Advise |
| % therapy interven post LPMHSS assess (age 0-17) | 80% | Aug 2026 | 92.6% | Usual | Hit and miss | n/a | Assure |
| % MH assess within 28 days (age 0-17) | 80% | Aug 2026 | 83.6% | Usual | Hit and miss | n/a | Assure |
| % MH assess within 28 days (age 18+) | 80% | Aug 2026 | 96.0% | Usual | Hitting target | n/a | Assure |
| % therapy interven post LPMHSS assess (age 18+) | 80% | Aug 2026 | 100.0% | Usual | Hitting target | n/a | Assure |
| Coding: % clinically coded - 1 month post discharge | 95% | Jul 2026 | 96.2% | Usual | Hit and miss | n/a | Assure |

**Alert (may require discussion):** Lack of confidence any action in place is sufficient to address the issue satisfactorily and/or within the scope of the team/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

## Triangulating our data: 1st April 2022 to 30th September 2026.

- Quality safety and risk – the number of incidents causing moderate harm or above reported by month is 135 in September 2026, performance has been relatively static since December 2025. September showed a slight decrease in the number of patient falls (208), medication errors (94) and cases of pressure damage (72) to the previous month. There has been a sustained decrease in the number of new complaints received since September 2025 (249) with (54) in September. We continue to have significant numbers of high and extreme risks on the risk register with 595 in September 2026. The number of new infections decreased in September reporting 65 cases (S. aureus = 7 cases, E. coli = 30 cases, C. difficile = 16 cases).
- Workforce – In month, staff sickness increased to 6.96% in September. Short-term sickness increased to 2.23% from previously 1.87% whilst long-term sickness remained relatively static at 4.73%. Note: The sickness metric reported in the alert section of this SBAR includes 12-month rolling data. Nursing and midwifery agency usage continues to remain static since March 2025 (91.72) with September recording 52.8 whole time equivalent (WTE). Rolling 12-month staff turnover percentage has decreased slightly to 6%, lowest recorded.

| Quality, safety and risk | Best | Worst | Latest | Trend |
|---|---|---|---|---|
| Reported incidents causing moderate harm or above | 131 | 305 | 135 | |
| Patient falls | 189 | 301 | 208 | |
| Medication errors | 61 | 148 | 94 | |
| Pressure damage developing or worsening during care | 54 | 215 | 72 | |
| New complaints by month received (ward level not available) | 54 | 249 | 54 | |
| Number of high and extreme risks (health board & function only) | 381 | 598 | 595 | |
| Infections: new cases | 51 | 89 | 65 | |
| Infections: C. difficile cases | 8 | 22 | 16 | |
| **Workforce** | | | | |
| Number of staff/contractor related incidents | 98 | 186 | 137 | |
| Sickness - short term | 1.7% | 2.6% | 2.2% | |
| Sickness - long term | 3.8% | 4.9% | 4.7% | |
| Number of vacancies | To follow | | | |
| Staff turnover (12 month rolling) | 6.0% | 9.8% | 6.0% | |
| Nursing and midwifery vacancies | To follow | | | |
| Nursing and midwifery agency (WTE) | 47.04 | 379.79 | 52.80 | |
| Bank (WTE) | 212.99 | 352.85 | 316.79 | |

## Internal escalation

### Health board internal escalation level overview as at 30 September 2026

| | |
|---|---|
| 1 | Reasonable assurance |
| 2 | Limited assurance |
| 3 | No assurance |
| 4 | No assurance and insufficient actions/engagement |

| | Function | Quality & safety | Governance | Workforce | Finance | Strategy, planning and fragile services | Population Health | Performance |
|---|---|---|---|---|---|---|---|---|
| Clinical Care Groups | Community and Integrated Medicine | 3 | 2 | 4 | 4 | 3 | 2 | 3 |
| | Chief Operating Officer Management | 1 | 1 | 3 | 2 | 1 | 1 | n/a |
| | Mental Health and Learning Disabilities | 3 | 2 | 2 | 3 | 3 | 1 | 3 |
| | Planned and Specialist Care | 2 | 2 | 3 | 4 | 3 | 2 | 3 |
| | Primary Care | 1 | 1 | 2 | 1 | 2 | 2 | 3 |
| | Operational Allied Health and Health Sciences | 3 | 1 | 2 | 3 | 3 | 1 | 3 |
| Executive Functions | Estates and Facilities | 2 | 1 | 2 | 3 | 1 | 2 | 3 |
| | Executive Director of Finance | 1 | 2 | 2 | 1 | 1 | 2 | n/a |
| | Medical | 1 | 1 | 2 | 1 | 1 | 2 | n/a |
| | Pharmacy and Medicines Management | 1 | 1 | 3 | 2 | 1 | 2 | n/a |
| | Executive Director of Nursing, Quality and Patient Experience | 1 | 2 | 2 | 1 | 1 | 2 | 3 |
| | Executive Director of Public Health | 1 | 1 | 4 | 1 | 1 | 1 | 2 |
| | Executive Director of Strategy and Planning | 1 | 1 | 2 | 1 | 1 | 2 | n/a |
| | Long Term Agreements (LTAs) | n/a | n/a | n/a | 3 | n/a | n/a | n/a |
| | Executive Director of Workforce and Organisational Development | 1 | 1 | 1 | 1 | 1 | 1 | n/a |
| | Governance and Communication | 1 | 1 | 2 | 1 | 1 | 1 | n/a |

Community & Integrated Medicine and Public Health have been escalated up to level 4 for workforce. This is the first time level 4 has been enacted for the workforce domain. Planned & Specialist Care are at risk of level 4 escalation next month if improvements are not made in October to reduce the number of overdue pay progressions within the clinical care group (CCG).

Community & Integrated Medicine is our most concerning CCG, with the function being escalated to 3 or 4 in 5 out of the 7 improvement domains. Key issues include the management of incidents/complaints, hospital acquired infections, overspend, significant gap on savings delivery, support for inpatient smokers, business continuity planning, ambulance handover delays, A&E waits and pathway of care delays. However, following improvements in risk management activity, the CCG has avoided being escalated up to level 4 and has since been de-escalated to level 2.

Please see the supporting document *Internal Escalation Update: September 2026* for further details.

## Argymhelliad / Recommendation

The Committee is asked to **DISCUSS** the IPAR – Month 6 2026/2027 and internal Escalation 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)**<br>**Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 2.1 The purpose of the Finance and Performance Committee is to provide advice and assurance to the Board on the following:<br>2.1.1 The financial performance and delivery against Health Board financial plans and objectives and<br>• give early warning of potential performance issues,<br>• make recommendations for action to continuously improve the financial position of the organisation,<br>• 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.<br>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, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | Risks are outlined throughout the report. |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | 7. All apply |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | 6. All Apply |

| | |
|---|---|
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | All Planning Goals Apply |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 9. All HDdUHB Well-being Objectives apply |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)* | 7. All Apply |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | 2026/2027 NHS Performance Framework |
| Rhestr Termau:<br>Glossary of Terms: | A&E – Accident and Emergency<br>BGH – Bronglais General Hospital<br>ED – Emergency Department<br>GGH – Glangwili General Hospital<br>IPAR – Integrated Performance Assurance Report<br>MIU – Minor Injury Unit<br>PPH – Prince Philip Hospital<br>PODCC – People, Organisational Development and Culture Committee<br>SPC – Strategy and Planning Committee<br>FPC – Finance and Performance Committee<br>WAST – Welsh Ambulance Services University NHS Trust<br>WGH – Withybush General Hospital |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | Operations, Finance, Performance, Quality and Safety, Nursing, Information, Workforce, Mental Health, Therapies and Primary Care<br>Strategy and Planning Committee |

| | |
|---|---|
| | People, Organisational Development and Culture Committee |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | Better use of resources through integration of reporting methodology<br>Integrated Impact Assessment Template |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Use of key metrics to triangulate and analyse data to support improvement.<br>Integrated Impact Assessment Template |
| **Gweithlu:<br>Workforce:** | Development of staff through pooling of skills and integration of knowledge<br>Integrated Impact Assessment Template |
| **Tegwch Iechyd:<br>Health Equity:** | Better use of resources through integration of reporting methodology |
| **Risg:<br>Risk:** | Better use of resources through integration of reporting methodology<br>Integrated Impact Assessment Template |
| **Cyfreithiol:<br>Legal:** | Better use of resources through integration of reporting methodology<br>Integrated Impact Assessment Template |
| **Enw Da:<br>Reputational:** | A number of our national performance measures have been showing concerning trends over a period of time. The SBAR outlines the issues impacting our capacity, which has subsequent impact on our performance. Over time, there is potential for our performance to have an adverse impact on our reputation as a Health Board, which then may impact recruitment and staff morale. Integrated Impact Assessment Template |
| **Gyfrinachedd:<br>Privacy:** | N/A<br>Integrated Impact Assessment Template |
| **Cydraddoldeb:<br>Equality:** | N/A<br>Equality Impact Assessment |

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

# Integrated Performance Assurance Report (IPAR) Overview

## As at 30th September 2026




For further details see the latest IPAR dashboard.

# Contents


## Overview
Key improvement measure summary

## Planned care
Delayed Follow-up appointments
New outpatient waits
Referral to treatment
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Ophthalmology R1 (high-risk patients)

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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)

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Neurodevelopmental assessment waits

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## Workforce
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## Finance
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## Appendix A
Summary Metric by Type


## Statistical process control (SPC) charts


Why use SPC charts? Anatomy of a SPC chart I Page 358 al variation within SPC charts Understanding SPC icons

The key metric summary table below has been revised to reflect changes to the 2026/27 performance framework, ministerial priorities and other local key performance metrics and is broken down my metric type in **Appendix A**.
Additional data, details of key issues and actions being taken to address can be found in the supporting document *IPAR overview*.
For data on all performance measures we are tracking, see our IPAR dashboard: Integrated Performance Assurance Report (IPAR) dashboard as at 30th September 2026.

| Metric | Target | Period | Actual | Variation | Assurance | Trajectory | 3A |
|---|---|---|---|---|---|---|---|
| % sickness absence rate of staff | 6.20% | Sep 2026 | 6.85% | n/a | n/a | n/a | Alert |
| Patients spending > 12 hours in A&E/MIU Hywel Dda | 0 | Sep 2026 | 1,649 | Usual | Missing target | n/a | Alert |
| % patients spending <4 hours in A&E/MIU Hywel Dda | 95% | Sep 2026 | 66.8% | Usual | Missing target | n/a | Alert |
| Pts waiting 14 wks+ for specified therapy (Exc. Audiology) | 0 | Sep 2026 | 4,255 | Concerning | Missing target | n/a | Alert |
| Pts waiting 8 wks+ for specified diagnostic | 0 | Sep 2026 | 7,903 | Concerning | Missing target | n/a | Alert |
| Ambulance handover > 4 hours Hywel Dda | 0 | Sep 2026 | 236 | Improving | Missing target | n/a | Alert |
| Ambulance handovers > 1 hour Hywel Dda | 0 | Sep 2026 | 796 | Improving | Missing target | n/a | Alert |
| Ambulance handover > 45 minutes Hywel Dda | 0 | Aug 2026 | 833 | Improving | Missing target | n/a | Alert |
| Number of Pathways of Care delayed discharges | n/a | Sep 2026 | 222 | Usual | n/a | n/a | Alert |
| Total days delayed for Pathways of Care delayed discharges | n/a | Sep 2026 | 8,063 | Improving | n/a | n/a | Alert |
| C. difficile: Number of confirmed cases (in-month) | 5 | Sep 2026 | 15 | Usual | Hit and miss | n/a | Alert |
| Waits over 52 weeks: new outpatient appointment | 0 | Sep 2026 | 625 | Improving | Missing target | n/a | Alert |
| Patients waiting 104 weeks+ RTT | 0 | Sep 2026 | 862 | Improving | Missing target | n/a | Alert |
| Patients waiting over 52 weeks RTT | 0 | Sep 2026 | 13,765 | Concerning | Missing target | n/a | Alert |
| % uptake of RSV vacc - 75+ years | 70% | Aug 2026 | 41.0% | n/a | n/a | n/a | Alert |
| Median time ambulance emergency category calls | 8 | Aug 2026 | 11 | n/a | n/a | n/a | Alert |
| Median time ambulance arrest category calls | 8 | Aug 2026 | 9 | n/a | n/a | n/a | Alert |
| % pts on single cancer pathway within 62 days | 75% | Aug 2026 | 62% | Improving | Missing target | n/a | Alert |
| % adult psychological therapy waits <26 weeks | 80% | Aug 2026 | 58.0% | Concerning | Missing target | n/a | Alert |
| Financial in month deficit | n/a | Sep 2026 | £3,615,000 | Concerning | n/a | Trajectory missed by over 5% | Alert |
| % child neurodevelopment assess waits <26 weeks | 80% | Aug 2026 | 26.0% | Improving | Missing target | n/a | Advise |
| S. aureus (MSSA) BSI: Number of laboratory confirmed cases (in-month) | 8 | Sep 2026 | 7 | Usual | Hit and miss | n/a | Advise |
| Patients waiting 26 weeks+ new outpatient | 0 | Sep 2026 | 7,153 | Improving | Missing target | n/a | Advise |
| % R1 eyecare patients waiting within 25% delay to target date | 95% | Aug 2026 | 46.5% | Improving | Missing target | Trajectory missed by over 5% | Advise |
| % of children who are up to date with scheduled vaccinations by age 5 | 95% | Jun 2026 | 88.4% | Usual | Missing target | n/a | Advise |
| % of children receiving HPV by age 15 | 90% | Jun 2026 | 79.2% | n/a | n/a | n/a | Advise |
| % uptake of flu vacc - 65+ years | 75% | Mar 2026 | 71.0% | n/a | n/a | n/a | Advise |
| Pts 12yrs+ with diabetes receiving all 8 NICE care processes | 50% | Sep 2026 | 46.2% | Improving | Missing target | n/a | Advise |
| Follow-up appts - delayed >100% | 11387 | Sep 2026 | 13,725 | Improving | Missing target | n/a | Advise |
| E. coli BSI: Number of hospital onset cases (in-month) | 5 | Sep 2026 | 0 | Usual | Hit and miss | n/a | Advise |
| % therapy interven post LPMHSS assess (age 0-17) | 80% | Aug 2026 | 92.6% | Usual | Hit and miss | n/a | Assure |
| % MH assess within 28 days (age 0-17) | 80% | Aug 2026 | 83.6% | Usual | Hit and miss | n/a | Assure |
| % MH assess within 28 days (age 18+) | 80% | Aug 2026 | 96.0% | Usual | Hitting target | n/a | Assure |
| % therapy interven post LPMHSS assess (age 18+) | 80% | Aug 2026 | 100.0% | Usual | Hitting target | n/a | Assure |
| Coding: % clinically coded - 1 month post discharge | 95% | Jul 2026 | 96.2% | Usual | Hit and miss | n/a | Assure |

Alert
(may require discussion)
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

Advise
(to monitor)
There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

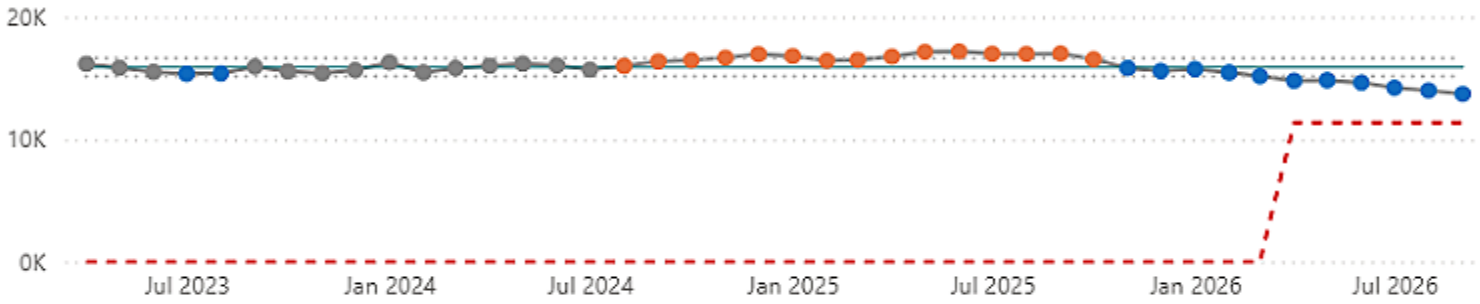
Assure
(to note)
There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

# Delayed follow up appointments

(Enhanced monitoring condition and Ministerial priority)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**Follow up outpatient appointments delayed over 100% past target date**




Performance is showing improving variation. Data in September 2026 (13,725) represents the fourth consecutive monthly improvement and the best performance in recent years.

| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| • Initiatives for reducing new outpatient waits have increased follow-up waits as more patients progress through pathways.<br>• Certain specialties have essential follow up pathways and may have additional pressure to reduce significantly due to case mix. | • The Outpatient Transformation Programme, led by the Executive Medical Director, was launched in July 2026 to deliver the National Planned Care Programme priorities across all specialties. The programme focuses on referral management, clinical triage, pathway redesign, and the expansion of self-management approaches including See on Symptoms (SoS) and Patient Initiated Follow Up (PIFU). | 31/03/27 |
| | • Specialty-level transformation plans are being implemented to reduce unnecessary follow-up activity, improve outpatient productivity, strengthen clinical validation processes, and enhance patient access and outcomes. | 31/03/27 |
| | • Significant progress has been made in the conversion of long-waiting follow-up patients to SoS/PIFU pathways. All specialties have completed this work, with the exception of Ophthalmology, where a dedicated transformation programme continues to deliver sustained improvements, including a reduction of more than 1,000 delayed follow-ups during 2026. | 31/03/27 |
| | • Although the national ambition to reduce delayed follow-up waits to below 12,000 was not achieved by March 2026, sustained improvements have been demonstrated throughout 2026/27. This has been supported by enhanced clinical validation, implementation of Clinical Implementation Network (CIN) guidance, and pathway redesign initiatives including the transfer of appropriate glaucoma patients to primary care management. | 31/03/27 |
| | • The Executive Medical Director-led transformation programme provides the clinical leadership, governance, and specialty accountability required to accelerate improvement. Based on current trajectories and planned interventions, the Health Board is expected to achieve and exceed the March 2027 target of 11,387 delayed follow-up waits, delivering the lowest position recorded and establishing undation for continued reduction. | 31/03/27 |

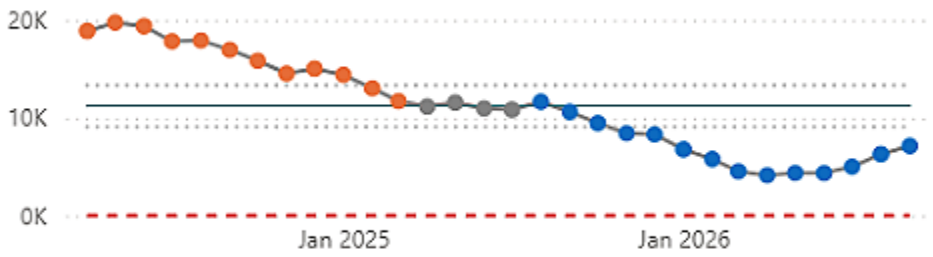
# Waits over 26 and 52 weeks for a first outpatient appointment

(Enhanced monitoring condition and Ministerial priority)



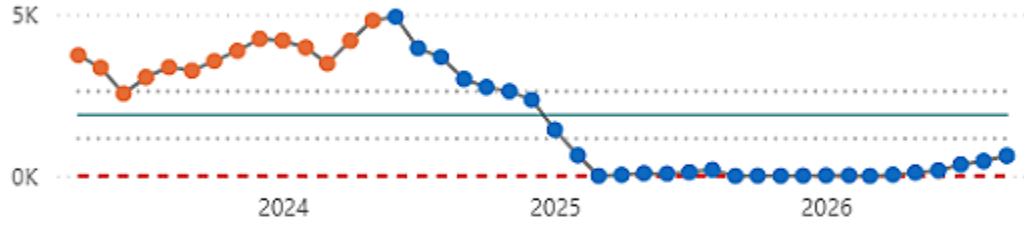
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**Patients waiting >26 weeks for a first outpatient appointment**




Performance has been deteriorating in recent months, and the 7,153 breaches recorded in September 2026 is the most since December 2025.

**Patients waiting >52 weeks for first outpatient appointment**



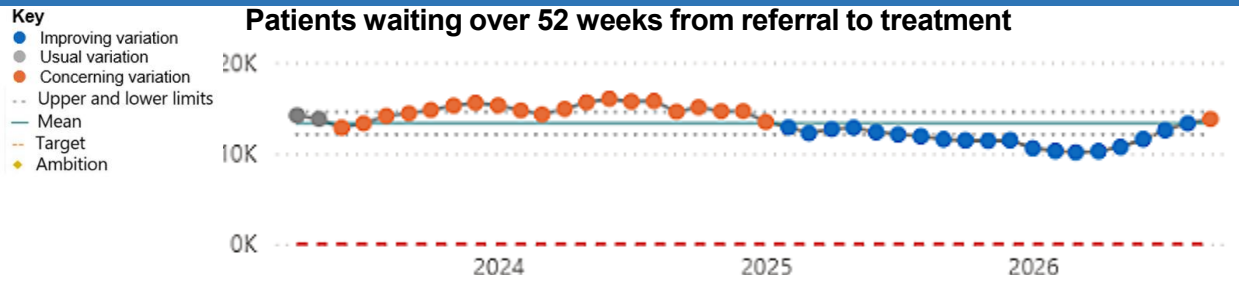

Performance has been deteriorating steadily since we met the target (0) in March 2026. Breaches in September 2026 (625) are the highest recorded in over 18 months. This is inline with our 2026/27 Annual Plan expectations.

| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| The Health Board reported 625 breaches of the 52-week Stage one outpatient target in September 2026. While this represents a deterioration in the breach position, this is consistent with the trajectory anticipated within the Annual Plan and reflects the current prioritisation of recovery resource. Recent Welsh Government recovery funding has principally focused on reducing >104-week total pathway waits, rather than Stage 1 outpatient waits. As a consequence, improvement in the 52-week Stage 1 position is expected to be more gradual while the Health Board prioritises the longest-waiting patients.<br><br>Specialty recovery plans remain in place, alongside outpatient transformation, demand and capacity management and targeted performance oversight. Colorectal, Vascular, Gastroenterology, Diabetic Medicine and Rehabilitation Medicine have achieved zero 26-week breaches. | • The Outpatient Transformation Programme, led by one of our consultant surgeons, is driving specialty-level improvement plans across all National Planned Care Programme priorities, including referral management, clinical triage, pathway redesign, expansion of See on Symptoms (SoS) and Patient Initiated Follow Up (PIFU) models, and outpatient productivity improvement.<br><br>• To strengthen recovery further, structured specialty deep-dive reviews are being undertaken during October 2026. These reviews will examine specialty-level trajectories, long waits, demand and capacity, clinic utilisation, DNA performance and follow-up demand, with targeted actions identified to maximise available capacity and strengthen delivery against the 26 and 52-week trajectories. While the 52-week position is expected to remain challenging in the short term, these actions will support progressive improvement alongside the Health Board's continued prioritisation of the longest total pathway waits. | 31/03/27<br><br>31/12/26 |

# Waits over 52 and 104 weeks from referral to treatment (RTT)

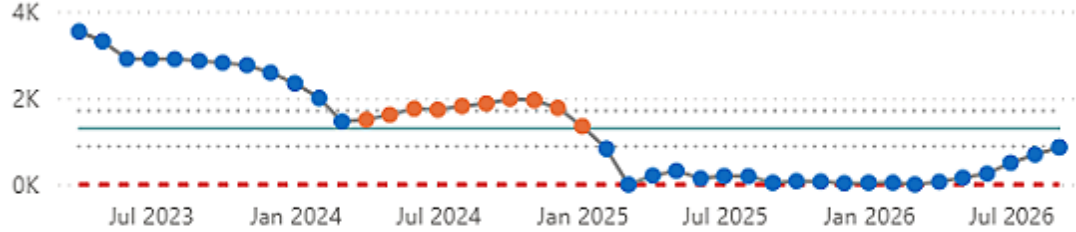
(Enhanced monitoring condition and Ministerial priority)

## Patients waiting over 52 weeks from referral to treatment




Performance is showing concerning variation for the first time in almost 2 years; waits have increased for the last 6 months to 13,765 in September 2026.

