



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **30/06/2026**
Time **09:30 - 12:30**
Location **HDD Picton - Dolau Cothi; Microsoft Teams meeting**

Finance and Performance Committee

HDD_Finance and Performance Committee
NHS Wales

Agenda - 30 June 2026

1 GOVERNANCE

09:30, 0 min

1.1 WELCOME AND APOLOGIES

09:30, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.2 DECLARATION OF INTERESTS

09:30, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.3 MINUTES OF FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 APRIL 2026

09:30, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.4 TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE COMMITTEE HELD ON 30 APRIL 2026

09:30, 0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

1.5 ASSURANCE AND RISK REPORT

09:30, 15 min

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

2 PERFORMANCE

09:45, 0 min

2.1 INTEGRATED PERFORMANCE ASSURANCE REPORT

09:45, 10 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

2.2 PERFORMANCE DEEP DIVE: ALERT AREAS

09:55, 15 min
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)

2.3 NWSSP PERFORMANCE REPORT QUARTER 4 2025/26

10:10, 5 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

2.4 UEC BUSINESS CASE: IMPLEMENTATION AND EVALUATION- TO FOLLOW

10:15, 15 min
Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

3 ESCALATION OVERVIEW

10:30, 0 min

3.1 ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

10:30, 15 min
Shaun Ayres (Hywel Dda UHB - Director of Delivery)

4 ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

10:45, 0 min