## Patients waiting over 104 weeks from referral to treatment




Performance has deteriorated for the last 6 months and breaches in September 2026 (862) are the highest since January 2025.

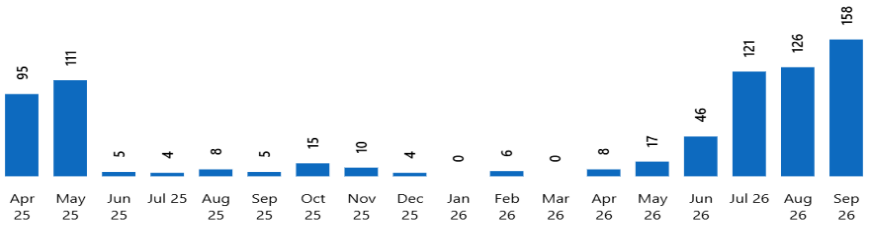
| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| • Current performance remains within the level anticipated in the 2026/27 Annual Plan trajectory. The revised recovery trajectory reflects the planned profile of improvement during the remainder of the year, with delivery now supported by the £12.85m Planned Care Recovery funding confirmed by Welsh Government on 23 September 2026.<br>• Achievement of the revised recovery trajectories is reliant upon full and timely delivery of the Health Board's approved Planned Care Recovery programme, following confirmation by Welsh Government on 23 September 2026 of the £12.85m recovery funding allocation. Delivery will require continued protection and optimisation of core capacity alongside the funded recovery schemes, with particular focus on Ophthalmology, Orthopaedics, ENT and Urology, which continue to carry significant long-wait cohorts. Progress will be monitored against agreed specialty trajectories, activity and waiting-list impact, with risks to delivery identified and mitigated through established recovery governance arrangements.<br>• Delivery of the Health Board's 2026/27 recovery ambitions remains dependent upon securing and deploying additional capacity, whilst balancing increasing demand, workforce constraints and financial sustainability requirements.<br>• Reducing unwarranted variation in productivity across specialties and sites remains a key challenge. Delivery of recovery funding is linked to demonstrating agreed productivity standards, including seven cataract procedures per operating list in Ophthalmology and four joint replacement procedures per list in Trauma & Orthopaedics, alongside wider getting it right first time (GIRFT) productivity requirements.<br>• Sustained delivery of a robust Stage 2 and Stage 3 administrative and clinical validation programme is planned from October 26 – March 27, to ensure waiting lists remain accurate; patients are clinically prioritised appropriately and recovery resources directed towards patients requiring treatment.<br>• Workforce availability, theatre utilisation, late starts, early finishes and the availability of specialist staffing continue to impact the ability to maximise elective capacity and maintain recovery trajectories.<br>• Continued delivery of the Theatre Optimisation Workstream and Outpatient Transformation Programme will be critical to achieving sustainable reductions in long waits and reducing reliance on non-recurrent recovery solutions. | • Approved Welsh Government Planned Care Recovery funding is being deployed to deliver targeted waiting list initiatives, clinical and administrative validation, and additional diagnostic and treatment capacity focused on the longest-waiting patients, accelerating reductions in waits over 104 weeks and overall waiting list size.<br>• Delivery trajectories remain under continuous review through robust demand and capacity planning arrangements, with a continued focus on achieving national planned care standards, reducing long waits and improving the long-term sustainability of services.<br>• The Theatre Optimisation Workstream is a key component of the Planned Care Recovery Programme. The workstream is led by the Clinical Care Group and reports to the Planned Care Transformation Programme Group, which is chaired by the Medical Director. It aims to improve theatre productivity and support delivery of GIRFT standards across specialties through a comprehensive review of staffing models, theatre utilisation, list loading and procedural productivity. Evidence-based standards are being implemented to reduce unwarranted variation between sites, maximise available capacity and support sustainable improvements in planned care performance. | 31/03/27<br>31/03/27<br>31/03/27<br>31/03/27 |

# Waits over 104 weeks from referral to treatment (RTT) - orthopaedic and ophthalmology

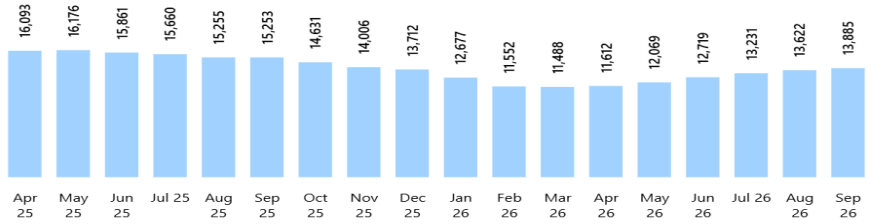
(Planned care recovery)



**Ophthalmology RTT waits over 104 weeks**

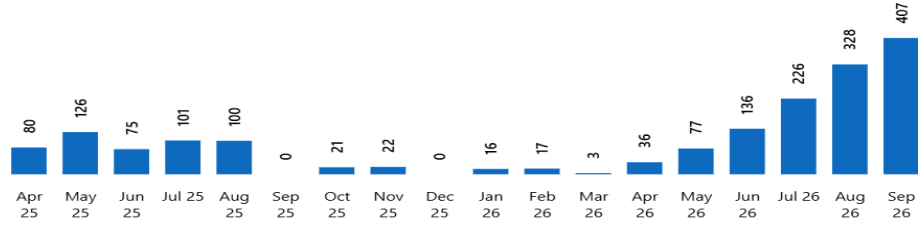



**Total Ophthalmology RTT waiting list**

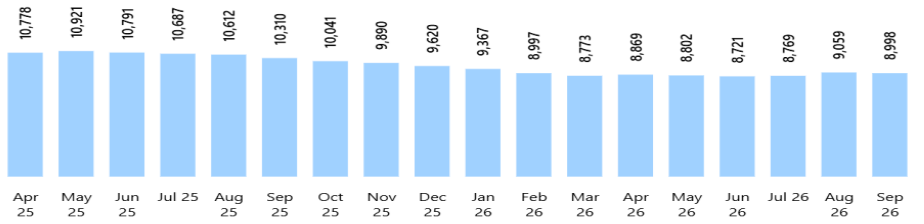



Ophthalmology patients waiting over 2 years for treatment has increased for the last 6 months to 158 in September 2026 while the total waiting list is also growing. This is inline with our 2026/27 Annual Plan expectations.

**Orthopaedics RTT waits over 104 weeks**




**Total Orthopaedics RTT waiting list**




Orthopaedics patients waiting over 2 years for treatment has increased for the last 6 months to 407 in September 2026 while the total waiting list volume is stable. Performance is outside our agreed 2026/27 Annual Plan trajectories due to the impact of Anaesthetics staffing in Bronglais Hospital and the recent scabies outbreak. Recovery actions have been agreed.

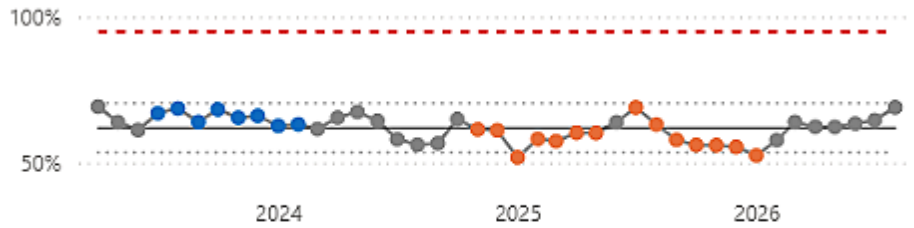
| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| • Continued Stage 2 and Stage 3 (awaiting diagnostic/post diagnostic pathway) administrative and clinical validation is required to ensure RTT pathways remain accurate and clinically prioritised, although currently meeting the Annual Plan trajectory. | • Administrative validation of all Stage 2 and 3 patients completed by 30 September 2026 to be followed by clinical validation and pathway review to ensure patients are appropriately prioritised and pathway data remains accurate. | 31/12/26 |
| | • Revised monthly trajectories agreed and underpin delivery plans for both Orthopaedics and Ophthalmology, strengthening accountability for reducing 104-week waits. | 31/03/27 |
| • Delivery of 104-week recovery trajectories remains dependent on securing sufficient treatment capacity and maintaining reductions in long-wait cohorts within Orthopaedics (T&O) and Ophthalmology. | • Achievement of revised recovery trajectories is reliant upon full and timely delivery of the Health Board's approved Planned Care Recovery programme, following confirmation by Welsh Government on 23 September 2026 of the £12.85m recovery funding allocation. Delivery requires continued protection and optimisation of core capacity alongside funded recovery schemes, with particular focus on Ophthalmology and Orthopaedics, which continue to carry significant long-wait cohorts. Progress will be monitored against agreed specialty trajectories, activity and waiting-list impact, with risks identified and mitigated through established recovery governance arrangements. | 31/03/27 |
| • Sustained productivity improvement required to achieve recovery ambitions, including delivery of 4 joint replacements per list and 7 cataract procedures per list where T&O and Ophthalmology form part of the allocation. | • Ophthalmology recovery actions include additional cataract capacity, outsourcing activity and pathway optimisation to maintain reductions in the longest waits. | 31/03/27 |
| | • Orthopaedic recovery actions include targeted insourcing/outsourcing, strengthened waiting list management and enhanced theatre utilisation to reduce 104-week waits. | 31/03/27 |
| • Required focus on maximising internal capacity via Treat in Turn principles, theatre utilisation, pathway optimisation and reduction of unwarranted cross-site variation. | • The Theatre Optimisation Workstream is implementing agreed productivity standards, including 7 cataracts per list, 4 joint replacements per list, improved theatre utilisation and getting it right first time-aligned practices. | 31/03/27 |
| | • Continued delivery of Treat in Turn principles, pathway optimisation and productivity improvements will support sustainable recovery a[illegible]e of internal capacity. | 31/03/27 |

# Ophthalmology R1 (high-risk patients) performance
(Targeted intervention )



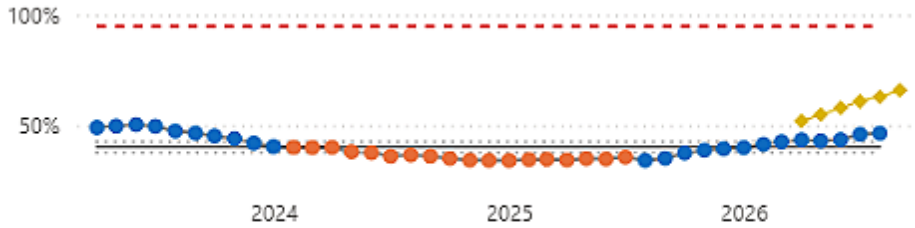
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**% R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date**




Performance has been improving for the last three months. Latest data (Aug 2026 = 69.1%) is the best recorded since April 2023.

**% R1 appointments waiting within their clinical target date or within 25% beyond their clinical target date**




Performance is showing steady improvement, with August 2026 (46.5%) the best performance in almost 3 years.

## Key challenges / issues

- R1 Ophthalmology remains a high-risk specialty, with Welsh Government prioritisation focussed on patients with the longest waits due to the increased clinical risk associated with delayed treatment. While prioritising these patients improves backlog reduction, it can negatively impact attended appointment performance in the short term as many have already breached. Performance is expected to improve as capacity increases and the backlog reduces.
- Workforce constraints continue to limit delivery, with vacancies across key medical roles including Consultants and Associate Specialists. Active recruitment remains ongoing.
- Outpatient nursing shortages at PPH and GGH continue to restrict Ophthalmology's ability to expand clinic capacity. The recruitment hold prevents additional clinics from being delivered, resulting in lost opportunities to increase activity and reduce waiting times.
- Insufficient nursing capacity is delaying the transfer of Intravitreal (IVT) services from Amman Valley Hospital (AVH) Day Theatre to AVH Outpatients three days per week. This prevents the release of Day Theatre capacity for additional cataract surgery, limiting opportunities to improve access and reduce backlogs.
- Plans to expand IVT provision at peripheral sites, including Debenhams, Carmarthen and Cross Hands Integrated Care Centre, were scoped to improve access closer to home. However, access to these facilities was not approved for Ophthalmology, limiting opportunities to increase capacity
- Without additional workforce and clinic capacity, there remains a significant risk to the recovery trajectory for R1 Ophthalmology performance and the timely treatment of high-risk patients.

## Key actions / initiatives

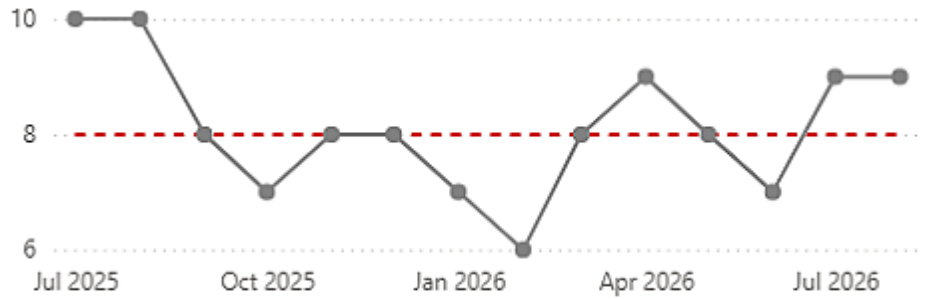
| Key actions / initiatives | Due date |
|---|---|
| • The service is exploring innovative workforce models, including the expanded use of Ophthalmology Technicians, to support outpatient delivery and increase capacity. | 01/03/27 |
| • Three combined Ophthalmology Technician / Health Care Support Worker posts are progressing through recruitment to strengthen clinical support capacity. | 01/04/27 |
| • One Specialty and Specialist (SAS) doctor has been successfully recruited and is awaiting a confirmed start date. | 01/02/27 |
| • One Consultant Ophthalmologist post is currently being progressed through the NHS Trac recruitment system. | 01/04/27 |
| • Following six unsuccessful recruitment campaigns, a regional Consultant Ophthalmologist for Age-related Macular Degeneration (AMD) has been appointed. The prolonged vacancy impacted the service's ability to deliver additional outpatient capacity, particularly for patients requiring medical retina follow-up and treatment. | 01/04/27 |
| • Delivery of the Cataract Plan continues, with outsourcing activity having begun in order to achieve zero patients waiting over 104 weeks by March 2027. | 01/04/27 |
| • A Plastics Recovery Plan is currently being developed to increase capacity, reduce long waits and support the zero patients waiting over 104 weeks by March 2027. | 01/04/27 |

## Embedded improvement actions

- The service remains actively engaged in regional Ophthalmology discussions to identify collaborative solutions, maximise capacity and support recovery across key areas. This will provide the greatest benefit to Cornea, Orthoptic and Adult Squint services.
- Validation activity continues, ensuring waiting lists remain accurate and clinically appropriate. Where suitable, patients are being discharged to community optometrists for ongoing monitoring, allowing acity to be focused on patients requiring specialist ophthalmic intervention.

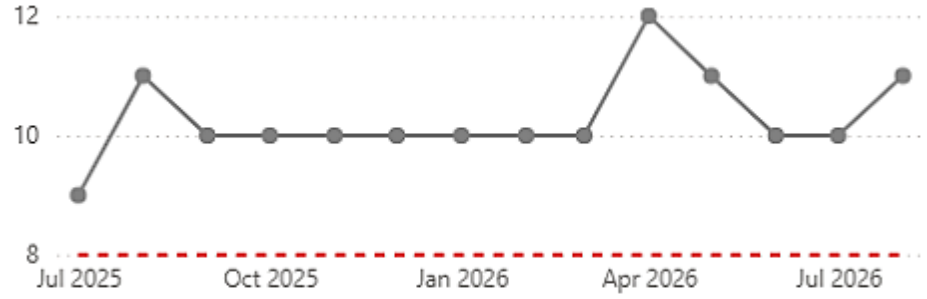
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**Median emergency ambulance response time to purple: arrest category calls**




In August, the median response time was 08:45 minutes for ARREST (Purple) Calls. There were 133 ARREST calls. Official WAST data is delayed by 1 additional reporting month.

**Median emergency ambulance response time to red: emergency category calls**




In August the median response time was 10:59 minutes for RED (Emergency) calls there were 608 calls. Official WAST data is delayed by 1 additional reporting month

## Key challenges / issues

- Unverified September performance was 11:20 minutes for arrest (55 incidents) and 11:05 minutes for emergency calls (374 incidents). Overall attended demand in Hywel Dda Health Board area for August 2026 has been almost as forecast.
- Hospital delays in ambulance handover for Welsh Ambulance Service Trust (WAST) ambulance crews, 2,814 hours lost at the 4 acute Hywel Dda hospital sites during September 2026, showing a deterioration over performance from July and August 2026.
- Notification to Handover within 15 minutes was at 31.9% in September for the 4 acute general hospitals, showing slight deterioration over August 2026.
- Orange NOW calls totaled 880 calls, with WAST providing an at scene attendance at 879 of these incidents.
- NOW response Median was 01:41 hours and the 90th Percentile was 05:9 hours across the Health Board for September 2026.
- Immediate Vehicle Requests (IVR) totaled 26 requests in September, of which 22 were actioned, and 4 were not. This represents an IVR acceptance rate of 84.62%.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| • Call Before Convey now LIVE across Health Board, early, unverified performance figures show significant reduction in Ambulance conveyances.<br>• WAST Operations joining 09:30 am Patient Flow call regularly to further support integrated working and collaboration. | 31/10/26 |

## Embedded improvement actions

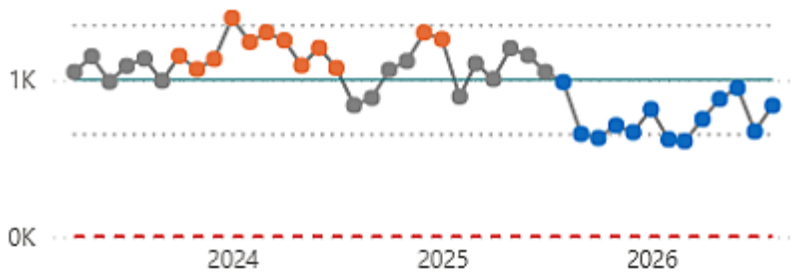
- Ongoing reviews of WAST resource escalation action plan (REAP) which identifies potential service pressures and is a system for managing and mitigating the impacts.
- Dynamic review of demand and area specific pressures using the clinical safety plan. Clinical safety plan provides a framework for WAST 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.
- Ambulance arrivals process standardised across the Health Board and making early progress.
- WAST resourcing reviews and targeted overtime allocation.
- Wait 45 initiative implemented, which will reduce length of ambulance wait times outside emergency departments, and project group now established with Senior Managers to deliver NHS Performance & Improvement actions. These meetings are now weekly for urgent progress.

# Urgent and Emergency Care – Ambulance and Emergency Departments / Minor Injury Units - Health board wide

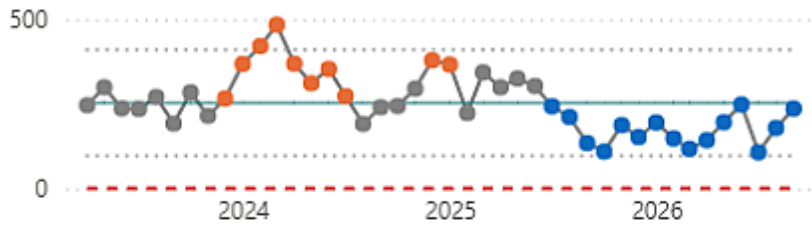
(Targeted intervention and Ministerial priority)



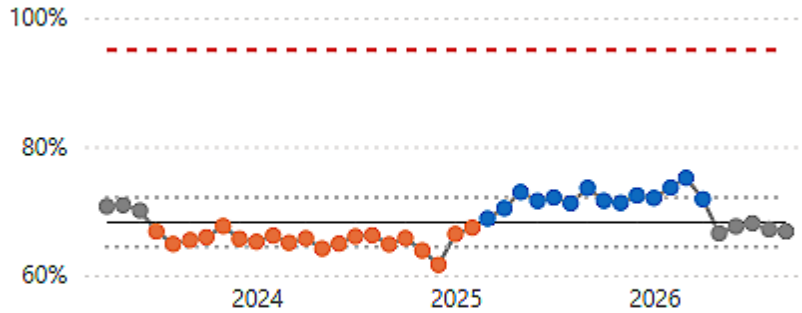

**Ambulance handovers taking over 45 minutes**



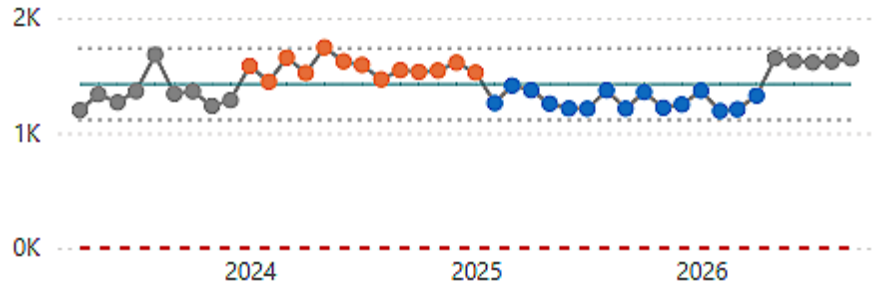

**Ambulance handovers taking over 4 hours**




**Patients waiting less than 4 hours in A&E/MIU**




**Patients waiting over 12 hours in A&E/MIU**




**>45 Minutes handovers:**
There has been a national change in definition for this metric, we are awaiting data for September. August 2026 is showing improving variation, 833 handovers > 45 minutes out of a total of 2,136 handovers.

**>4 hours handovers:**
Latest data is showing improving variation, 236 handovers > 4 out of a total of 1,981 = 12%, which is an increase of 4% from last month.

**Waits < 4 hours:**
Latest data is showing usual variation 10,849 patients out of 16,237 new attendances seen in < 4 hours, 67%.

**Waits > 12 hours:**
Latest data is showing usual variation. 1,649 patients waited over 12 hours, out of 16,237 new attendances, 10.2%.

## Key actions / initiatives – tactical urgent and emergency programme

Hywel Dda's Urgent and Emergency Care (UEC) Programme delivery is focused on implementing the national Three Pillars approach through a whole-system approach, including strengthening community-based alternatives (e.g. falls response and prevention services), improving front-door streaming and Same Day Emergency Care (SDEC), and reducing avoidable admissions and discharge delays. The three pillars are based on pre-hospital and community care, the hospital front door and first 72 hours care and ward based patient flow and discharge. Central to this is the implementation of the Seven-Day Clinical Streaming, Hospital@Home and SDEC business case, the co-development of a 45-minute ambulance handover improvement plan and the continued roll out of the Optimal Hospital Flow programme. These aims to improve patient flow, enhance outcomes, and align with ministerial priorities by enabling earlier intervention, reducing emergency department demand, and supporting a sustainable 'shift-left' model of care across acute and community pathways. Currently the Go-Live date for Seven-Day Clinical Streaming and Hospital@Home is November 2026, and the 7-day WGH SDEC is planned to be phased in from January 2027.

Please see the updates for each of our 4 acute site for the relevant issues faced and key actions we are taking to address:

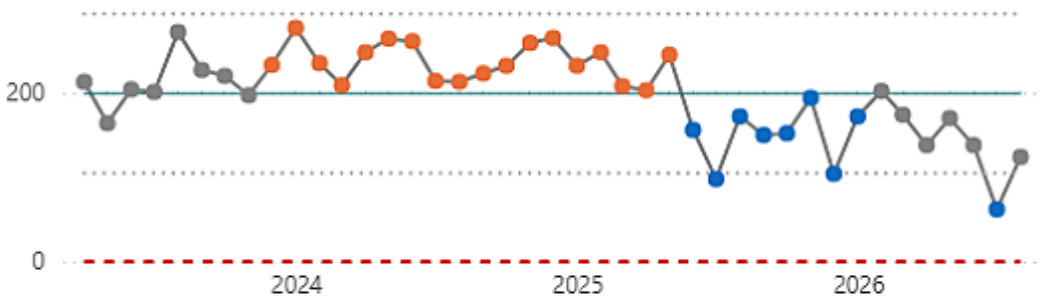
- Bronglais Hospital
- Glangwili Hospital
- Prince Philip Hospital
- Withybush Hospital

# Urgent and Emergency Care – Ambulances – Bronglais Hospital

(Targeted intervention and Ministerial priority)

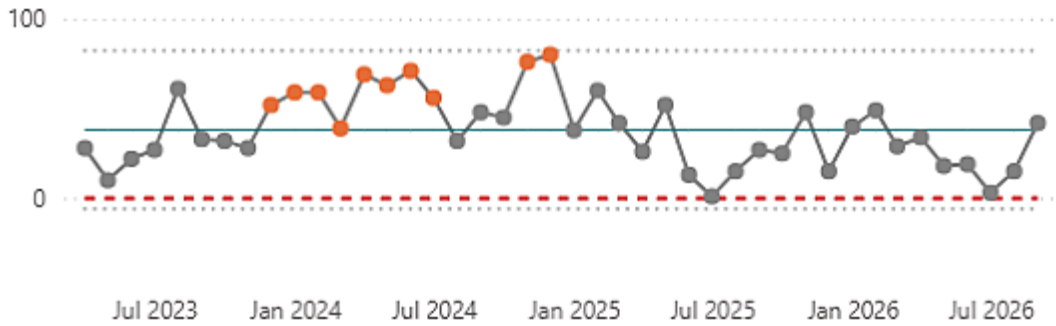
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

### Ambulance handovers taking over 45 minutes




There has been a national change in definition for this metric, we are awaiting data for September. August 2026 is showing usual variation. 124 handovers >45 minutes reported out of a total of 405 handovers, 31%.

### Ambulance handovers taking over 4 hours




September 2026 is showing usual variation. 42 handovers >4 hours was reported out of 368 total handovers 11%.

## Key challenges / issues

- Limited Emergency and Urgent Care Centre (EUCC) clinical space and inpatient capacity constrain ambulance handover, especially when arrivals cluster.
- Clinically optimised patients awaiting discharge, community support or social care reduce bed availability for patients in EUCC.
- Delayed senior decisions, medicines, transport and diagnostics can carry discharge pressure through the weekend into Monday.
- Limited surge capacity requires close oversight of staffing, patient safety and plans to stand down escalation areas.
- Surges in patient demand (winter pressures, seasonal illnesses, major incidents) causing greater demand than capacity.
- Accurately reporting handover times is often a challenge. Requirement of dual pin to ensure handover times are recorded appropriately.
- Sustained emergency demand above available capacity.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| • Reinforce the 45-minute handover standard operating procedure (SOP): escalate at 30 minutes, use bedside handover and transfer promptly when a ward bed is ready. | 30/11/26 |
| • Maximise discharge before midday. Trial discharge lounge when staffing allows. | 14/10/26 |
| • Maximise weekend discharge. Trial acute physician at the front door on weekend of 17th/18th October. | 17/10/26 |
| • Miya system emergency department (ED) module roll out to support flow | 01/01/27 |

## Embedded improvement actions

- New Senior Nurse Manager for EUCC in post.
- Continue consultant and ED Navigator oversight, ward-manager coordination and shared system ownership of handover performance.
- Maintain twice-daily flow reviews, live MIYA updates and daily review of clinically optimised patients. Use “Our Next Patient” for ward transfers.
- Continue the weekly multi disciplinary team (MDT) handover touchpoint chaired by the Assistant General Manager. Review breaches over 45 minutes and track actions with WAST.
- Maintain early senior decisions, criteria-led discharge and weekend therapy/mobility plans. Assign [illegible]onday barriers and confirm the discharge list by 10:00
- [illegible]onvey initiative – to prevent avoidable conveyances.

# Urgent and Emergency Care – Emergency Departments – Bronglais Hospital

(Targeted intervention and Ministerial priority)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

### Patients waiting less than 4 hours in A&E/MIU

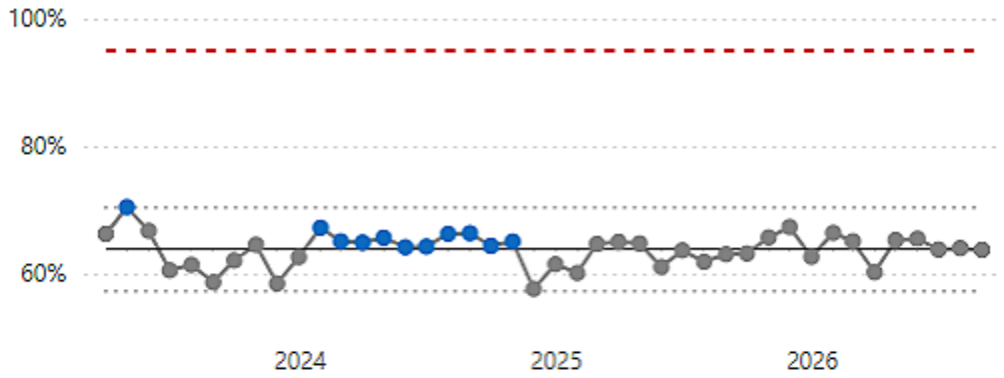
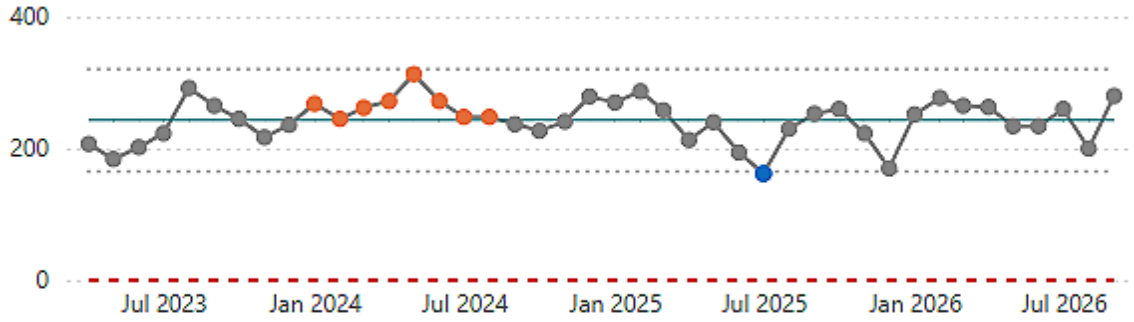



Chart is showing usual variation. 980 breaches out of 2,704 new attendances, 36%

### Patients waiting over 12 hours in A&E/MIU




The chart is showing usual variation. 280 breaches out of 2,704 new attendances, 10%.

## Key challenges / issues

- Physical space limitations within the Emergency Department footprint including limited assessment and trolley spaces to absorb ambulance arrivals during peak times leading to overcrowding and corridor usage.
- Limited senior medical workforce across the Ceredigion Acute & Community System can lead to delays in initial assessment, diagnostics and treatment.
- High bed occupancy on wards leading to long lengths of stay and delays in transfers to wards.
- Limited community capacity and social care packages.
- Sustained emergency demand above available capacity.
- Delayed transfers of care affecting patient flow - downstream capacity.
- Increase in infection across ward areas resulting in closed beds.
- Limited surge bed capacity across the Acute site.
- Delays in access to theatres contributes to poorer outcomes for patients and subsequent increased length of stay.

## Key actions / initiatives

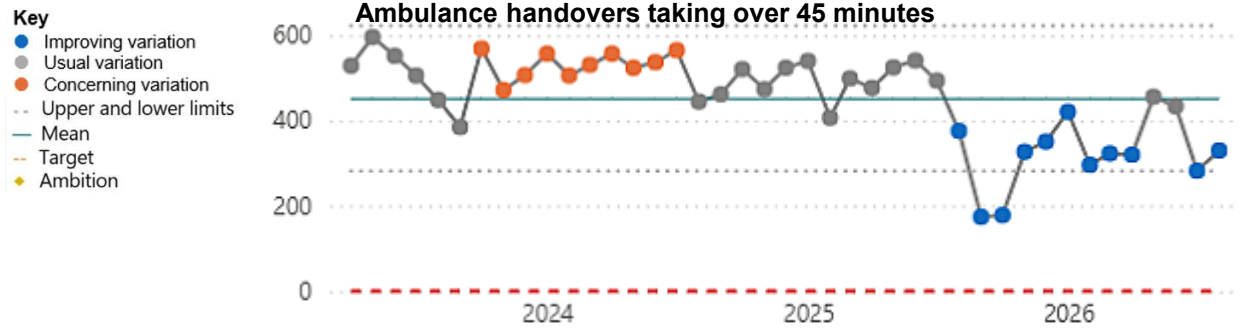
| Key actions / initiatives | Due date |
|---|---|
| • Reconfiguration of the Emergency Department footprint to enhance flow throughout the department - MDT approach to design. | Completion April 2027- work started |
| • Review of clinical pathways across the Ceredigion Acute & Community System. | Ongoing |
| • Quality improvement projects – weight and creatinine/VTE, clinical frailty score, MRI/CT requests, patient information and assurance. | 01/11/26 |
| • Focussed daily scrutiny on prevention and reduction of 12-hour wait breaches. | Ongoing |

## Embedded improvement actions

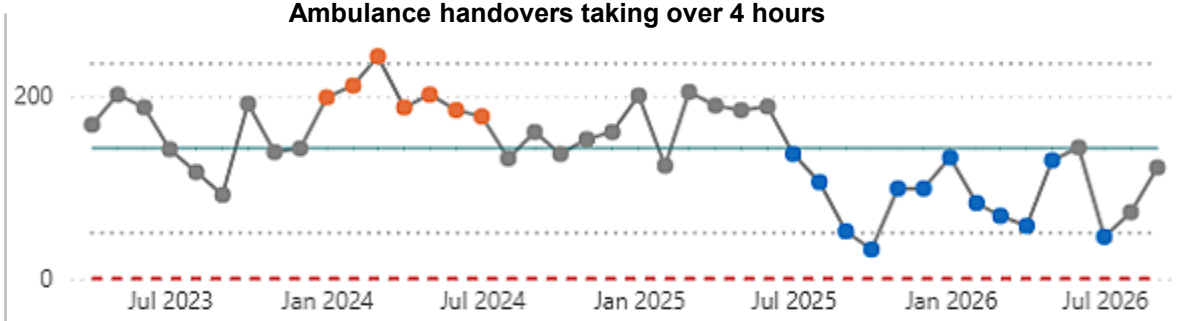
- Successful recruitment of Senior Nurse Manager for the Emergency Department.
- Increased scrutiny on patients in non-clinical areas.
- Review of Your Next Patient
- Daily review of all patients at risk of breaching 12 hours with escalation SOP embedded
- Daily review of all clinically optimised patients
- Focus on earlier in the day discharges
- Bedside handover SOP implemented
- Escalation of delayed pathway of care patients
- S[illegible]tnership working with Local Authority to minimise delays in discharge

# Urgent and Emergency Care – Ambulances – Glangwili Hospital

(Targeted intervention and Ministerial priority)




There has been a national change in definition for this metric, we are awaiting data for September. August 2026 shows improving variation. 329 handovers >45 minutes reported out of a total of 820 handovers, 40%.




September 2026 is showing usual variation. 122 handovers >4 hours reported out of a total of 800 handovers, 15%.

## Key challenges / issues

Significant overcrowding and sustained surge pressures continue in ED. Whilst there are some encouraging signs of improvement, demand across the system remains extremely challenging. These factors contribute to ongoing pressure.

- We have seen a small reduction in ambulance arrivals compared to the same period last year; however, overall ED attendances have increased, resulting in continued pressure on capacity and resources. Despite the reduction in ambulance conveyances, combined with the increased volume of patients attending the department's, the overall patient flow has remained static.
- Patient flow out of the ED remained slow, which affected our ability to create sufficient capacity for timely ambulance handovers. As a result, achieving the 45-minute ambulance handover target remained challenging, with delays occurring during periods of peak demand.
- Continued poor flow through the hospital is closely linked to the increasing number of clinically optimised patients who are ready to leave hospital but are awaiting onward care or discharge arrangements. The number of these patients within GGH has increased further this month, placing additional pressure on inpatient bed capacity and consequently impacting patient flow from the ED.
- Operational pressures further exacerbated by significant workforce challenges. We experienced substantial nursing workforce shortfalls due to additional sickness absence on top of and planned annual leave. Similar pressures observed within the medical workforce, compounded by the annual junior doctor changeover period, which has impacted staffing availability and service resilience across the site.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| • Redline standard operating procedures (SOP) signed off and implemented, this initially could impact negatively (in reducing boarding space), however this should maintain clinical spaces, to allow timely handover and a safer department. | 30/11/26 |
| • Handover 45 minute standard operating procedure being worked up by Health Board. | 31/10/26 |
| • Developing a QR code to "man mark" ambulance handover delays, this will give us a tool to monitor the delays and support change which is in our sphere of influence. | 30/11/26 |
| • Call before convey initiative implemented through the clinical streaming hub to avoid conveyances to acute hospital, with continued monitoring. | 31/10/26 |
| • Further work needed to develop actions for streamline clinical pathways. Patients requiring a specialty bed should have one allocated in a timely manner, without needing an ED attendance. | 31/12/26 |
| • Further work needed to develop actions for the Carmarthenshire falls and head injuries pathway to ensure only appropriate patients are transferred to Glangwili. Collaborative working required between community and the Eastgate streaming hub. | 31/12/26 |

## Embedded improvement actions

Continue to monitoring early discharges and the utilisation of the discharge lounge. Out of area patient cohort being monitored twice weekly. This enables specialty patient pathways to be managed. Clinically optimised patients are reviewed through a structured senior nurse team. Escalation process embedded regarding any delay in patent care or patient care pathways delays. Same Day Emergency Care (SDEC) team actively "pull" from ED. Daily Site Flow Coordination. Site flow calls are embedded to provide real-time oversight of capacity, patient movement, and escalation requirements, ensuring timely decision making and prioritisation of transfers. Myia flow being monitored with the EDs and actual [illegible]onthly collaborative meetings with GGH operational team and WAST.

# Urgent and Emergency Care – Emergency Departments – Glangwili Hospital

(Targeted intervention and Ministerial priority)

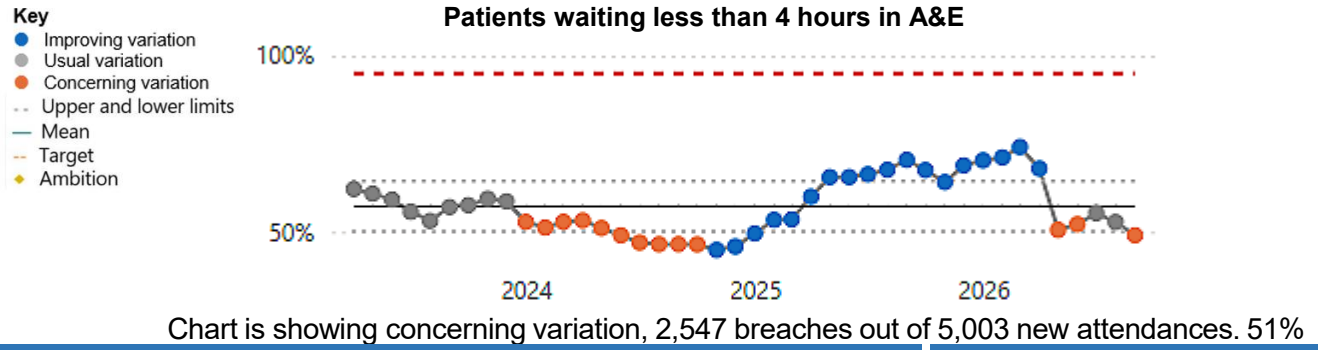



Chart is showing concerning variation, 2,547 breaches out of 5,003 new attendances. 51%

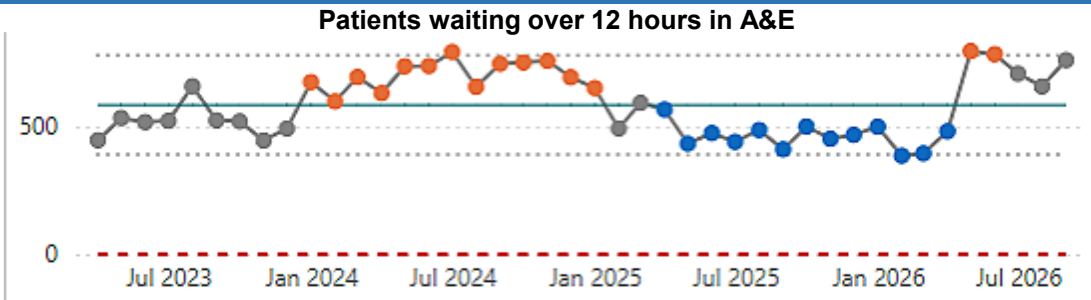



Chart is showing usual variation 758 breaches out of 5,003 new attendances, 15%.

## Key challenges / issues

- Sustained demand, high patient acuity and ongoing challenges in maintaining patient flow through the hospital.
- Delays in transferring patients to wards reduce ED capacity, contributing to longer waits for assessment, treatment & admission.
- Demand remained particularly high among medical patients, with delays in discharge and onward care arrangements continuing to place significant pressure on overall ED performance.
- The drivers of 12-hour waits are inpatient capacity constraints, delayed discharges and extended lengths of stay for patients with complex medical and social care needs. These limit bed availability and restrict patient flow. During periods of heightened demand, these pressures intensify, resulting in an increased number of patients experiencing prolonged stays within the ED.
- Continued focus on whole-system patient flow, discharge optimisation and reducing delays in discharge and onward care will be essential to improving performance and reducing the number of patients experiencing extended waits within the ED. The new Call Before You Convey process, delivered with the Welsh Ambulance Services NHS Trust, has helped reduce breaches of the 45-minute ambulance handover target. However, transferring patients into hospital more quickly has increased pressure on wards and required surge capacity to maintain flow.
- Patient flow has also been disrupted by scabies outbreak on individual pathway wards which resulted in reduced bed capacity and delays in patient transfers from the ED.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| • Operational and clinical teams continue to prioritise patient flow through early senior clinical review, maximising SDEC and ambulatory care pathways, and expediting discharge processes. Daily oversight of long-wait patients, supported by MDT flow meetings and strengthened escalation arrangements, helps facilitate timely decision-making and minimise delays across the patient pathway. Expected to become embedded actions by the end of October 2026. | 31/10/26 |
| • Maintain a “Home First” ethos, actively exploring opportunities to avoid unnecessary admission and facilitate discharge where clinically appropriate. Expected to become embedded actions by the end of October 2026. | 31/10/26 |
| • Utilise the Liaison Medical Team to provide proactive clinical oversight of patients experiencing extended waits in ED, ensuring patients are medically managed whilst awaiting definitive placement. | 31/10/26 |
| • Provide assurance that all patients received a clinical review and documented management plan. | 31/10/26 |
| • Ensure that patients requiring admission are on an agreed specialty pathway, with clear ownership and escalation where delays occur. Further development of the occupational change process and development of dedicate triumvirate with the clinical lead and senior nurse, need to takes place. | 04/01/27 |
| • Work collaboratively with community, therapy, discharge and patient flow teams to maximise opportunities to support patients out of hospital and improve flow across the system. Integrated community and medicine 7 day working. | 31/10/27 |

## Embedded improvement actions

Explore opportunities to utilise Clinical Decision Unit, SDEC and MIU capacity for appropriate patients requiring monitoring and observation, reducing pressure within the ED. To undertake a twice-daily review of the ten patients experiencing the longest waits in the ED, identifying themes, delays, risks and alternative opportunities rather than admission. Track and monitor all patients waiting more than 12 hours through the site management meetings, ensuring timely escalation and oversight of prolonged waits .Continue to monitoring early discharges and the utilisation of the discharge lounge. Out of area patient cohort being monitored twice weekly. This enables specialty patient pathways to be managed. Clinically optimised patients [illegible] through a structured senior nurse team. Escalation process embedded regarding any delay in patent care or patient care pathways delays. SDEC team actively "pull" from ED.

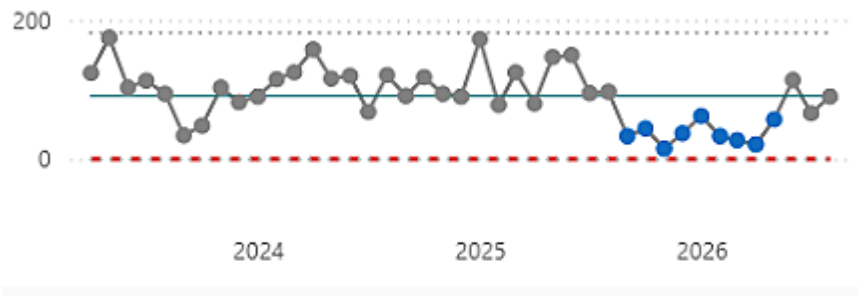
# Urgent and Emergency Care – Ambulances – Prince Philip Hospital

(Targeted intervention and Ministerial priority)



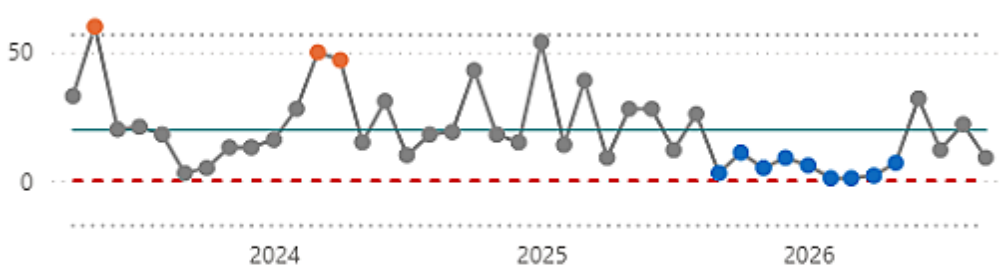
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**Ambulance handovers taking over 45 minutes**




There has been a national change in definition for this metric, we are awaiting data for September. August 2026 is showing usual variation. 90 handovers >45 minutes reported out of a total of 243 handovers, 37%.

**Ambulance handovers taking over 4 hours**




September 2026 is showing usual variation. 9 handovers >4 hours reported out of a total of 191 handovers, 5%.

## Key challenges / issues

- Prince Philip Hospital continues to face significant pressure from high urgent and emergency care demand, high bed occupancy, delayed discharges and workforce constraints. These pressures affect bed availability, ambulance handovers and the movement of patients through the Emergency Department, assessment areas and inpatient wards.
- The new Call Before You Convey process, delivered with the Welsh Ambulance Services NHS Trust, has helped reduce breaches of the 45-minute ambulance handover target. However, transferring patients into hospital more quickly has increased pressure on wards and required surge capacity to maintain flow.
- Patient flow has also been disrupted by a prolonged scabies outbreak. Isolation, treatment, deep cleaning and environmental decontamination led to ward bays being closed for extended periods, reducing bed capacity, delaying patient placement and requiring substantial clinical, operational and domestic support. The outbreak was controlled through joint working between clinical teams, Infection Prevention and Control specialists and operational managers, but it affected hospital performance during the reporting period.
- Medical patients in the Minor Injury Unit continue to be prioritised for transfer to the Acute Medical Assessment Unit. They are reviewed daily and tracked through site flow meetings, while a weekly task-and-finish group is refining handover criteria and redesigning the pathway. Daily multidisciplinary oversight, the Patient Flow Unit and escalation arrangements remain central to maintaining safe care and improving flow.

## Key actions / initiatives

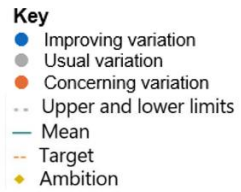
| | Due date |
|---|---|
| • Continue Call Before You Convey to confirm that hospital transfer is clinically appropriate and reduce avoidable conveyances during operational pressure. | 31/12/26 |
| • Manage scabies outbreaks promptly by isolating suspected or confirmed cases, contact tracing, enhancing cleaning and decontamination, and monitoring risks through Infection Prevention and Control teams. | Ongoing |
| • Protect available capacity by using surge areas where appropriate, prioritising discharges and transfers, and balancing isolation needs with demand for side rooms and cubicles. | 31/10/26 |

## Embedded improvement actions

- Maintain real-time patient flow oversight through the Patient Flow Unit, coordinating admissions, discharges, transfers and bed use to support timely ambulance handovers.
- Coordinate daily operational decisions through site flow meetings, with clinical, operational, domestic and infection-control teams identifying alternative patient placements and reopening affected areas safely.
- Strengthen multidisciplinary oversight through daily flow discussions, escalation meetings, Manager of the Day leadership and Patient Flow Unit coordination, so barriers are resolved quickly and delays are reduced.
- Prioritise medical patients in the Minor Injury Unit for transfer to the Acute Medical Assessment Unit, reviewing patient location, transfer delays, bed availability and capacity throughout the day.
- Escalate transfer barriers in real time and continue weekly task-and-finish work to improve handover criteria, move patients to the right care setting earlier and protect Minor Injury Unit capacity.

# Urgent and Emergency Care – Emergency Departments – Prince Philip Hospital

(Targeted intervention and Ministerial priority)




**Patients waiting less than 4 hours in MIU**

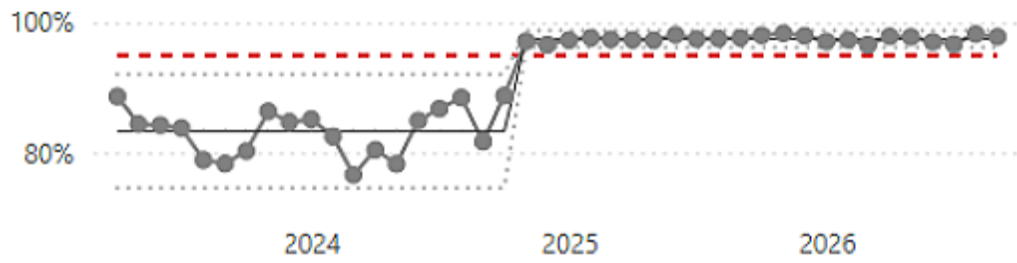



Chart is showing usual variation. 59 breaches out of 2,748 new attendances 2%

**Patients waiting over 12 hours in MIU**

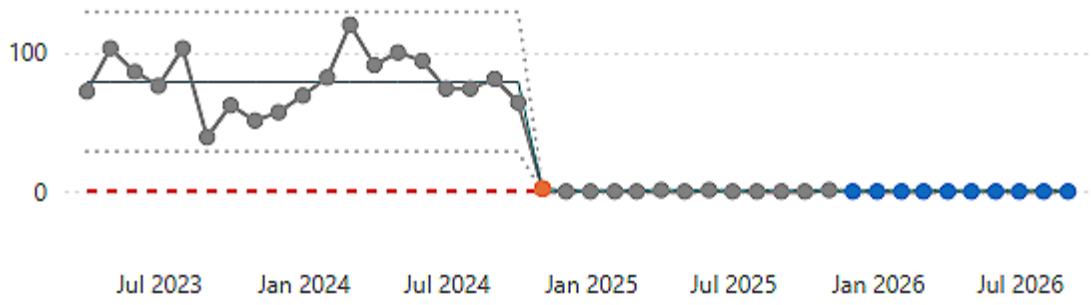



Chart is showing improving variation. Zero breaches out of 2,748 new attendances.

## Key challenges / issues

- A scabies outbreak was declared at Prince Philip Hospital on 21 September 2026 after a patient with highly infectious crusted scabies was admitted. Seven patient cases were confirmed. Nine staff and around 60 other contacts required assessment, treatment or follow-up. Immediate control measures were introduced jointly by Infection Prevention and Control, clinical teams, Occupational Health and operational management.
- Development of the Urgent Care Centre (UCC) model is progressing through joint working between the Minor Injury Unit and Same Day Emergency Care teams. This has improved service integration, understanding of demand and use of care pathways. Aligning processes is helping direct patients to the right service sooner, reduce duplication and improve timely assessment and treatment. Joint workforce planning is also supporting skill sharing, role development and greater flexibility. The model aims to reduce avoidable use of acute hospital pathways, expand ambulatory and same-day care, improve patient flow and experience, use clinical resources more efficiently, and create capacity to meet future urgent and emergency care demand.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| • Complete contact tracing for all potentially exposed patients, staff and visitors, including patient movements, discharged patients and staff contacts. | 31/10/26 |
| • UCC: Maintain preparations for the 23 November launch, building on successful testing of pathways, triage, patient flow, staffing and clinical-risk oversight, ensuring the IT issues identified during the pilot are resolved through handover and commissioning before go-live. | 30/11/26 |

## Embedded improvement actions

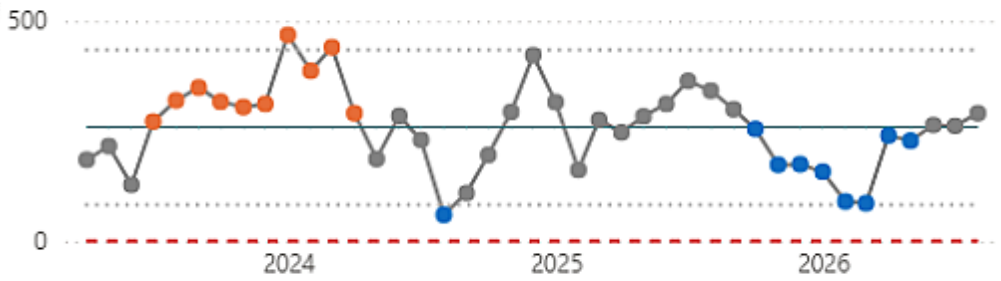
- Issue clear “Warn and Inform” advice on exposure, symptoms, treatment and follow-up to affected people and relevant healthcare providers.
- Maintain proportionate visiting restrictions, individual risk assessments for essential visits, patient isolation, enhanced cleaning, protective clothing and symptom surveillance.
- Continue tracing and monitoring linked cases across Wards 4 and 7, Ward 5 Step-Down Unit and Mynydd Mawr Rehabilitation Unit, managing confirmed cases under outbreak-control procedures.
- Confirm containment through ongoing surveillance and report actions, learning and recommendations through the October 2026 Scabies Outbreak Review and Health Board governance routes.
- Work with community health, social care and discharge teams to reduce delays for medically optimised patients and improve flow.
- Expand General Medicine Hot Clinic capacity through job planning where clinically and operationally feasible.
- Introduce enhanced daily multidisciplinary reviews for patients with complex discharge needs.
- Continue weekly task-and-finish meetings to develop the future UCC operating model.
- Continue working w[illegible]vention and Control to minimise transmission and protect patients and staff.

# Urgent and Emergency Care – Ambulances – Withybush Hospital

(Targeted intervention and Ministerial priority)

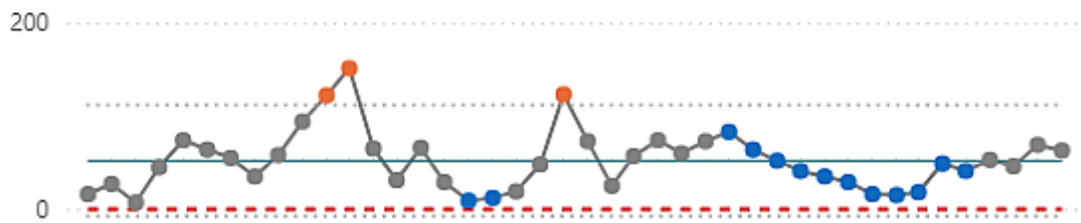
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

## Ambulance handovers taking over 45 minutes




There has been a national change in definition for this metric, we are awaiting data for September. August 2026 is showing usual variation. 290 handovers >45 minutes reported out of a total of 667 handovers, 43%.

## Ambulance handovers taking over 4 hours




September 2026 is showing usual variation. 63 handovers >4 hours reported out of a total of 622 handovers, 10%.

## Key challenges / issues

- Trend of increasing monthly total conveyances seen month on month since April 2026 with a reduction of approximately 50 ambulances received when comparing August with September.
- Ambulance handover performance was negatively impacted by an increase of approximately 500 patients admitted to ED in both July and August (recognized as increased seasonal demand) with a high number of these cases being out of area patients with a degree of complexity (frailty, multiple comorbidities, no local recourse to social care).
- Local challenges across Health & Social Care in Pembrokeshire across July and August were noted, a result of higher rates of planned leave combined with an increased sickness absence rate.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| • Revised daily meeting schedule with the Health Board Patient Flow Unit – now meeting 0930hrs & 1430hrs to support regular oversight and early escalation of ambulance handover challenges | 21/09/26 - ongoing |

## Embedded improvement actions

- WAST Handover Microsoft Teams Channel (Withybush) providing direct interface between WAST
- MIYA Flow process (Digital Hospital Bed Management)
- Dedicated resource (Band 6 nurse) allocated to "Pitstop" to lead on ambulance handover coordination
- Direct referrals from WAST into Clinical Streaming Hub, Same Day Emergency Care and Frailty Same Day Emergency Care.
- Close co-ordination with WAST regarding daily Advanced Paramedic Practitioner (APP) Navigator cover in Pembrokeshire
- Call Before Convey Go-Live 28th Sept 2026 - monitoring output

# Urgent and Emergency Care – Emergency Departments – Withybush Hospital

(Targeted intervention and Ministerial priority)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**Patients waiting less than 4 hours in A&E**

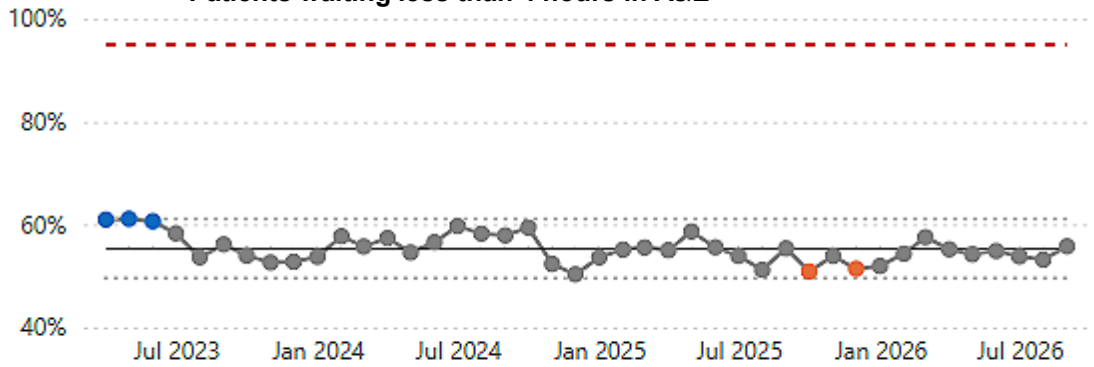



Chart is showing usual variation. 1,773 breaches out of 4,009 new attendances, 44%.

**Patients waiting over 12 hours in A&E**

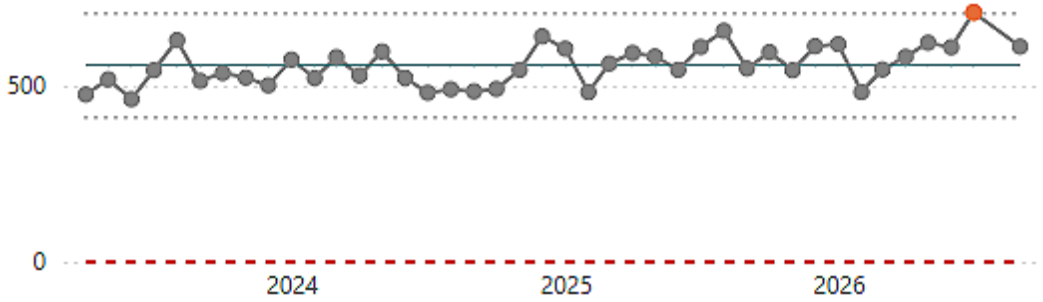



Chart is showing usual variation. 611 breaches out of 4,009 new attendances, 15.%.

## Key challenges / issues

- Increased total monthly ED attendances trend since April 2026 with a peak in July of 4,504 followed by August on 4,466. For context April saw 3,873 attendances at Withybush ED. September saw a reduction to 4,031 – in keeping with seasonal challenges.
- Periods of high demand matched with high acuity of patient caseload with the ED department. Inpatient capacity compounded by limited flow out of the acute with a noted increased discharge delays across August – Pathway Of Care Delays in part due to multi-agency challenges maintaining operational capacity across August due to annual leave and sickness.
- Additional challenges seen with increased mental health attendances including for mental health patients already admitted to an Hywel Dda Mental Health inpatient service – plans now in place to better support direct admissions to medicine for those cases from inpatient Mental Health services to eliminate the unnecessary visit to ED.
- Local challenge with re-ablement beds pathway in September – Pembrokeshire Council working closely with health to support, but staffing was an issue for the Local Authority.

## Key actions / initiatives

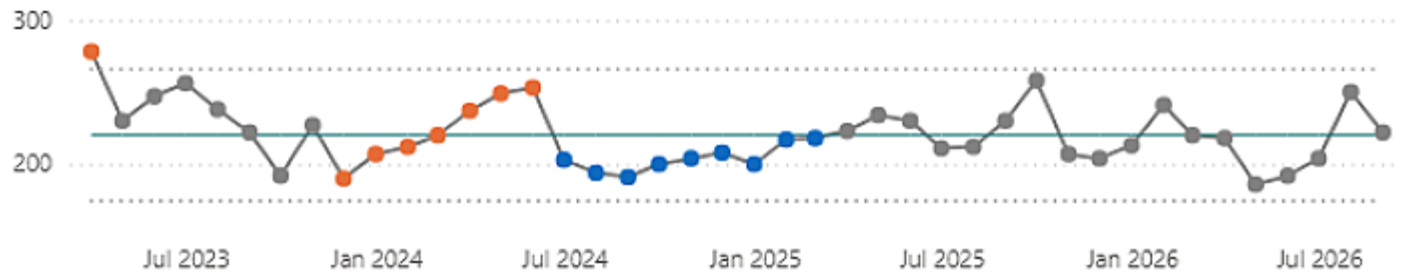
| Key actions / initiatives | Due date |
|---|---|
| New ownership model for overnight post-take patients agreed with consultants, encouraging specialty in-reach into ED to manage post-takes in the first instance | 19/10/26 |
| Expand Medical Same Day Emergency Care Unit into a working 7-day model | 31/01/27 |
| Deploy senior decision maker alongside the Frailty Assessment Model in the Emergency Department | 31/01/27 |
| Drive average length of stay reduction, targeting cases from 0-50 days in the acute hospital setting, improving flow and admitting capacity. | 31/01/27 |

## Embedded improvement actions

- Frequent reviews of 12hr waits to ensure that they are marked for the correct ward and pathway
- Wards to attend the ED at start of shift to review patients awaiting beds and develop plans for transfer of these patients to the wards
- MIYA Flow Process (Digital Bed Management)
- Direct referrals from WAST into the Clinical Streaming Hub, Frailty Same Day Emergency Care and Medical Same Day Emergency Care Unit
- Acute Medicine and Specialty In-reach into ED
- Proactive screening and pull through of Frailty patients from ED into the Acute Frailty Unit and Frailty

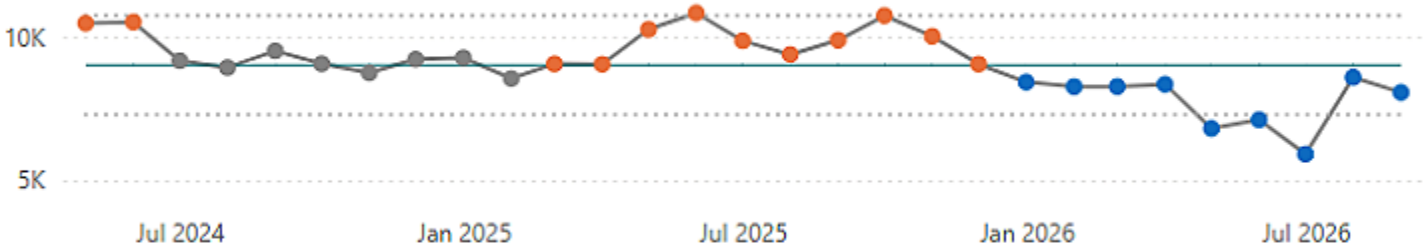
**Key**
- Improving variation
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**Total number of pathways of care delayed discharges (non-MH + MH & LD)**




- Number of pathway of care delays as at 16th September 2026 census was 222 patients, and the chart shows usual variation.
- The total days delayed for non-mental health decreased in September to 7,251 days from 7,954 in August. Mental health and learning disability delays increased in September to 812 from 634 in July.
- Assessment issues remain the largest proportion of grouped delays reasons.
- 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.

**Total days delayed for Pathways of Care delayed discharges (non-MH + MH & LD)**




**Top 10 delay reasons for census count patients (non-MH + MH & LD)**

| Delay Reason | Carmarthenshire | Ceredigion | Pembrokeshire | Out of Area | Total Patient Count | Total Days Delayed | Average Days Delayed |
|---|---|---|---|---|---|---|---|
| Awaiting completion of assessment by social care | 37 | 2 | 3 | 1 | 43 | 1,243 | 29 |
| Awaiting reablement community care package | 32 | 1 | 2 | 0 | 35 | 1,192 | 34 |
| Awaiting start of new community care package funded by social care | 13 | 2 | 11 | 0 | 26 | 1,058 | 41 |
| Identifying Residential Home | 2 | 1 | 4 | 0 | 7 | 386 | 25 |
| Awaiting Continuing Healthcare (CHC) Assessment | 5 | 2 | 2 | 0 | 9 | 289 | 32 |
| Identifying Nursing Home | 4 | 0 | 0 | 0 | 4 | 278 | 20 |
| Awaiting completion of AHP Allied Health Professional Assessment | 5 | 1 | 5 | 0 | 11 | 273 | 34 |
| Awaiting care home manager to visit assess and provide outcome (Resid | 1 | 2 | 0 | 0 | 3 | 271 | 55 |
| Identifying Dementia residential home | 5 | 0 | 0 | 0 | 5 | 264 | 20 |
| Home unsafe and requires attention | 0 | 2 | 1 | 1 | 4 | 256 | 38 |
| Other | 38 | 10 | 27 | 0 | 75 | 2,553 | 37 |
| **TOTALS:** | **142** | **23** | | **2** | **222** | **8063** | **36** |

| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| **Non Mental Health:** Scabies outbreak/infection prevention and control measures within acute hospitals and care homes in the community across the Carmarthenshire system, and associated impact on staffing, have affected Pathway of Care Delays (PoCD).<br>• Ongoing challenges accessing local authority resources to support discharge, particularly within Carmarthenshire, continue to delay discharge.<br>• Wider acute and community pressures, ambulance handover delays, staffing shortages and increasing patient/family expectations continue to impact discharge.<br>• Limited rehabilitation capacity, delays to allied health professional assessments, and housing and care home capacity constraints continue to impact discharge. | **Non Mental Health:** UEC Pillar 3 Oversight Group established, led by the Executive Director of Nursing, Quality and Patient Experience.<br>• Wider system PoCD deep-dive and internal audit completed.<br>• Progressing commissioning of 15 care home beds within Carmarthenshire (to March 2027).Developing a regional strength-based communication approach with health and local authority partners via the Regional Innovation Hub.<br>• Working with Allied Health Professionals (AHP) leads to develop a prioritisation and escalation tool supported by the Executive Director of Allied Health Professionals and Health Sciences.<br>• Ward manager sessions focused on empowerment and discharge planning, including board rounds, afternoon huddles and prevention of deconditioning. | 31/12/26<br>31/10/26<br>31/10/26<br>31/10/26<br>31/10/26 |
| **Mental Health & Learning Difficulties:**<br>• PoCD has increased from 16 to 22 cases since August across adult mental health (AMH) and older adult mental health (OAMH) services due to ongoing discharge barriers.<br>• OAMH accounts for most delays (16/22 cases), primarily within Bryngolau, Enlli and St Non's Wards, where dementia nursing, specialist mental health and step-down placements remain difficult to secure.<br>• Two PoCD cases exceed 100 days (St Caradog Ward, 163 days; Bryngolau Ward, 113 days), indicating continued challenges securing solutions for individuals with complex placement and community care requirements.<br>• Placement-related delays remain the predominant driver of PoCD, particularly dementia nursing and specialist mental health placements. Delays in community care packages, funding decisions and housing continue to extend lengths of stay. | **Mental Health & Learning Difficulties:**<br>• Targeted scrutiny of >100-day PoCD cases within Bryngolau and St Caradog Wards continues alongside implementation of the OAMH clinical governance improvement plan.<br>• System-level engagement with Local Authorities, commissioning teams and independent sector providers continues to improve access to residential, nursing, dementia and specialist mental health placements and reduce placement-related delays.<br>• Focused management of housing and accommodation-related delays continues across AMH and OAMH through liaison with Local Authority housing teams.<br>• Continued scrutiny of funding decisions, social care assessments and community care package implementation to support timely discharge.<br>• Focused review of AMH homelessness and accommodation-related delays continues with Local Authority housing services and policing partners.<br>• Development of a multi-agency workshop continues to reduce recurring PoCD associated with non-clinical barriers. | 30/11/26<br>31/10/26<br>31/10/26<br>31/10/26<br>31/10/26<br>31/10/26 |

## Embedded improvement actions

**Non Mental Health**: Memorandum of Understanding between Health and LA partners in place. Regional West Wales Optimal Flow and Discharge Delivery Group overseeing Optimal Hospital Flow delivery, POCD Action plan and Enhanced Community Care. Acute frailty and discharge improvement programmes continue through agreed action plans and governance arrangements. Additional social worker and reablement capacity funded through WG investment remains.

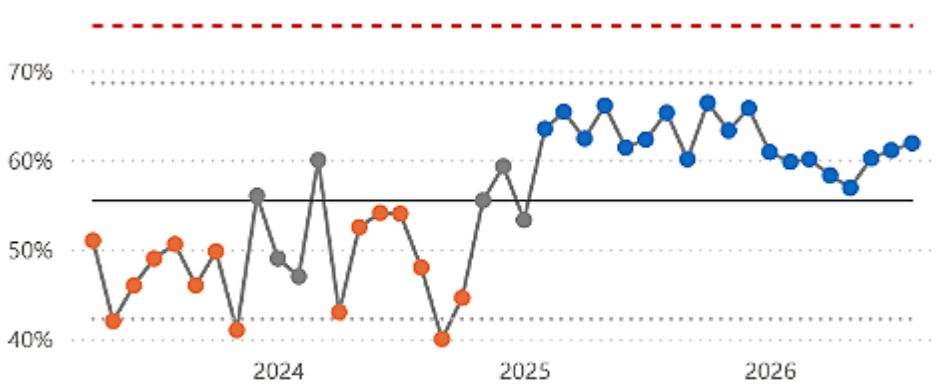
**Mental Health & Learning Disabilities:**

Daily multidisciplinary and multi-agency escalation arrangements remain embedded across AMH inpatient services, alongside daily Older Adult Mental Health Acute Pathway oversight. Weekly PoCD deep-dive and escalation meetings continue across AMH and OAMH. Discharge to Recover and Assess principles remain embedded, supporting early discharge planning and proactive management of discharge barriers. Dementia Wellbeing stepped-care model remains established across regional care homes, supporting admission avoidance, discharge planning and system flow. Multi-agency working with Local Authorities remains established, supporting n of PoCD status and escalation of complex placement requirements.

# Single cancer pathway
(Enhanced monitoring condition and Ministerial priority)

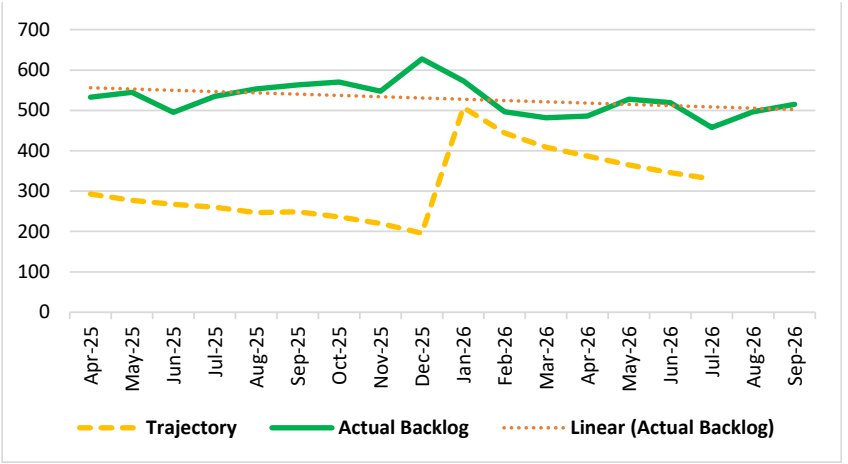
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**% single cancer pathway patients starting treatment within 62 days**




Performance increased to 61.9% in August. 277 patients out of 448 patients were referred to treatment within 62 days.

**Number of single cancer pathway patients waiting over 62 days**




In September 2026 there were 515 patients waiting over 62 days for referral to treatment. It is important to note that not all patients waiting will have a confirmed cancer diagnosis.

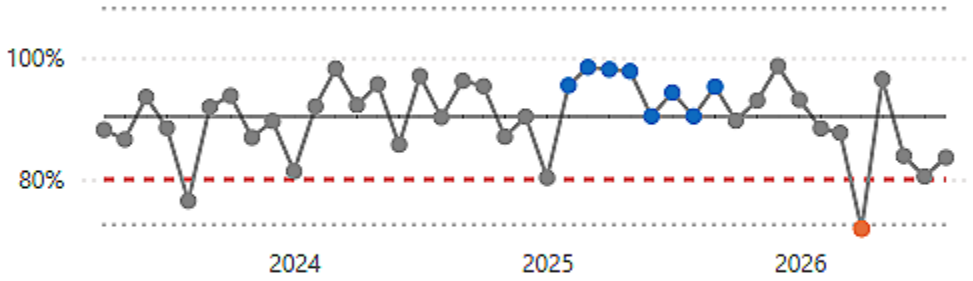
| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| Single Cancer Pathway performance remains fragile due to diagnostic capacity constraints across radiology, pathology and endoscopy, alongside workforce pressures within cancer tracking and multi-disciplinary team (MDT) coordination. The backlog remains concentrated within Urology, Gynaecology, Lower Gastrointestinal and Skin, with tumour-site-specific diagnostic and treatment capacity affecting timely pathway progression. | Outsourcing MRI for prostate patients started in November 2025, extended for Q1 2026/27. Equates to 20 patients per week with a 3-day turnaround reporting time. The ongoing impact on the waiting times is currently being assessed. | 31/12/26 |
| | Outsourcing CT scanning and 48-hour reporting. Started 05/01/2026. Although the funding for this workstream was not committed in the recovery allocation, the Health Board have committed to this continuing until end December 2026. | 31/12/26 |
| Continued reliance on supplementary diagnostic capacity, constrained theatre and procedural capacity, and dependencies on tertiary providers present ongoing risks to delivery of the revised recovery trajectories and progress towards the national 75% standard. | The use of Penthrox (Hysteroscopy under sedation) starts in October, this will include the 80 patients currently waiting for Hysteroscopy under general anaesthetic. This will reduce; overall waiting volumes, patients waiting over 62 days and accelerate the diagnostic pathway. | 31/10/26 |
| | Cancer Transformation funding of £99k has been awarded to support a pilot to introduce WIDeasy (cervical and vaginal swab) as an alternative diagnostic test to Hysteroscopy. This is a less invasive test than Hysteroscopy with faster turnaround times which will accelerate the diagnostic pathway and improve patient experience. | 31/03/27 |

# Mental health assessments within 28 days
(Enhanced monitoring condition)



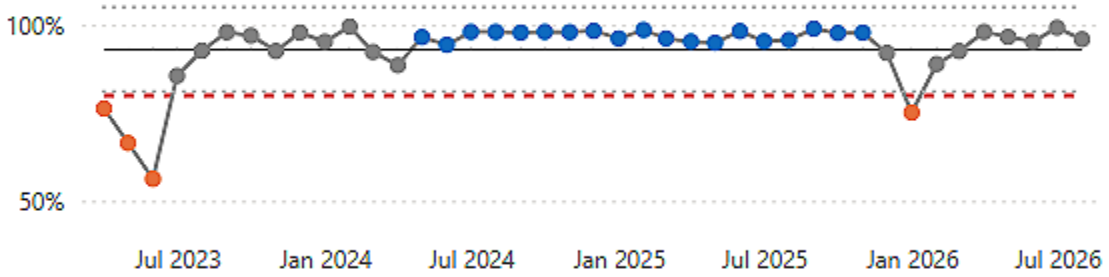
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**% mental health assessments undertaken within 28 days (persons aged 0-17)**




Latest performance of 83.6% is showing usual variation and the target of 80% was met.

**% mental health assessments undertaken within 28 days (persons aged 18+)**




Latest performance of 96% is showing usual variation and the target of 80% was met.

## Key challenges / issues

**% mental health assessments undertaken within 28 days (persons aged 0-17):**
56 of 67 assessments were undertaken within target in August, showing continued compliance with April as the exception. The irregular compliance profile is indicative of seasonal changes in demand, attempts to recover performance for therapeutic interventions, and small overall numbers which mean a few additional breaches increase variance.

**% mental health assessments undertaken within 28 days (persons aged 18+):**
Compliance has slightly dipped but remains above required target. The service continues to monitor assessment times which can impact on compliance with the performance target. Sickness, along with staff movement could potentially impact on compliance over the next month or two, however, this will be monitored closely.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| **% mental health assessments undertaken within 28 days (persons aged 0-17):** Enabling Quality Improvement in Practice (EQIiP) 'demonstrator project' to move to a more preventative and responsive 'One at a Time' approach as part of implementation of Welsh Government Mental Health strategy. The new approach will be launched in November 2026. | 31/03/27 |

## Embedded improvement actions

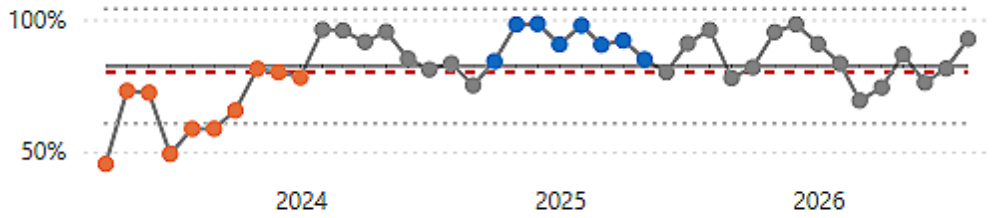
**% mental health assessments undertaken within 28 days (persons aged 18+):**
All teams are utilising the Primary Care Liaison Service (PCLS) at point of referral supporting reducing pressure on LPMHSS enhancing the patient journey.

# Therapeutic interventions following primary mental health assessment
(Enhanced monitoring condition)



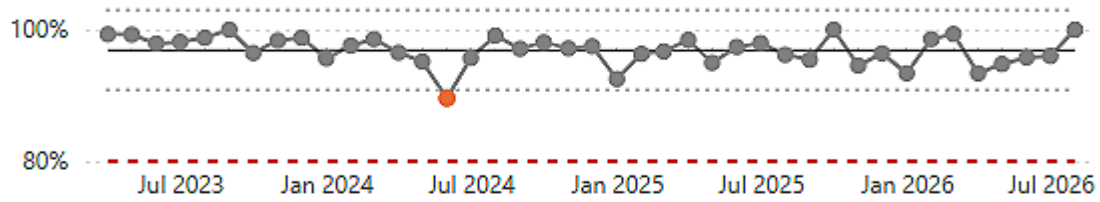
Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limit
- Mean
- Target
- Ambition

**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17)**




Latest performance of 92.6% is showing usual variation and the target of 80% was met.

**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+)**




Latest performance of 100% is showing usual 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):**
50 of 54 interventions commenced within target for this month, showing compliance for three out of the last four months. The largest team (Carmarthenshire) shows an improved staffing position enabling an overall improved rate of allocation.

**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):**
Compliance remains well above the required target, reflecting the team's hard work. Estates access is challenging across each geographical area with varying access to GP practices resulting in use of private accommodation in some areas. Two cohorts of staff have completed Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) training to reduce the impact of the withdrawal of the SPRING trauma intervention programme.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| **% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17):** Enabling Quality Improvement in Practice (EQIiP) 'demonstrator project' to move to a more preventative and responsive 'One at a Time' approach as part of implementation of Welsh Government Mental Health strategy. The new approach will be launched in November 2026. | 31/03/27 |

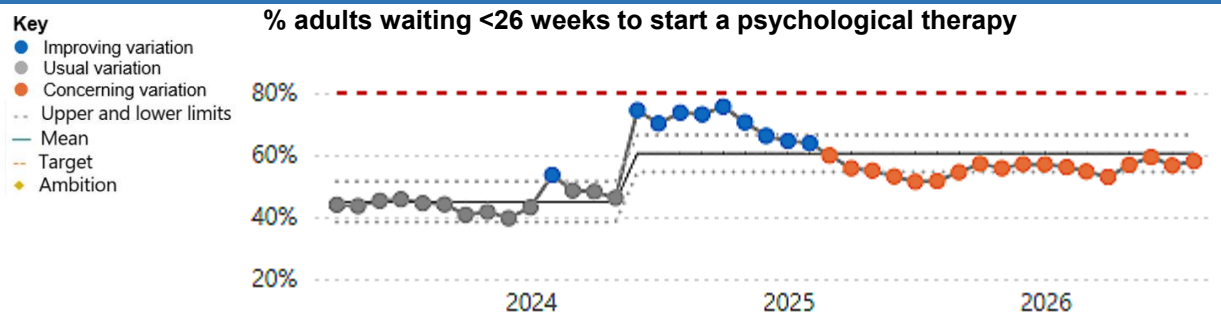
## Embedded improvement actions

**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17):**
Strengthen weekly monitoring of capacity and demand, coordinate assessment and intervention resources across localities, and improve the timeliness of follow-up contacts and intervention starts.

**% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+):**
Utilisation of supportive intervention options through third sector, SilverCloud and our Primary Care Liaison Service (PCLS) which is operating across the three counties with positive outcomes of reducing potential referrals to LPMHSS. A focus on group interventions remains in place.

# Psychological therapy waits
(Performance framework)






Performance in August of 58% shows concerning variation and the target of 80% was not met.

- 467 out of 804 (58.1%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 3 out of 4 (75%) were waiting <26 weeks to start an adult psychology assessment;
- 46 out of 77 (59.7%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

## Key challenges / issues

**Integrated Psychological Therapies Service (IPTS):**
Compliance has increased by 1.4% since last month. The MEDIO digital consultation platform is now operational; however, delivery problems have resulted in cancelled/delayed groups which potentially could impact on referral-to-treatment (RTT) performance. Despite this, mitigations have been implemented promptly, and no widespread system issues have been identified. The ongoing development of the group therapy programme has contributed to an approximate 2% improvement month on month in RTT performance since April 2026. Current trajectories indicate that the service remains on track to achieve its RTT target within the agreed time frame. These groups will be supported by the newly recruited nurse workforce who will release high intensity (HI) therapists to undertake 1:1 sessions.

**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 continues to be high demand for complex Court of Protection (CoP) work which is intensive and resource heavy. We are also seeing increased demands on Psychology and Behaviour specialists (P&Bs) for highly specialist complex assessments requiring therapeutic input, complex behaviour challenging assessments and treatment/intervention which contributed to waits over 26 weeks.

**Adult Psychology Mental Health (AMH):**
Performance for our 26-week target to start an adult psychology assessment is the highest recorded since we started tracking in April 2021.

## Key actions / initiatives

| Key actions / initiatives | Due date |
|---|---|
| **IPTS:** | |
| • Implementation of the Patient Knows Best (PKB) platform has reached the final testing phase, with a pilot planned in October 2026 to enhance service user communication, questionnaire completion, access to therapeutic resources, and outcome measure collection. | 01/10/27 |
| • Therapist job plans have been aligned to maximise clinical capacity in response to increasing demand, while regular waiting list reviews continue to focus on fragile therapy pathways, identifying opportunities to utilise alternative evidence-based interventions where clinically appropriate. | Complete |
| **LDs:** | |
| • Develop the Memory Clinic pathway and the Behaviour that Challenges pathway which aim to upskill other colleagues to reduce lower-level demands on P&Bs. | 30/03/27 |
| • Two new Assistant Psychology posts approved to cover Carmarthenshire/Pembrokeshire & Ceredigion to make up for shortfall in hours is now out for advert. | 31/10/26 |

## Embedded improvement actions

**LDs:**

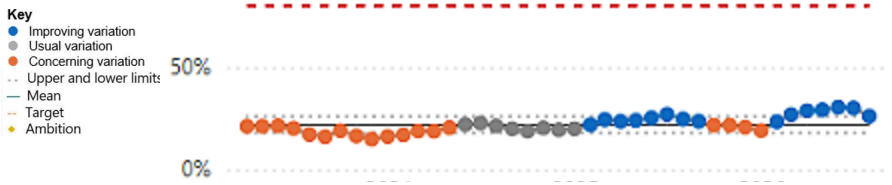
- As part of our organisational change process, we seek to recruit a co-ordinator for CoP cases who can link in with legal services to support writing court reports/managing cases to enable professionals to continue to effectively undertake their clinical roles. We are offering additional training to all staff within the network around CoP work.
- Developing group therapy work with plan to upskill colleagues to develop skills in therapeutic models to support in delivery. Monthly meetings to develop this are in place.
- We are in discussion with Welsh Government about the separate reporting of therapeutic interventions vs Behaviour that Challenges interventions to give greater transparency and oversight.

**AMH:**

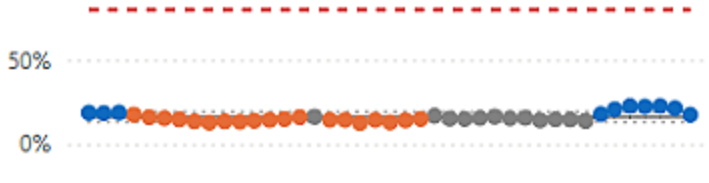
- All four clinicians are providing consultations to other services, decreasing referrals to AMH.
- 'Grow You[illegible]ns are in place.

# Neurodevelopmental assessment waits
(Performance framework)

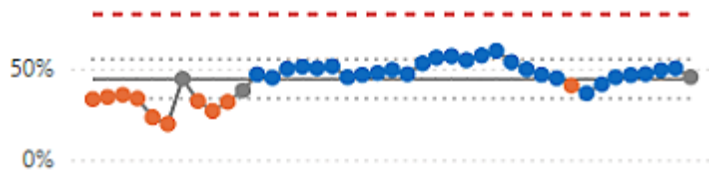
**% children & young people waiting < 26 weeks to start a neurodevelopment assessment**




**% 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 August 2026 of 26%, shows improving variation but the target of 80% was not met. Performance is driven by ASD, where 549 of 3,144 (17.5%) patients had an ASD assessment < 26 weeks. 624 out of 1,371 (45.5%) patients had an ADHD assessment <26 weeks.

## Key challenges / issues

**Attention Deficit Hyperactivity Disorder (ADHD):**
The longest current wait for an ADHD assessment is 100 weeks, with 462 individuals waiting longer than 52 weeks. Referral levels continue to be significantly higher than demand, having increased by 100%, placing sustained pressure on service capacity and highlighting the need for further expansion to achieve performance targets. Despite ongoing work to improve the efficiency of the ADHD assessment pathway and maximise available resources, demand continues to exceed capacity, even with a fully established medical workforce. Demand for Quantitative Behavioural (QB) testing, a key component of the diagnostic pathway, also remains higher than current capacity. In addition, limited clinic room availability across all sites continues to present challenges.

**Autism Spectrum Disorder (ASD):**
There are 3,144 children and young people awaiting an ASD assessment, with 2,595 waiting longer than the 26-week target. Compliance against the target dropped as expected during August, linked to the school summer holidays which reduced the number of referrals to less than half the average rate and prevented the school cluster clinics being held. There are currently three members of staff on long term sickness absence which will affect throughput.

## Key actions / initiatives

| | Due date |
|---|---|
| **ADHD:** | |
| • Expand core capacity by increasing access to QB testing. Currently, only one device is available with a limited number of Healthcare Support Workers trained in its use. Securing investment has been challenging due to ongoing licence fee costs and per-test charges. Alternative options are being explored, including QB Check, a digital platform with the potential to increase access to QB testing across all sites where clinically appropriate. | 31/03/27 |
| • Explore digital options, such as Magic Notes, to support appointments and reduce clinician administrative time. | 31/03/27 |
| • Options paper submitted to address capacity and demand issues. | 31/03/27 |
| **ASD:** | |
| • Working group to progress joint ASD/ADHD pathway for under 18s. Proposal to trial joint clinics in January 2027. | 31/01/27 |
| • Parent/carer feedback tool being developed to assess school cluster project. | 31/12/26 |
| • Patient Knows Best platform has needed to be discounted as a method of communication for individuals under 16 given the parental responsibility/carer limitations. Will be progressed for those aged over 16. | 31/12/26 |
| • Essential training updates secured for staff. | 31/12/26 |
| • Exploring use of evidence-based screening tools to reduce delays in receiving supplementary information. | 31/03/27 |
| • Proposal to use internal capacity to run additional clinics out of hours using Neurodevelopment (ND) Improvement Programme funding is currently awaiting Executive approval. This is a time limited opportunity which aims to complete assessments for those individuals who fall outside the eligibility criteria for outsourcing and who form the longest waits. | 31/03/27 |

## Embedded improvement actions

**ADHD:**
- Work ongoing to address clinical room pressures through the Bandi appeal and reconfiguration of Puffin Ward, which are expected to provide longer-term improvements in clinical capacity.
- Continue to maximise clinic utilisation through flexible clinic management and robust job planning.

**ASD:**
- Assess school cluster pil

# Diagnostics waits over 8 weeks

(Enhanced monitoring condition, Ministerial priority & Planned care recovery 2026/27)

Key

- Upper and lower limits
- Mean
- Target
- Ambition

**Variation - how are we doing over time**

- Improving variation
- Usual variation
- Concerning variation

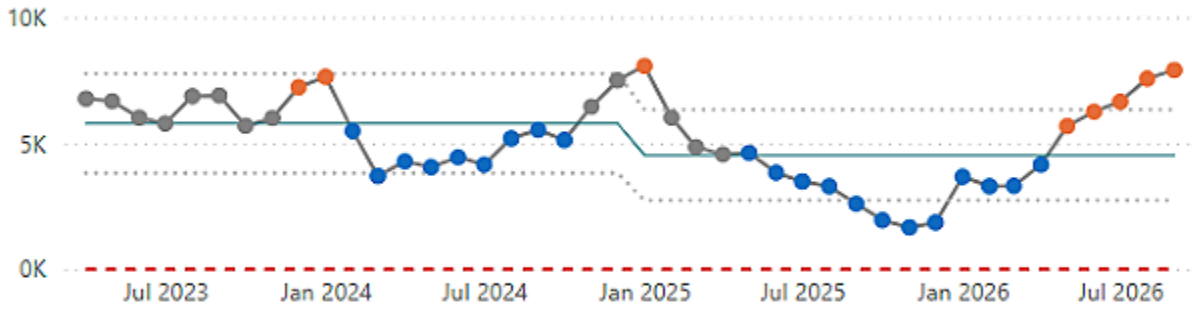
**Assurance - performance against target**

- Always hitting target
- Hit and miss target
- Always missing target

**Trajectory - performance against our ambition**

- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

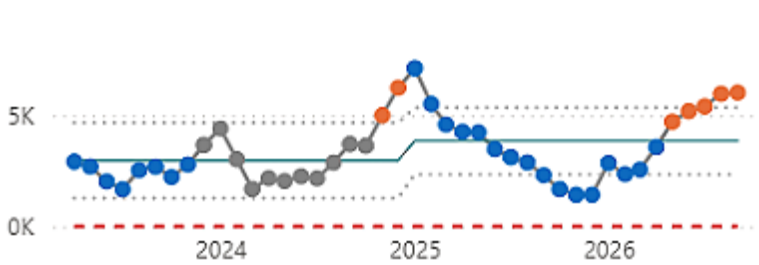
## Patients waiting >8 weeks for a specified diagnostic



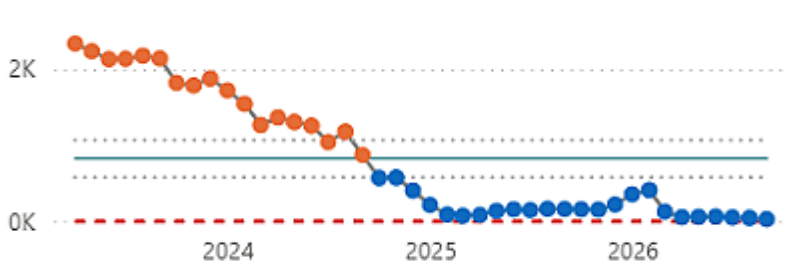

In September 2026 there were 7,903 patients waiting over 8-weeks for a specified diagnostic. The chart is showing concerning variation.

| Diagnostic | Latest period | Latest actual | Variation | Assurance |
|---|---|---|---|---|
| All | September 2026 | 7,903 | ● | ▣ |
| Radiology | | 6,016 | ● | ▣ |
| Cardiology | | 1,750 | ● | ▣ |
| Phys measure | | 43 | ● | ▣ |
| Endoscopy | | 28 | ● | ▣ |
| Imaging | | 60 | ● | ▣ |
| Neurophysiology | | 6 | ● | ▣ |

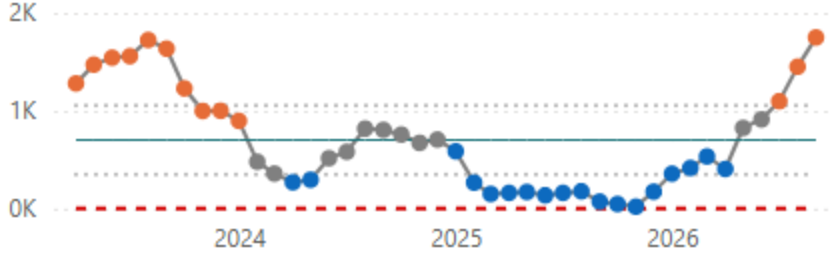
## Patients waiting >8 weeks for a radiology diagnostic



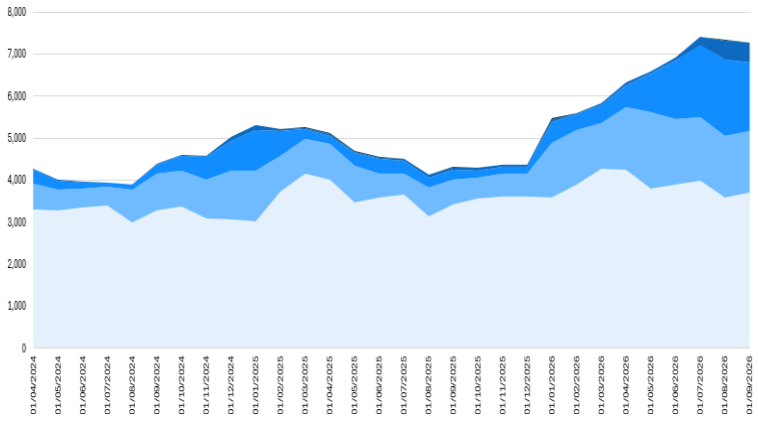

## Patients waiting >8 weeks for an endoscopy diagnostic



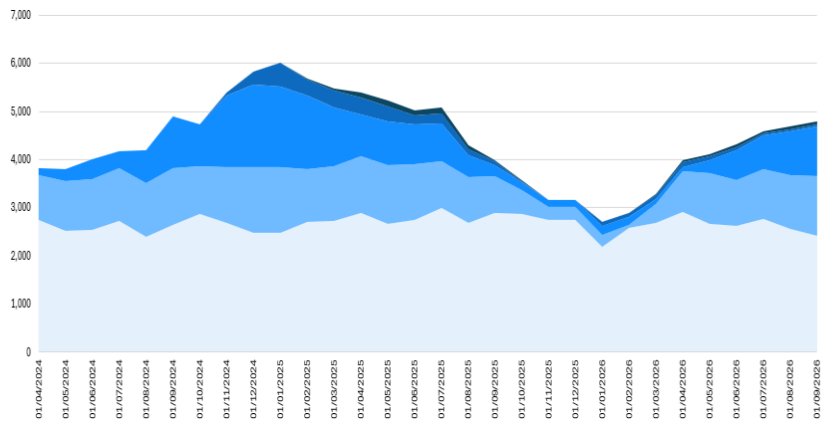

## Patients waiting >8 weeks for a cardiology diagnostic



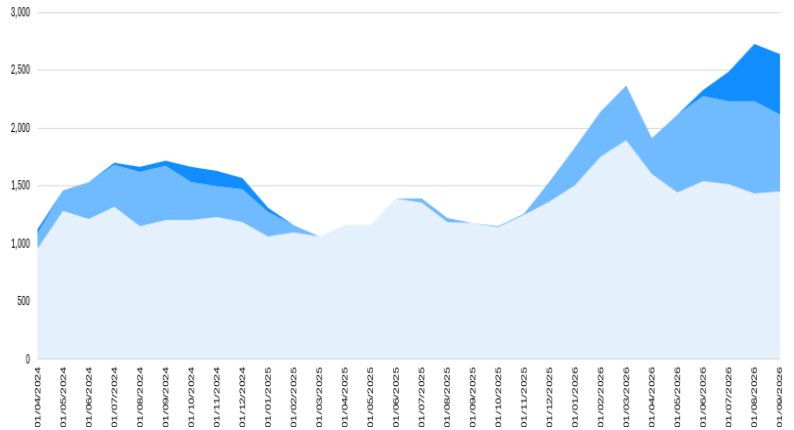

## Total waiting list – Non-Obstetric Ultrasound



## Total waiting list – Magnetic Resonance Imaging



## Total waiting list – Echocardiogram



Key: 0 – 7 weeks | 8 – 13 weeks | 14 – 25 weeks | 26 – 39 weeks | 40 + weeks

# Diagnostics waits over 8 weeks

(Enhanced monitoring condition and Ministerial priority)

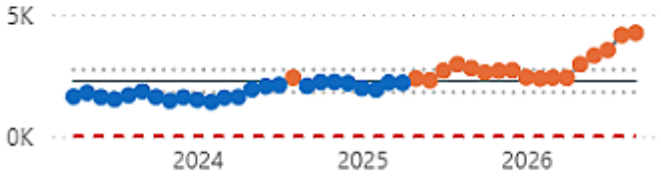
| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| **Radiology:**<br>• Radiology performance remains under pressure, with 6,016 patients waiting over eight weeks in September 2026. The breach trend continues to deteriorate, with the chart showing concerning variation. Although activity increased in September, core capacity remains insufficient to meet sustained demand growth.<br>• Additional demand arising from the National Outpatient Appointment Insourcing project continues to affect performance. Demand and breaches for Magnetic Resonance Imaging (MRI) and Non-Obstetric Ultrasound (NOUS) have exceeded the projections developed in 2025/26.<br>• The task and finish group has concluded its review of the data quality issues associated with the newly implemented Radiology Informatics System Procurement (RISP) system. The group has produced revised radiology recovery trajectories and submitted them to Welsh Government.<br>• Welsh Government has offered £2.8 million of the £4.1 million requested. This funding is expected to support reductions in eight-week breaches and improve cancer diagnostic performance up to 31 December 2026. Further funding will be required to support delivery of the target of no patients waiting over eight weeks by 31 March 2027. | **Radiology:**<br>• NOUS insource contract extended, with additional capacity being sought. Internal staffing (insourcing) ongoing funded by vacancy.<br>• The WG funding received will allow procurement additional MRI capacity (1000 patient per month) from 12/10/26.<br>• Computed Tomography (CT) van extended to end of December 2026 with additional funding (250 urgent suspected cancer patients per month).<br>• Demand management pathway work underway with physiotherapy, podiatry and maternity to increase capacity via workforce diversification (Delayed slightly due to change in Head of Service of Podiatry, meeting rescheduled) | 31/03/27<br>31/12/26<br>31/12/26<br>31/10/26 |
| **Endoscopy:**<br>• An underlying capacity deficit in the gastrointestinal endoscopy pathway reflected in the Annual Plan (equivalent to additional 3 lists per week or 5% increase in 2026/2027) has been mitigated via insourcing until the end of March 2027 via WG funding. | **Endoscopy:**<br>• Insourcing undertaken May-September in gastrointestinal endoscopy to bridge baseline capacity deficit in-order-to-maintain the 8 week performance standard and to continue until the end of March 2027. The service continues to maximise core capacity and management of referral demand through robust clinical vetting. | 31/3/27 |
| **Cardiology:**<br>• Echocardiography breaches continue to be primarily driven by longstanding shortfalls in in-house diagnostic capacity. The position has remained challenged throughout this reporting period due to ongoing workforce pressures, including the impact of both short and long-term sickness absence and maternity leave. Myocardial Perfusion Scan (MPS) waiting times remain elevated following the April 2026 system outage, which significantly increased the backlog. Recovery has been constrained by ongoing capacity limitations, and the breach position has continued to deteriorate. This remains a fragile service and is reflected on the Directorate risk register. Reliance on a single consultant presents a significant risk to service resilience, capacity, and recovery of waiting list performance. | **Cardiology:**<br>• Echocardiography – September saw the first monthly reduction in the waiting list achieved through use of recovery funding and engagement of an external provider to increase diagnostic capacity. Cardiology Management Team continuing to closely monitor demand and capacity to ensure funding and capacity commissioned will deliver the forecasted end-of-year recovery trajectory.<br>• Myocardial Perfusion Scans (MPS) - Cardiology Management Team continues to work closely with Radiology colleagues to manage risk for long-waiting patients, ensure appropriate clinical prioritisation and maximise available capacity to support waiting list recovery. Focused demand and capacity review planned for October/November 2026. | 30/10/26<br>30/11/26 |

# Therapy waits over 14 weeks
(Enhanced monitoring)



Performance as September 2026 shows concerning variation with 4,255 waits over 14 weeks, the highest number recorded.

## Patients waiting >14 weeks for a specified therapy



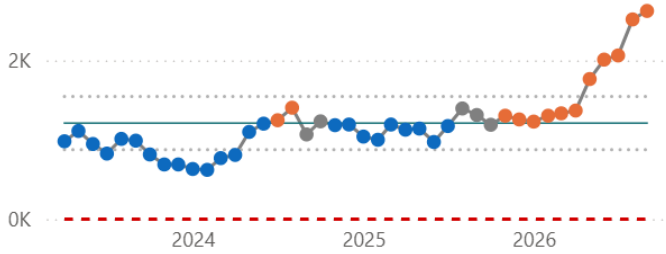

Key
- Upper and lower limits
- Mean
- Target
- Ambition

**Variation - how are we doing over time**
- Improving variation
- Usual variation
- Concerning variation

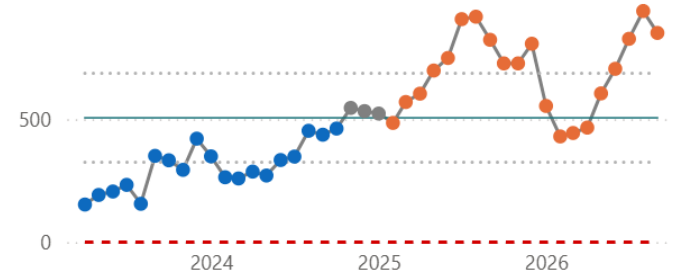
**Assurance - performance against target**
- Always hitting target
- Hit and miss target
- Always missing target

**Trajectory - performance against our ambition**
- Trajectory met
- Within 5% of trajectory
- More than 5% off trajectory

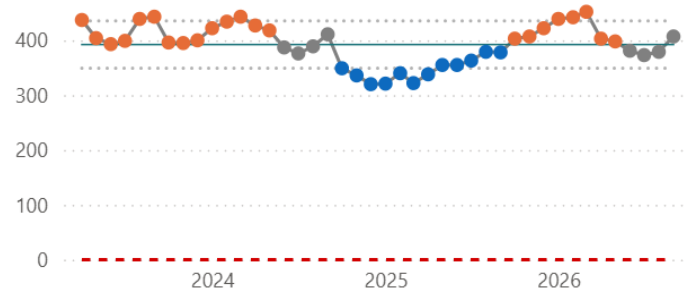
## Number of patients waiting 14 weeks plus for Physiotherapy



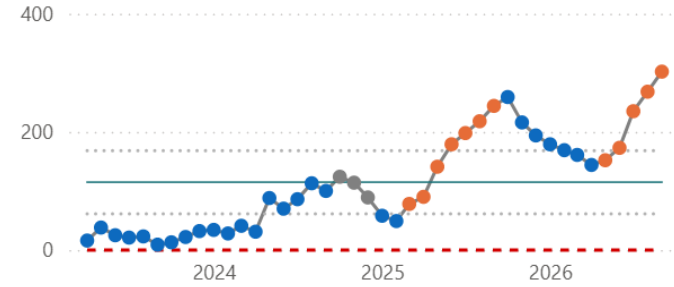

## Number of patients waiting 14 weeks plus for Podiatry



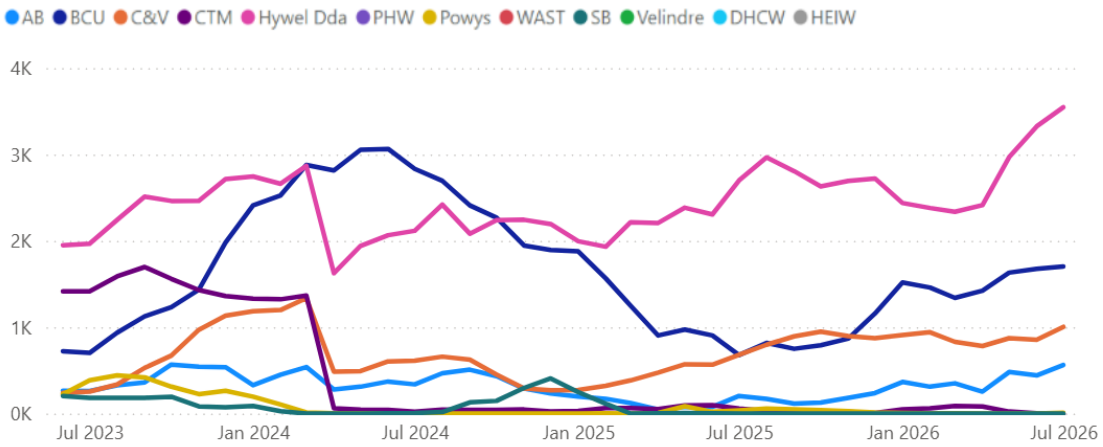

## Number of patients waiting 14 weeks plus for Occupational Therapy




## Number of patients waiting 14 weeks plus for Dietetics (excluding Weight Management)




## Patients waiting 14 weeks or more for a specified therapy: Welsh Health Boards (July 2026)




| Therapy | Latest period | Latest actual | Variation | Assurance |
|---|---|---|---|---|
| All | September 2026 | 4,255 | ● | ▣ |
| Physiotherapy | | 2,623 | ● | ▣ |
| Podiatry | | 851 | ● | ▣ |
| Occupational Therapy | | 407 | ● | ▣ |
| Dietetics | | 302 | ● | ▣ |
| Speech & Language Therapy | | 41 | ● | ▣ |
| Art therapy | | 31 | ● | ▣ |

## Therapy waits over 14 weeks (continued) (Enhanced monitoring)

| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| **Physiotherapy**<br>96% of breaches are in Musculoskeletal (MSK). Demand continues to grow and is greater than capacity, driven by shifting work from primary and secondary care toward MSK Physiotherapy services. Demand growth is compounded by:<br>Increased proportion of urgency in demand (now >50%) in MSK and community services).<br>Reduced service capacity (3 whole time equivalent (WTE) vacancies, 1WTE Band 3 maternity) compounded by recent availability issues for bank to backfill. | **Physiotherapy**<br>• A review of community prioritisation criteria aligned to clinical risk matrix has been completed in Carmarthenshire. Cross county discussions on outcome and scalability to be undertaken as next phase.<br>• Three projects being developed through Enabling Quality Improvement in Practice (EQIiP) program. 1) development of agnostic condition management classes; 2) patient activation and chronicity risk stratification as part of self referral processes; 3) pilot of new model for telemedicine assessment in MSK. | 30/11/26<br>31/03/27 |
| **Occupational Therapy (Paediatrics)**<br>Overall demand has increased by approximately 40%, while available service capacity decreased by 2.0 WTE during July and August 2026. Further workforce turnover was anticipated at the end of September. These pressures are expected to result in further deterioration in waiting-time performance through to December 2026. The service presented this forecast deterioration at the September Operational Delivery Review meeting with the Director of Operational Planning. | **Occupational Therapy (Paediatrics)**<br>• Development of Paediatric Sensory Workshop to support universal and targeted offer. Implementation review and further refinement in progress.<br>• Development of triage process to improve access, reduce delays and inappropriate referrals.<br>• A review of referral pathways and activity criteria within the Carmarthenshire Integrated Service to establish a clear distinction between Health and Social Care activity, demand and waiting lists. | 31/12/26<br>31/12/26<br>30/10/26 |
| **Podiatry**<br>Podiatry breaches reduced slightly to 851 in September following validation and increased telephone triage. Demand has risen approximately 40% over six years without corresponding capacity growth. Increasing patient complexity compounds pressures. The identified requirement for three additional WTE remains unfunded, leaving the capacity gap unresolved and risking further waiting-list growth. | **Podiatry**<br>• Develop the Consultant Podiatrist role to improve patient flow, clinical governance and waiting times.<br>• Maintain monthly waiting list validation, standardise WPAS closure processes, sustain telephone triage capacity, and monitor demand, complexity, waiting times and breaches through routine performance reporting.<br>• Review triage outcomes to ensure patients are directed to the most appropriate pathway and use the demand and capacity review to support the case for the additional 3 WTE staff required. | 02/11/26<br>02/11/26<br>02/11/26 |
| **Dietetics**<br>Paediatric patients account for the majority of Nutrition and Dietetic breaches, with paediatric breaches increasing from 142 in May 2026 to 274 in September 2026. Demand exceeding capacity and long-term sickness absence continue to drive this deterioration. Agency support of 1.6 whole-time equivalent (WTE) remains in place until March 2027 to help stabilise the service. Community breaches increased to 24, in line with forecasts following recent staff turnover. Demand and capacity modelling indicates a continuing capacity shortfall, with further increases in breaches projected unless additional capacity becomes available. | **Dietetics**<br>• Paediatrics: Present the updated Situation, Background, Assessment and Recommendation (SBAR) to the November Clinical Care Group, setting out mitigation proposal.<br>• Referral criteria review is complete, pending electronic patient referral implementation; support from Specialist Child and Adolescent Mental Health Services has not been secured.<br>• Community: Continue contingency measures, including revised prioritisation and triage processes, to ensure patients with greatest clinical need are prioritised. Scope wider Group-level interventions to address the gap between demand and capacity. | 17/11/26<br>31/12/26<br>31/03/27 |

### Embedded improvement actions

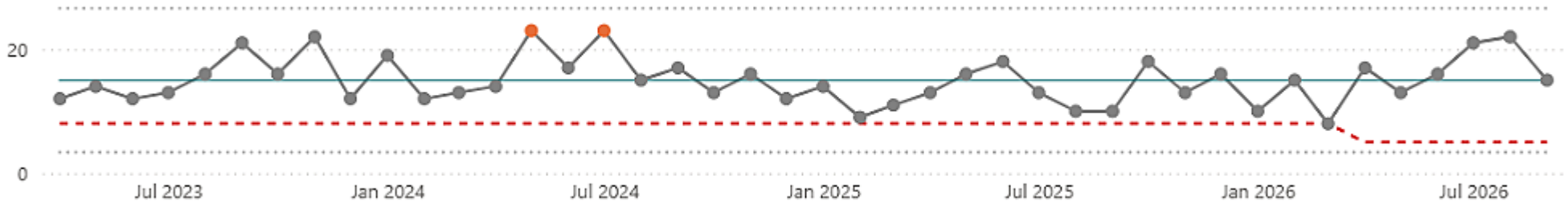
**Physiotherapy**

- Second MSK waiting list validation undertaken 01/08/26. 3,336 questionnaires issued; 1,632 responses receive[illegible] equested removal from waiting list. Action complete.

## C. Difficile (all cases)
(Targeted intervention)

Key
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

**Number of laboratory confirmed C. difficile cases hospital and community onset (in-month)**



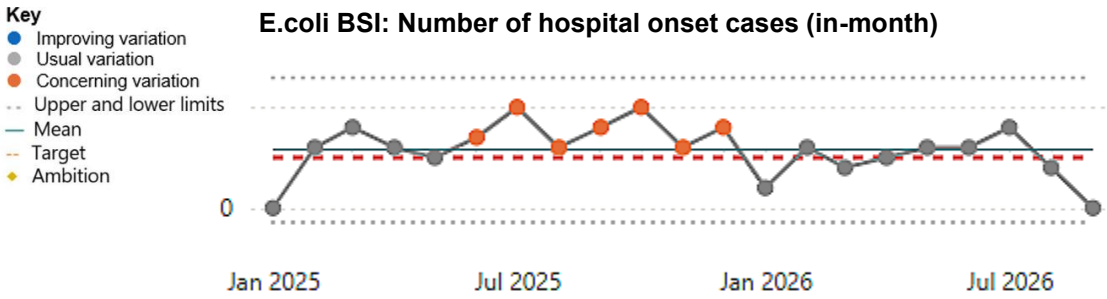

In September 2026 there were 15 confirmed cases and the chart is showing usual variation

| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| • C. difficile remains a key improvement priority. A total of 104 cases have been reported in 2026/27 to the end of September, compared with the Welsh Health Circular improvement trajectory of 138 cases or fewer for the full year.<br>• September performance improved compared with the preceding two months, reducing from 21 cases in July and 22 in August to 15 in September.<br>• The balance of infection in September shifted towards community onset, with 8 Community onset cases compared with 7 Hospital onset cases. Continued review of healthcare exposure and case attribution remains important.<br>• Hospital-onset infection nevertheless remains a concern, with 55 Hospital onset cases year-to-date, representing 53% of all cases.<br>• Ongoing improvement priorities remain antimicrobial stewardship, timely recognition/isolation and diagnosis, environmental cleanliness, compliance with bare below the elbows, and completion of mandatory Level 2 Infection Prevention and Control training.<br>• Environmental cleaning assurance and post-discharge cleaning should remain under review where case investigation identifies possible environmental contribution. | • Continue monthly multidisciplinary review of C. difficile cases, with particular focus on hospital-onset cases, healthcare exposure, antimicrobial prescribing, Proton Pump Inhibitor use where relevant, timeliness of isolation/testing and environmental factors.<br>• Maintain focus on antimicrobial stewardship, including Electronic prescribing and medicines administration (ePMA) - enabled improvement and intravenous-to-oral switching.<br>• Use findings from case reviews and infection prevention and control (IPC) indicator audits to target improvement support to clinical areas where recurring themes or gaps are identified.<br>• Continue monitoring environmental cleanliness and strengthen assurance around post-discharge/terminal cleaning where required.<br>• Continue improvement work on bare below the elbows and hand hygiene compliance, Infection Prevention and Control mandatory training and clinical practice assurance.<br>• Triangulate C. difficile cases with ward-level Infection prevention and control audit findings to identify recurrent themes and areas requiring focused intervention. | 31/10/26<br>31/10/26<br>31/10/26<br>31/10/26<br>31/10/26<br>31/10/26 |

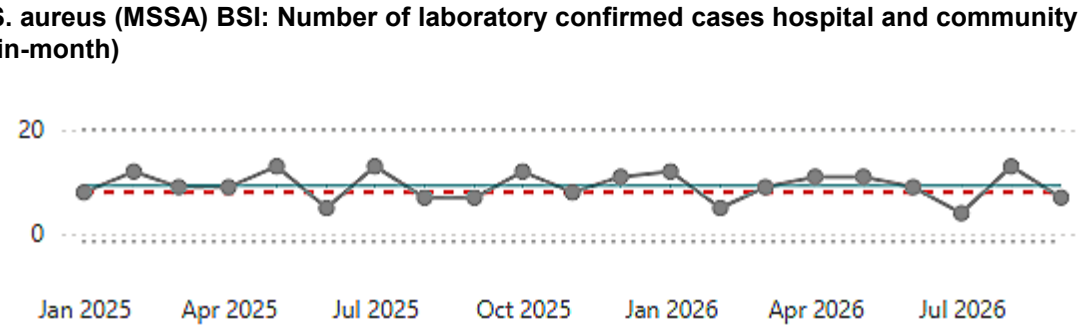
**Embedded improvement actions** for ALL infection types

- Healthcare-associated infection cases reviewed monthly with learning shared through appropriate clinical and governance forums.
- Infection Prevention and Control Indicator Audit findings used to identify and monitor ward-level improvement actions.
- Monthly hand-hygiene assurance maintained through clinical areas.
- Clinical Care Groups continue self-assessment against the Quality Statement for Infection Prevention and Control.
- Continue monitoring Aseptic Non-Touch Technique (ANTT)/aseptic practice and relevant staff competency.
- Escalate recurrent or unresolved infection prevention and control concerns through established governance arrar

# E. coli and S. aureus cases (hospital onset)
(Targeted intervention)



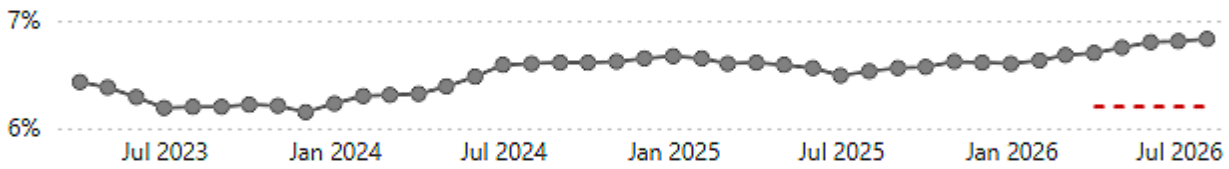

In September 2026 there were 0 confirmed hospital onset cases, the chart is showing usual variation.




In September 2026 there were 7 confirmed cases, the chart is showing usual variation.

| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| **E. coli:** | **E. coli:** | |
| • 184 E. coli bacteraemia cases were reported between April and September 2026, 3 fewer than the equivalent period in 2025/26. | • Continue monthly review of hospital-onset E. coli Bloodstream infection, identifying potentially avoidable healthcare-associated factors and sharing learning through Clinical Care Groups. | 31/10/26 |
| • Of these, 29 were hospital onset (16%) and 155 community onset (84%), demonstrating that the overall burden remains predominantly community onset. | • Maintain ward-level assurance against urinary catheter care bundles, with improvement actions where gaps are identified. | 31/10/26 |
| • September recorded 30 E. coli bacteraemia cases, with no hospital-onset cases, compared with 4 hospital-onset cases in August and 8 in July. | • Continue hand hygiene validation and observational audit through established senior nurse assurance processes. | 31/10/26 |
| • The September hospital-onset position therefore represents a notable improvement, although sustained monitoring is required to determine whether this improvement is maintained. | • Triangulate hospital-onset cases with infection prevention and control Indicator Audit findings to identify recurrent themes and areas requiring targeted improvement. | 31/10/26 |
| • The improvement priority remains reduction of hospital-onset E. coli BSI, alongside continued focus on potentially preventable healthcare-associated risk factors. | | |
| **S. aureus** | **S. aureus** | |
| • 57 S. aureus bacteraemia cases were reported from April to September 2026, of which 18 were hospital onset (32%). | • Continue review of hospital-onset S. aureus bloodstream infection, with learning used to inform targeted improvement. | 31/10/26 |
| • September recorded 7 cases, comprising 1 hospital-onset and 6 community-onset cases. This compares with 13 cases in August, including 3 hospital onset. | • Maintain assurance against peripheral venous catheter care bundles and address identified compliance gaps. | 31/10/26 |
| • Hospital-onset S. aureus therefore reduced during September, with the hospital-onset proportion falling to 14%, compared with 23% in August and 50% in July. | • Continue focus on aseptic non-touch technique (ANTT) compliance and competency. | 31/10/26 |
| • Continued focus is required on prevention of healthcare-associated S. aureus bacteraemia, including vascular access and aseptic practice. | • Maintain hand hygiene validation and ward-level observational audit. | 31/10/26 |
| | • Use case reviews alongside infection prevention and control audit findings to identify whether recurrent themes require targeted intervention. | 31/10/26 |

## % staff sickness rate (12 months rolling)



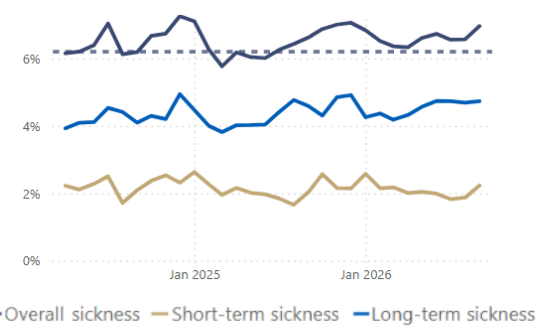

Rolling 12-month staff sickness percentage rate comparisons for September:

- September 2024: 6.61%
- September 2025: 6.56%
- **September 2026: 6.85%**

2026-2027 Rolling 12-month target = 6.2%

## % staff sickness rate (in month)

**September 2026 (in month) = 6.96%**
Short-term sickness = 2.23%
Long-term sickness = 4.73%




**Services with 60+ staff with the highest levels of <u>in-month</u> sickness rates in September 2026:**

| Team | Staff | R12m | In-month |
|---|---|---|---|
| Domestic Services - GGH | 133 | 13.8% | 19% |
| Health Protection – Immunisation Team | 67 | 15% | 17.6% |
| Hotel Services - PPH | 71 | 13% | 15.3% |
| Pembs Hospital at Home | 60 | 8.7% | 14.6% |
| Radiology - GGH | 96 | 8.3% | 13.6% |

## Key challenges / issues

Sickness absence remains a significant workforce challenge, driven mainly by long-term health conditions. Rates have remained broadly stable during 2026, with limited sustained improvement. Long-term cases and wellbeing pressures continue to affect services, particularly operational and patient-facing areas where staffing and resilience remain challenging.

Latest data shows that absence drivers remain largely unchanged, with psychological and musculoskeletal conditions accounting for most working time lost.

Mental health-related absence remains the largest contributor, accounting for almost 38% of days lost in September 2026 and affecting workforce resilience and organisational performance.

Musculoskeletal conditions remain the second largest contributor, with back problems and related disorders accounting for about 13% of days lost.

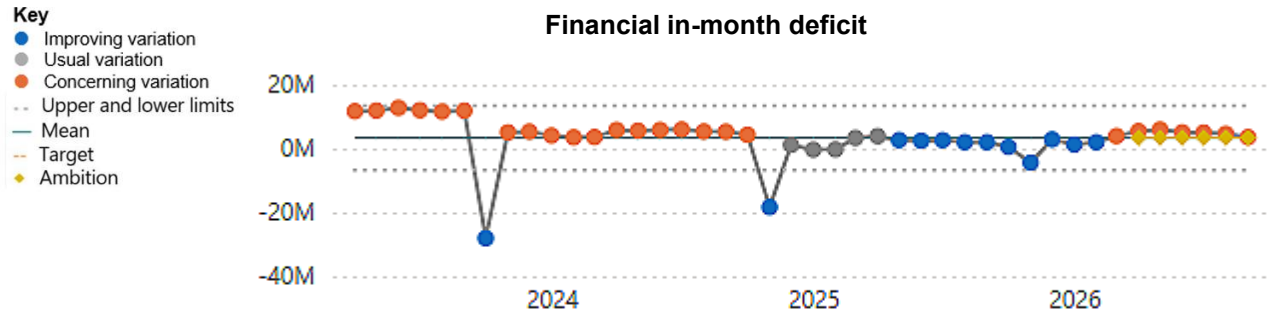
Gastrointestinal illness, injuries and fractures also have a significant impact, while respiratory illness is rising ahead of winter.

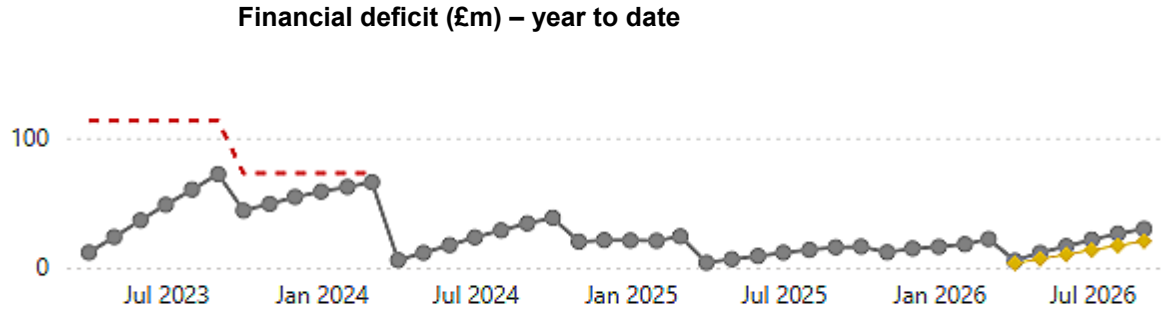
## Embedded improvement actions

- The Absence Grip and Control Programme continues to be embedded across Clinical Care Groups, with an increased focus on reducing long-term sickness absence.
- Workforce and Occupational Health teams are providing targeted support to managers to improve compliance with the Attendance Management Policy
- Enhanced performance reporting and dashboard development are supporting improved oversight of attendance management activity, enabling services to identify hotspots and intervene more effectively.
- Service-level reviews continue to focus on the predominant causes of absence, particularly mental health and musculoskeletal conditions, with targeted wellbeing, rehabilitation and prevention initiatives being progressed.
- Winter preparedness activity has commenced, including promotion of staff vaccination programmes, wellbeing support offers and workforce planning actions aimed at maintaining service resilience during periods of increased operational pressure.
- Work is underway to improve the timeliness of attendance management interventions, including return-to-work discussions, attendance review meetings and long-term absence case management, to support sustainable reductions in sickness absence over the remainder of 2026/27.

# Financial deficit
(Targeted intervention)






| Key challenges / issues | Key actions / initiatives | Due date |
|---|---|---|
| The Health Board's Planned Deficit is £41.0m with a Savings Target of £42.8m. Gross forecast position is £57.7m, with required mitigating actions of £20.2m to be finalised, to achieve the revised reported end of year forecast position of £37.5m following the £3.5m Welsh Risk Pool improvement. Total savings delivery are £32.8m, leaving a delivery gap of £10.0m against the savings target. | **Mid Year Forecast Assessment -** The reported deficit has improved by £3.5m, from the Annual Plan position of £41.0m to £37.5m. This movement is wholly attributable to the Health Board's share of the all-Wales reduction in the Welsh Risk Pool risk assessment and does not represent an underlying improvement in operational performance. The year-end forecast remains under review. Without a material improvement in performance and the delivery of robust mitigating actions, the forecast is likely to deteriorate in future reporting periods. | 13/10/26 |
| **The reported deficit has improved from the Annual Plan position of £41.0m to £37.5m.** This improvement is wholly attributable to the Health Board's share of the revised Welsh Risk Pool assessment (£3.5m) and does not reflect an underlying improvement in operational performance. The Health Board will continue to review the likely year-end position, including the extent to which non-recurrent measures can be converted into sustainable recurrent improvements during Quarter 3. | **Dental Allocation Underspend Risk -** Welsh Government have confirmed that forecast dental funding underspends will be recovered. On going review of the dental financial position and delivery plans to maximise utilisation of the ring-fenced allocation and mitigate potential funding recovery. Current revised ringfenced underspend as at Q2 £5.1m | 30/11/26 |
| The in-month financial position is a deficit of £3.6m, which is an adverse variance against the £3.4m deficit plan. This is driven by a core operational overspend of £1.9m, offset by a £1.8m year-to-date recognition of the Welsh Risk Pool improvement, and a £0.1m under identification of savings, with £3.5m savings identified against the savings target of £3.6m. | **Identification and delivery of robust savings plans -** Whilst there has been a significant shift in the identification and conversion of underspends, there remains an identification gap to achieve the plan. There is an inequity across services with some over-delivering against target, and others under-delivering. | Overdue |
| | **Recurrent Conversion of Savings - (In Year Rec Gap)** - The current savings position includes a significant element of non-recurrent benefit. Further work with is required to maximise recurrent savings opportunities and reduce the underlying financial deficit. | Overdue |
| | **Medical pay and rostering -** Additional cover at premium costs - Continuing use of additional medical cover, including pr nd agency. | 15/12/26 |

# IPAR key metrics by type

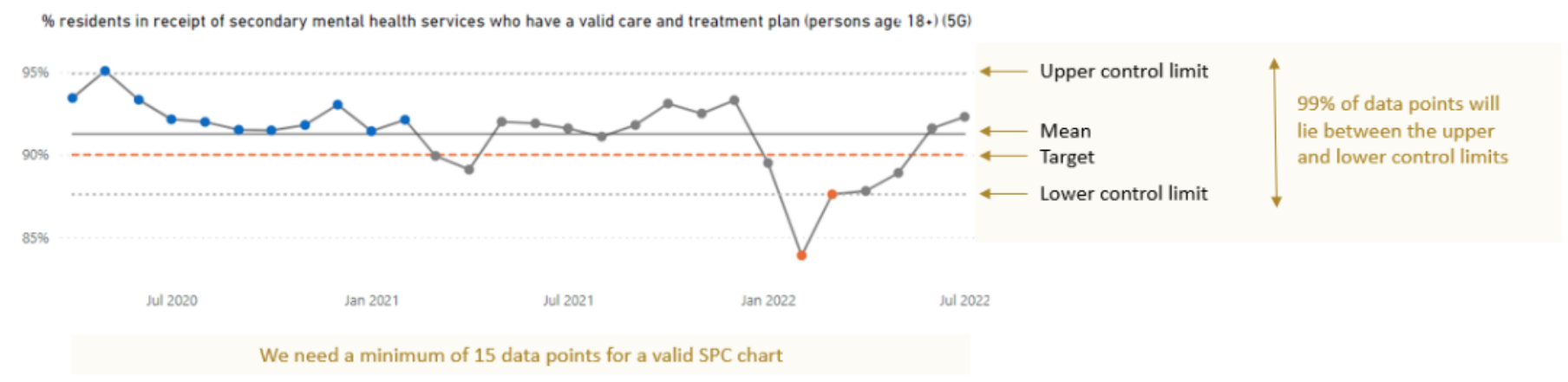
*July 2026*

| Metric ID | Metric name | Annual plan | Enhanced monitoring | Local | Ministerial priority | Performance framework | Targeted intervention |
|---|---|---|---|---|---|---|---|
| 27 | C. difficile: Number of confirmed cases (in-month) | Y | - | - | - | Y | Y |
| 51 | Coding: % clinically coded - 1 month post discharge | Y | - | - | Y | Y | - |
| 80 | Pts waiting 8 wks+ for specified diagnostic | Y | Y | - | Y | Y | - |
| 87 | Ambulance handovers > 1 hour Hywel Dda | Y | - | Y | - | - | Y |
| 88 | % patients spending <4 hours in A&E/MIU Hywel Dda | - | - | - | - | Y | - |
| 89 | Patients spending > 12 hours in A&E/MIU Hywel Dda | Y | - | - | Y | Y | Y |
| 150 | Financial in month deficit | Y | - | Y | - | - | Y |
| 155 | % sickness absence rate of staff | Y | - | - | - | Y | - |
| 275 | % adult psychological therapy waits <26 weeks | - | - | - | - | Y | - |
| 276 | % child neurodevelopment assess waits <26 weeks | - | - | - | - | Y | - |
| 277 | % pts on single cancer pathway within 62 days | Y | Y | - | Y | Y | - |
| 303 | Follow-up appts - delayed >100% | - | Y | - | - | Y | - |
| 320 | % MH assess within 28 days (age 0-17) | - | Y | - | - | Y | - |
| 321 | % MH assess within 28 days (age 18+) | - | Y | - | - | Y | - |
| 322 | % therapy interven post LPMHSS assess (age 0-17) | - | Y | - | - | Y | - |
| 323 | % therapy interven post LPMHSS assess (age 18+) | - | Y | - | - | Y | - |
| 433 | Patients waiting 104 weeks+ RTT | Y | Y | - | Y | Y | - |
| 443 | Waits over 52 weeks: new outpatient appointment | Y | Y | Y | - | - | - |
| 449 | Pts 12yrs+ with diabetes receiving all 8 NICE care processes | - | - | Y | Y | - | - |
| 483 | Ambulance handover > 4 hours Hywel Dda | - | - | Y | - | - | - |
| 501 | Patients waiting over 52 weeks RTT | Y | - | Y | - | - | - |
| 504 | % uptake of flu vacc - 65+ years | Y | - | - | - | Y | - |
| 515 | Number of Pathways of Care delayed discharges | Y | - | Y | Y | - | Y |
| 525 | % of children who are up to date with scheduled vaccinations by age 5 | Y | - | - | Y | Y | - |
| 542 | % of children receiving HPV by age 15 | Y | - | - | Y | Y | - |
| 545 | Pts waiting 14 wks+ for specified therapy (Exc. Audiology) | Y | Y | - | - | Y | - |
| 559 | Median time ambulance arrest category calls | - | - | - | - | Y | - |
| 560 | Median time ambulance emergency category calls | - | - | - | - | Y | - |
| 561 | Ambulance handover > 45 minutes Hywel Dda | - | - | - | Y | Y | - |
| 566 | % R1 eyecare patients waiting within 25% delay to target date | - | - | - | - | Y | Y |
| 571 | % uptake of RSV vacc - 75+ years | - | - | - | - | Y | - |
| 575 | Patients waiting 26 weeks+ new outpatient | - | Y | - | - | Y | - |
| 580 | E.coli BSI: Number of hospital onset cases (in-month) | Y | - | - | - | Y | Y |
| 581 | S. aureus (MSSA) BSI: Number of hospital onset cases (in-month) | Y | - | - | - | Y | Y |
| 588 | Total days delayed for Pathways of Care delayed discharges | Y | - | Y | Y | - | - |

## Why use SPC charts?

- Plotting data over time can inform better decision-making
- There are many factors that impact our performance and therefore month-on-month variation is to be expected
- RAG data in a table can hide what is happening
- SPC charts enable us to determine if changes are showing special cause variation (concerning or indeed improving) or if the changes are within our expected performance range. They also help us easily compare our performance against target.
- There is a strong evidence base to support the use of SPC charts to inform NHS improvement.
- We started using SPC charts for performance reporting to Board and Committee in March 2021. The feedback has been very positive, with SPC charts helping to change the conversation to focus on improvement.

## Anatomy of a SPC chart



## Rules for special variation within SPC charts

Special variation is change that is unlikely to have happened by chance.

We are using the Making Data Count approach for SPC charts. There are 4 rules:



A single data point outside the process limits



Two out of three points close to the process limit



Shift of 7* or more points above or below the mean line



Run of 7* or more points in ascending/descending order

* A pattern of 7 has a 1 in 128 (0.8%) probability of occurring by chance.

## Understanding the SPC icons

Each SPC chart produces 2 types of icons i.e.. one for variation and another for assurance.

| | | |
|---|---|---|
| **Variation** How are we doing over time | ● | Concerning trend = a decline that is unlikely to have happened by chance |
| | ● | Usual trend = common cause variation / a change that is within our usual limits |
| | ● | Improving trend = an improvement that is unlikely to have happened by chance |
| | | |
| **Assurance** Performance against target | ▣ | Missing target = will consistently fail target without a service review |
| | ▣ | Hit and miss target = Indicates that the Board cannot have sufficient assurance that the target can be consistently achieved over time, and the delivery of the target is particularly sensitive to external factors |
| | ▣ | Hitting target = will consistently meet target |
| Note: remember **blue** is good, orange is **bad** | | |



# Internal escalation update

## October 2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

# Headlines

Data as at 30th September 2026

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The table below summarises key points to highlight from the latest escalation scoring:

| Areas to highlight | Points to highlight | 3A |
|---|---|---|
| Workforce - level 4 | Level 4 has been enacted for the first time this month (October) in the Workforce domain for:<br>• Community & Intergrated Medicine - significant deterioration of overdue pay progression<br>• Public Health – continued deterioration and lack of engagement for PADR and Job Planning compliance.<br>CEO recovery meetings will be arranged in October/November for both functions. | Alert<br>Alert |
| Finance – level 4 | Community & Integrated Medicine and Planned & Specialist Care have been escalated to level 4 for finance since July 2026. Both CCGs are forecasting large end of year overspends and are unable to meet their savings requirements for this financial year. | Alert |
| Planned and Specialist Care | There has been significant improvements in job planning within the Workforce domain.<br>However, the increase in overdue pay progression cases remains a concern. At least a 40% reduction is needed to avoid escalation up to level 4 next month. | Assure<br>Alert |
| Community and Integrated Medicine | Last month, the CCG was at risk of escalation to level 4 for the Governance domain. Following improvements in risk management activity, this was avoided, and the CCG has since been de-escalated to level 2. | Assure |
| Population Health | As a result of improvements to Business Continuity Plan compliance, 4 functions were de-escalated this month within the Population Health domain. The staff flu vaccination programme began at the end of September; this seasonal measure will be included from the next Escalation scoring review in November. | For information |
| Finance recovery meetings | Finance recovery meetings have been arranged in November & December to focus on forecast, core budget and savings, with expectations around new savings or run rate improvements. Sessions have been arranged for: Community & Integrated Medicine, Planned & Specialist Care, Estates, Facilities, Long Term Agreements, Mental Health & Learning Disabilities, Operational Allied Health & Health Sciences and Pharmacy & Medicines Management | For information |

# Background and overview

The Our Improving Together Framework was approved by Board in March 2025. It sets out our approach to embedding performance improvement through our organisation. The framework's ultimate aim is to improve outcomes for our patients, staff and population.

Improvements are focused around seven key domains:
(1) quality & safety,
(2) governance,
(3) workforce,
(4) finance,
(5) strategy, planning & fragile services,
(6) population health (introduced September 2025) and
(7) performance.

## Health board escalation level overview as at 30th September 2026

| | |
|---|---|
| 1 | Reasonable assurance |
| 2 | Limited assurance |
| 3 | No assurance |
| 4 | No assurance and insufficient actions/engagement |

| | Function | Quality & safety | Governance | Workforce | Finance | Strategy, planning and fragile services | Population Health | Performance |
|---|---|---|---|---|---|---|---|---|
| Clinical Care Groups | Community and Integrated Medicine | 3 | 2 | 4 | 4 | 3 | 2 | 3 |
| | Chief Operating Officer Management | 1 | 1 | 3 | 2 | 1 | 1 | n/a |
| | Mental Health and Learning Disabilities | 3 | 2 | 2 | 3 | 3 | 1 | 3 |
| | Planned and Specialist Care | 2 | 2 | 3 | 4 | 3 | 2 | 3 |
| | Primary Care | 1 | 1 | 2 | 1 | 2 | 2 | 3 |
| | Operational Allied Health and Health Sciences | 3 | 1 | 2 | 3 | 3 | 1 | 3 |
| Executive Functions | Estates and Facilities | 2 | 1 | 2 | 3 | 1 | 2 | 3 |
| | Executive Director of Finance | 1 | 2 | 2 | 1 | 1 | 2 | n/a |
| | Medical | 1 | 1 | 2 | 1 | 1 | 2 | n/a |
| | Pharmacy and Medicines Management | 1 | 1 | 3 | 2 | 1 | 2 | n/a |
| | Executive Director of Nursing, Quality and Patient Experience | 1 | 2 | 2 | 1 | 1 | 2 | 3 |
| | Executive Director of Public Health | 1 | 1 | 4 | 1 | 1 | 1 | 2 |
| | Executive Director of Strategy and Planning | 1 | 1 | 2 | 1 | 1 | 2 | n/a |
| | Long Term Agreements (LTAs) | n/a | n/a | n/a | 3 | n/a | n/a | n/a |
| | Executive Director of Workforce and Organisational Development | 1 | 1 | 1 | 1 | 1 | 1 | n/a |
| | Governance and Communication | 1 | 1 | 2 | 1 | 1 | 1 | n/a |

# Domain overview: Quality & Safety

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Chief Operating Officer Management | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Mental Health & Learning Disabilities | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Planned & Specialist Care | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 2 | 3 | 3 | 2 |
| Primary Care | n/a | n/a | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 1 |
| Operational Allied Health & Health Sciences | 2 | 2 | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 3 | 3 |
| Estates & Facilities | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Executive Director of Finance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Medical Director | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Pharmacy & Medicines Management | n/a | n/a | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Nursing, Quality & PE | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 |
| Executive Director of Public Health | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Strategy & Planning | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Long Term Agreements (LTAs) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Workforce & OD | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Governance & Communication | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

# Domain overview: Governance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 |
| Chief Operating Officer Management | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Mental Health & Learning Disabilities | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 |
| Planned & Specialist Care | 2 | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Primary Care | n/a | n/a | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Operational Allied Health & Health Sciences | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Estates & Facilities | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Finance | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Executive Medical Director | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Pharmacy & Medicines Management | n/a | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Nursing, Quality & PE | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 |
| Executive Director of Public Health | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Strategy & Planning | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Long Term Agreements (LTAs) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Workforce & OD | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Governance & Communication | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

# Domain overview: Workforce

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 4 |
| Chief Operating Officer Management | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 |
| Mental Health & Learning Disabilities | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| Planned & Specialist Care | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 |
| Primary Care | n/a | n/a | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 |
| Operational Allied Health & Health Sciences | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Estates & Facilities | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 2 |
| Executive Director of Finance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 |
| Executive Medical Director | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 |
| Pharmacy & Medicines Management | n/a | n/a | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 3 |
| Executive Director of Nursing, Quality & PE | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 |
| Executive Director of Public Health | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 4 |
| Executive Director of Strategy & Planning | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 |
| Long Term Agreements (LTAs) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Workforce & OD | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Governance & Communication | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 2 |

# Domain overview: Finance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr-26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 4 | 4 |
| Chief Operating Officer Management | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Mental Health & Learning Disabilities | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Planned & Specialist Care | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 4 | 4 |
| Primary Care | n/a | n/a | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Operational Allied Health & Health Sciences | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Estates & Facilities | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Executive Director of Finance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Medical Director | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Pharmacy & Medicines Management | n/a | n/a | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Executive Director of Nursing, Quality & PE | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Public Health | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Strategy & Planning | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Long Term Agreements (LTAs) | 1 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 3 |
| Executive Director of Workforce & OD | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Governance & Communication | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

# Domain overview: Population Health

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May-26 | Jun-26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 2 |
| Chief Operating Officer Management | 1 | 3 | 3 | 3 | 3 | 3 | 3 | 1 | 1 | 1 | 1 | 1 |
| Mental Health & Learning Disabilities | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 1 |
| Planned & Specialist Care | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 |
| Primary Care | n/a | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 |
| Operational Allied Health & Health Sciences | 3 | 3 | 3 | 3 | 3 | 2 | 1 | 1 | 1 | 1 | 2 | 1 |
| Estates & Facilities | 1 | 3 | 3 | 2 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 2 |
| Executive Director of Finance | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Executive Medical Director | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Pharmacy & Medicines Management | n/a | n/a | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 2 |
| Executive Director of Nursing, Quality & PE | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Executive Director of Public Health | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Strategy & Planning | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 |
| Long Term Agreements (LTAs) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Workforce & OD | 1 | 2 | 2 | 2 | 3 | 3 | 3 | 1 | 1 | 1 | 1 | 1 |
| Governance & Communication | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 |

# Domain overview: Strategy, Planning & Fragile Services

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May-26 | Jun-26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Chief Operating Officer Management | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Mental Health & Learning Disabilities | 2 | 2 | 2 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Planned & Specialist Care | 3 | 3 | 3 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Primary Care | n/a | n/a | 2 | 2 | n/a | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Operational Allied Health & Health Sciences | 3 | 3 | 3 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Estates & Facilities | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Finance | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Medical Director | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Pharmacy & Medicines Management | n/a | n/a | 2 | 2 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Nursing, Quality & PE | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Public Health | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Executive Director of Strategy & Planning | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Long Term Agreements (LTAs) | n/a | n/a | n/a | n/a | n/a | 1 | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Workforce & OD | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Governance & Communication | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

# Domain overview: Performance

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Escalation levels by function & month**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community & Integrated Medicine | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Chief Operating Officer Management | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Mental Health & Learning Disabilities | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Planned & Specialist Care | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Primary Care | n/a | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Operational Allied Health & Health Sciences | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Estates & Facilities | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Executive Director of Finance | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Medical Director | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Pharmacy & Medicines Management | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Nursing, Quality & PE | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Executive Director of Public Health | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Executive Director of Strategy & Planning | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Long Term Agreements (LTAs) | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Executive Director of Workforce & OD | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Governance & Communication | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |

# Trends for our most concerning functions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

### Community and Integrated Medicine

| Domain | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr-26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 4 | 4 |
| Performance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Population health | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 2 |
| Quality & safety | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Strategic planning & fragile services | 3 | 3 | 3 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Governance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 |
| Workforce | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 4 |

### Estates and Facilities

| Domain | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Performance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Population health | 1 | 3 | 3 | 2 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 2 |
| Quality & safety | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Strategic planning & fragile services | 1 | 1 | 1 | 1 | n/a | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Governance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Workforce | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 2 |

# Trends for our most concerning functions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

## Mental Health and Learning Disabilities

| Domain | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Performance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Population health | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 1 |
| Quality & safety | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Strategic planning & fragile services | 2 | 2 | 2 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Governance | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 |
| Workforce | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |

## Operational Allied Health and Health Services: escalation levels by month and domain

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Performance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Population health | 3 | 3 | 3 | 3 | 3 | 2 | 1 | 1 | 1 | 1 | 2 | 1 |
| Quality & safety | 2 | 2 | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 3 | 3 |
| Strategic planning & fragile services | 3 | 3 | 3 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Governance | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Workforce | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

# Trends for our most concerning functions (3)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

**Planned and Specialist Care: escalation levels by month and domain**

| Function | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 | Jul 26 | Aug 26 | Sep 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | 4 | 4 |
| Performance | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Population health | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 2 | 2 | 2 | 2 |
| Quality & safety | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 2 | 3 | 3 | 2 |
| Strategic planning & fragile services | 3 | 3 | 3 | 3 | n/a | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Governance | 2 | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Workforce | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 |

# Escalation criteria

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

| Quality & Safety | Governance | Workforce | Finance | Strategy, Planning and Fragile Services | Population Health | Performance and Outcomes |
|---|---|---|---|---|---|---|
| Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response:<br>1. Incidents<br>2. Complaints<br>3. Duty of Candour<br>4. HIW/CIW<br>5. Deteriorating patients<br>6. Patient experience | Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response:<br>1. Risks<br>2. Audits/ inspections<br>3. WHCs/ Ministerial Directions<br>4. Governance arrangements<br>5. Policies | Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response:<br>1. Employee relations cases<br>2. Sickness<br>3. PADRs<br>4. Turnover<br>5. Mandatory training<br>6. Overdue pay progressions<br>7. Rosters & job plans (includes agency use) | Assurance the directorate will:<br>1. Operate within budget or deliver a recovery plan which will return to budget in year.<br>2. Identify and delivery recurrent savings to the level required. | Assurance the directorate will manage the risk of a service failure occurring within the next six months through robust mitigating plans.<br><br>Has a triangulated plan to operate services effectively for the year. | Determines if opportunities are being taken to encourage patients to embrace healthier lifestyles or to ensure that our population is resilient to future challenges. | Assurance the directorate will meet improvement trajectories to achieve target performance. |

5.2

**12:05, 5 Mins**

# 5.2 - PUBLIC SECTOR EMISSIONS REPORTING

***Douglas Wilson (Hywel Dda UHB - Senior Performance Management Analyst)***

For assurance

## Attachments

5.2 Public Sector Emissions Reporting FPC Oct 2026.pdf

# Pwyllgor Cyllid a Pherfformiad/ Finance and Performance Committee

| | |
|---|---|
| **DYDDIAD Y CYFARFOD:**<br>**DATE OF MEETING:** | **27 OCTOBER 2026** |
| **TEITL YR ADRODDIAD:**<br>**TITLE OF REPORT:** | Public Sector Emissions Reporting |
| **CYFARWYDDWR ARWEINIOL:**<br>**LEAD DIRECTOR:** | Huw Thomas, Executive Director of Finance |
| **SWYDDOG ADRODD:**<br>**REPORTING OFFICER:** | Sarah Thorne, Senior One Health Practitioner<br>Douglas Wilson, Performance Management Analyst |

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

## ADRODDIAD SCAA
## SBAR REPORT

### Sefyllfa / Situation

In 2017, the Welsh Government set the ambition of achieving a carbon neutral public sector by 2030. In March 2019, the Welsh Government published *Prosperity for All: A Low Carbon Wales* which includes policy 20: *Support the public sector to baseline, monitor and report progress towards carbon neutrality.*

The national aim is to:

- Baseline: To understand the current quantity of organisational emissions and removals for a consistently drawn boundary, quantifying the likely emission gap to carbon neutral operations by 2030.
- Identify mitigation potential: To assess and identify significant sources of emissions enabling organisations and the Welsh Public Sector to prioritise action needed to move to carbon neutral operations by 2030.
- Monitor progress: To gather, collate and analyse data on an annual basis to assess whether organisations are on track to achieving their goals of carbon neutrality by 2030.

There is a national requirement to complete and submit a carbon accounting form to Welsh Government annually.

This SBAR provides a summary of the Health Board's August 2026 submission to Welsh Government and highlights the principal reported sources of emissions. **The submission remains subject to national review and finalisation, which included a national correction to an anomalous supply-chain emission factor, confirmed on 14 October 2026.** Final figures will be confirmed once the reviewed reporting spreadsheet is returned to the Health Board**.**

## Cefndir / Background

The Welsh Public Sector Net Zero Carbon reporting guide provides principles and priorities for carbon reporting, its operational and organisational scope and the data which Welsh public bodies need to assemble annually in order to fulfil the reporting requirements. The Net Zero reporting template spreadsheet is published alongside this guide. This is our sixth round of submitting our carbon estimate to Welsh Government, with reporting requirements evolving each year.

## Asesiad / Assessment

**Emissions overview: 2024/25 to 2025/26**
Total emissions with reductions across most operational areas.

| 2024/25 | 2025/26 | Overall direction |
|---|---|---|
| 156,486,472 | 143,373,762 | ▼ Decreased |

**What changed?**

**▼ Reduced areas**
- Buildings
- Streetlighting
- Fleet and equipment
- F-gases
- Medical gases
- Business travel
- Homeworking
- Supply chain

**▲ Increased areas**
- Staff commuting
- Organisational waste

**Key message**
The submitted estimate shows an overall decrease, driven primarily by the spend-based supply-chain calculation.

Staff commuting increased by 219,161 kgCO2e and organisational waste emissions increased by 2,660 kgCO2e.

The Health Board's initial submitted estimate showed an increase in emissions from 156,486,472 kgCO2e in 2024/25 to 185,286,986 kgCO2e in 2025/26. A correction was subsequently applied to one spend-based supply-chain emission factor before the return was finalised. This resulted from an anomalous emission factor identified by the national reporting team. The corrected spreadsheet has since been returned and confirmed a decrease of 41,913,224 kgCO2e to 143,373,762 kgCO2e.

The table below shows the Health Board's carbon generation (kgCO2e) in 2025/26 and how it compares to 2024/25 and the trend.

| Categories | 2024/25 | 2025/26 | Trend |
|---|---|---|---|
| **Buildings, fleet & other assets** | | | |
| Buildings | 21,362,374 | 18,406,724 | ↓ |
| Streetlighting | 4,294 | 1,424 | ↓ |
| Fleet and equipment | 563,624 | 313,171 | ↓ |
| F-gases | 101,719 | 0 | ↓ |
| Medical gases | 1,818,546 | 1,100,005 | ↓ |
| **Business travel, commuting & homeworking** | | | |
| Business travel | 2,084,307 | 2,002,881 | ↓ |
| Staff commuting | 15,733,993 | 15,953,154 | ↑ |
| Homeworking | 920,110 | 780,954 | ↓ |

| | | | |
|---|---|---|---|
| **Waste** | | | |
| Organisational waste | 460,656 | 463,316 | ↑ |
| **Supply chain - Tier 1 and Tier 2 combined** | | | |
| Supply chain | 113,436,849 | 104,352,134 | ↓ |
| **Total emissions** | | | |
| **Total emissions** | **156,486,472** | **143,373,762** | ↓ |

Whilst this shows an increase in emissions from waste tonnage and staff commuting; staff commuting is the only category where the increase is directly attributable to more activity, with an estimated additional 985,710 commuting miles in 2025/26. Waste emissions increased following updates in emissions factors, not because more waste was produced which fell by 54 tonnes.

Decreases in emissions have been found in the following 8 categories:

- F-gases (-100%)
- Streetlighting (-67%)
- Fleet (-44%)
- Medical gases (-40%)
- Homeworking (-15%)
- Buildings (-14%)
- Supply chain (-8%)
- Business travel (-4%)

The table below shows the Health Board's activity and supply chain spend in 2025/26 and how it compares to 2024/25 and the trend.

| Categories | 2024/25 | 2025/26 | Trend | Standard unit |
|---|---|---|---|---|
| **Buildings, fleet & other assets** | | | | |
| Buildings – electricity & fuels | 92,334,287 | 81,551,202 | ↓ | kWh |
| Water – consumption & treatment | 468,727 | 467,931 | ↓ | m3 |
| Streetlighting | 15,829 | 5,802 | ↓ | kWh |
| Fleet and equipment | 1,972,387 | 1,091,562 | ↓ | kWh |
| F-gases | 54 | 0 | ↓ | kg |
| Medical gases | 4,161,039 | 2,711,597 | ↓ | litres |
| **Business travel, commuting & homeworking** | | | | |
| Business travel | 6,142,271 | 5,892,816 | ↓ | Vehicle miles |
| Staff commuting | 50,155,180 | 51,140,890 | ↑ | Vehicle/passenger miles |
| Homeworking | 2,756,638 | 2,339,726 | ↓ | FTE hours |
| **Waste** | | | | |
| Organisational waste | 2,596 | 2,542 | ↓ | tonnes |
| **Supply chain - Tier 1 and Tier 2 combined** | | | | |
| Supply chain* | 507,165,191 | 518,030,928 | ↑ | £ |

*Supply chain spend in 2025/26 includes an additional £7,836,489.89 re-allocated from NWSSP to individual Health Boards based on consumption from Bridgend stores and does not account for inflationary factors.

The table below shows the Health Board's generation and exports of renewable energy (kWh).

| Categories | 2024/25 | 2025/26 | Trend |
|---|---|---|---|
| **Renewable electricity generated** | | | |
| Onsite renewables - heat | 3,893,750 | 3,513,125 | ↓ |
| Onsite renewables - electricity | 684,193 | 369,515 | ↓ |
| **Renewable electricity exported** | | | |
| Onsite renewables - electricity | 73,109 | 29,748 | ↓ |

The full submission can be viewed here:
HDUHB Net Zero Reporting Data Collection Form 2025-26.xlsx

The reporting guide is: Welsh Public Sector Net Zero Carbon Reporting Guide (gov.wales)

**Improvements in performance since 2024/25 submission:**

Reasons for improvements in performance across the categories are as follows:

Buildings:
- Overall emissions from electricity have dropped from 6,380,280kgCO2e in 2024/25 to 5,833,818kgCO2e in 2025/26 and emissions from fuels (natural gas, LPG, gas oil and kerosene) reduced from 14,828,520kgCO2e to 12,315,697kgCO2e.
- Whilst emissions through our water supply and treatment increased due to revised emission factors, there was a modest decrease in water consumption (64.8m3) in 2025/26.
- LPG consumption continues to increase at GGH following commissioning in November 2023 from 5,900,935kWh in 2024/25 to 6,851,791kWh in 2025/26. Use of gas oil continues to decrease from 6,868,655kWh in 2024/25 to 4,550,452kWh in 2025/26. This fuel switch reduced emissions by 503,439kgCO2e.

Fleet:
- Overall vehicle mileage from petrol and diesel in our fleet has reduced for the second consecutive year from 235,853 miles in 2023/24 to 110,837 miles in 2025/26.
- Diesel mileage (50,728 miles in 2025/26) is the lowest recorded. We are fading out diesel from our fleet with the exception of some vehicles like large vans which are fit for purpose in diesel.
- We now have 10 electric vehicles (EVs) in our pool car fleet since the first was introduced in April 2024. These accounted for 72,954 miles in 2025/26. We hope to add seven more EVs to the fleet in 2027.

F-gases:
- No refrigeration f-gas additions were recorded in surveys or refrigerant logs during 2025/26 (four in 2024/25, none in 2023/24) at acute and community hospital sites.

Medical gases:
- Use of Nitrous Oxide has reduced by more than half since 2024/25 with a 15% reduction in Entonox (50% nitrous oxide and 50% oxygen).

Business travel:

- Business mileage has decreased by 4% to 5,537,417 miles in 2025/26 (14,487,837 miles in 2019/20).
- Courier mileage has reduced 8% from 232,461 miles in 2024/25 to 213,153 miles in 2025/26. We aim to improve our co-ordination to ensure multiple items are conveyed on a vehicle.

Homeworking:

- A continued decrease in emissions from homeworking from 920,110 kgCO2e in 2024/25 to 780,954 kgCO2e in 2025/26 due to a reduction in homeworking across all staff groups except for 'Add Prof Scientific and Technic,' 'Administrative and Clerical' and 'Healthcare Scientists' since the previous staff travel survey in 2023.

Renewables:

- We generated 8,491kWh from our new solar canopies, carports with solar panels on them, at South Pembrokeshire Hospital.

**Decline in performance since 2024/25 submission:**

Staff commuting:

- Staff commuting miles continue to increase following the COVID-19 pandemic, from 50,155,180 miles in 2024/25 to 51,140,890 miles in 2025/26. Emissions have, however, been partly offset by usage of electric and hybrid private vehicles which now account for 14.7% of total staff commuting miles.

Renewables:

- Woodchip consumption decreased from 3,893,750kWh in 2024/25 to 3,513,125kWh in 2025/26. This decrease is due to downtime as a result of work by a new provider in April 2025 to replace various parts and other maintenance.
- Overall Solar photovoltaic (PV) power generated onsite decreased from 684,193 kWh in 2024/25 to 369,515 kWh in 2025/26. Our solar farm at Hafan Derwen, which accounts for about half of the Health Board's solar generation capacity, was offline from April 2025 to February 2026 due to significant maintenance issues. There were also maintenance issues with several smaller systems. We are working with procurement to get maintenance contracts set up for solar panels through revenue funding.

Waste:

- Despite a decrease in waste tonnage which fell by 54 tonnes and total tonnage at 2,542 tonnes being the lowest since 2020/21 (2,136 tonnes), there has been an increase in emissions of 2,660kgCO2 since 2024/25.
- Black bag waste has increased from 97 tonnes in 2024/25 to 133 tonnes in 2025/26. However, this follows a sustained reduction for three consecutive years from 331 tonnes in 2021/22 to 97 tonnes in 2024/25.
- Recycling tonnage has reduced for the third consecutive year from 1,263 tonnes in 2024/25 to 1,244 tonnes in 2025/26. However, this follows more significant improvements in previous years (1,011 tonnes in 2021/22).
- Recycling of mixed plastics has increased from 3 to 38 tonnes. This follows the introduction of Workforce Recycling Regulations on acute hospital sites which was previously limited to healthcare and community sites.
- Anaerobic digestion continues to reduce from 255 tonnes in 2024/25 to 226 tonnes in 2025/26 as a result of catering implementing practices to reduce food waste such as cook/freeze.

**Changes in methodology since 2024/25 submission:**

Whilst staff commuting is the only category whereby our increase in carbon emissions is directly connected with increased activity, the bulk of our increase is due to changes in the methodology connected to our supply chain. The nominal increase in our procurement spend from £507,165,191 to £518,030,928 does not account for a re-allocation in 2025/26 from NWSSP to individual health boards, based on Bridgend stores consumption and inflationary factors.

Methodological changes resulting in increase in emissions:

- Changes to Tier 1 emission factors associated with the move to SIC 2022 codes have materially affected the submitted supply-chain estimate.
  - Following submission, the national Welsh Government Energy Services (WGES) Net Zero reporting team identified an exceptional increase in the factor for SIC code 46,**"**Wholesale trade services, except motor vehicles and motorcycles", from 0.022 to 3.895 kgCO2e/£. This represents an increase of more than 17,000%.
  - The national WGES team considers that applying the published 2022 factor would materially distort the reported footprint without reflecting a genuine change in underlying activity. The Department for Environment, Food and Rural Affairs has acknowledged that the movement is unusually extreme but has not yet provided a full explanation.
  - For the 2025/26 return, the national WGES reporting team intends to retain the previous factor of 0.022 kgCO2e/£ for this category. The correction will be made nationally during the review process, and no further action is currently required from the Health Board.
  - The Health Board's final supply-chain and total emissions position will be updated when the reviewed spreadsheet is received.
  - The underlying spend and coding within this category are also being considered nationally with NHS Wales Shared Services Partnership because the impact is concentrated particularly within NHS bodies.
- Unlike previous years, stores-related expenditure is now allocated to individual Health Boards to better reflect actual consumption whereas it was previously reported under the NWSSP Net Zero reporting submission. As a result, reallocation percentages provided by NWSSP Finance were applied to transfer 10.51% stores consumption to Hywel Dda UHB. This represented a spend increase of £7,836,489.89 and an additional 3,823,475 kgCO2e to our reported emissions.

**Additional notes:**

- Supply chain and medical gases are completed by NWSSP, who led on these parts of the report. A supply chain methodology report has been published by national Procurement to provide assurance of their approach to carbon reporting.
- Tier 1 emission factors represent the average emissions relating to each Standard Industrial Classification (SIC), and the emission factors relating to actual products within the group can be quite different. As a result, Tier 1 emissions estimates will not reflect any efforts made to reduce emissions through efficiencies in the supply chain or setting targets for emission reduction efforts.
- We are migrating to Tier 2 through the collation of supplier specific emissions using the requirement for suppliers of NHS contracts worth over £5 million (excluding VAT) over 4 years to produce and maintain a 'Carbon Reduction Plan'. At present, 5 areas of our supply emissions out of a total of 15 categories intended are covered by these plans to cover all areas of emissions with further work required to standardise accounting. The aim is to have supplier specific emissions per unit of product with a historic line of sight.
- It is important to note that the inclusion of additional categories in future will affect individual suppliers' Tier 2 emission factors as derived from their carbon reduction plans. This might

increase the emissions that company report on their carbon reduction plan and therefore slightly increase their Tier 2 emission factor.

- 783 NHS Wales' suppliers now have Carbon Reduction Plans enabling the collation of Tier 2 emissions factors, equating to 36.83% of reportable expenditure. This is an increase of 27.7% of spend with NHS Wales' suppliers who have Carbon Reduction Plans in 2024/25.
- Staff commuting was calculated based on the following data:
  - A staff headcount of 13,261 in 2025/26, working on average 4.37 days per week, with homeworking factors built in;
  - The mode of transport from responses in the staff travel survey conducted in May-August 2025;
  - An average commuting distance of 11.4 miles. This was calculated by the Carbon Trust using a bespoke tool with Hywel Dda University Health Board's payroll expenses data in 2018/19;
  - Two commuting journeys per day;
  - 46 working weeks.
- Homeworking was based on responses to the May-August 2025 staff travel survey and weighted according to staff group. The staff group is now calculated by the mapping of responses to the staff travel survey where possible to Electronic Staff Record. This represents a data quality improvement than in previous submissions where subjective staff group responses were used in calculations with gaps due to unknown responses.

Assurance position:

- The Health Board submitted its return within the required timetable.
- No action is currently required from the Health Board.
- The final reviewed spreadsheet will be retained as the definitive 2025/26 reporting record and any material change will be reflected in subsequent reporting.
- A consistent correction has been applied nationally to resolve an issue relating to a nationally published emission factor identified by the national reporting team through its scrutiny and quality-assurance process, which initially accounted for an increase in emissions.

## Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **Note** the Health Board's submitted 2025/26 emissions position and the operational reductions achieved across several reporting categories;
- **Note** that the supply-chain and total emissions figures remain provisional, pending completion of the national review and correction of an anomalous emission factor;
- **Take assurance** that an issue relating to an anomalous nationally published emission factor has been identified through the national scrutiny process, that the correction was made centrally and that no further action is currently required from the Health Board; and
- **Note** that the final validated figures will be used in subsequent organisational reporting and performance monitoring.

| **Amcanion: (rhaid cwblhau)<br>Objectives: (must be completed)** | |
|---|---|
| Cyfeirnod Cylch Gorchwyl y Pwyllgor:<br><br>Committee ToR Reference: | 3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake |

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| | deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery.<br>3.1.18 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies. |
| Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol:<br>Datix Risk Register Reference and Score: | Not Applicable |
| Parthau Ansawdd:<br>Domains of Quality<br>Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Galluogwyr Ansawdd:<br>Enablers of Quality:<br>Quality and Engagement Act (sharepoint.com) | Not Applicable |
| Amcanion Strategol y BIP:<br>UHB Strategic Objectives: | All Strategic Objectives are applicable |
| Nodau Cynllunio 2026/27<br>Planning Goals 2026/27 | All Planning Goals Apply |
| Hypergyswllt i Amcanion Llesiant HDdUHB 2026<br><br>Hyperlink to HDdUHB Well-being Objectives 2026 | 1. Deliver plans that increase our contribution to a sustainable, low carbon future<br>2. Strengthen resilience by planning for and adapting to climate change |
| Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)<br><br>A Social Model for Health and Wellbeing: (*complete for strategic* | Not Applicable |

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|---|---|
| *change and/or significant service changes)* | |
| **Gwybodaeth Ychwanegol:<br>Further Information:** | |
| Ar sail tystiolaeth:<br>Evidence Base: | The data to inform the report has been collated from the relevant directorates across the Health Board. |
| Rhestr Termau:<br>Glossary of Terms: | GGH – Glangwili General Hospital<br>LPG – Liquid Petroleum Gas<br>NWSSP – NHS Wales Shared Services Partnership<br>SIC – Standard Industrial Classification |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn:<br>Parties / Committees consulted prior to this meeting: | All organisational/national data owners |

| **Effaith: (rhaid cwblhau)<br>Impact: (must be completed)** | |
|---|---|
| **Ariannol / Gwerth am Arian:<br>Financial / Service:** | The Executive Director of Public Health has the lead for the carbon plan which outlines the actions to be taken to reduce our emissions. The impact on finances, services would be outlined within that plan. |
| **Ansawdd / Gofal Claf:<br>Quality / Patient Care:** | Not Applicable |
| **Gweithlu:<br>Workforce:** | Not Applicable |
| **Tegwch Iechyd:<br>Health Equity:** | Not Applicable |
| **Risg:<br>Risk:** | Not Applicable |
| **Cyfreithiol:<br>Legal:** | Not Applicable |
| **Enw Da:<br>Reputational:** | There is a Welsh Government target to be carbon neutral by 2030. The Executive Director of Public Health has the lead for the carbon plan which outlines the actions to be taken to reduce our emissions. The reputational impact of not achieving net zero would be picked up as part of that plan. |
| **Gyfrinachedd:<br>Privacy:** | Not Applicable |
| **Cydraddoldeb:<br>Equality:** | Not Applicable |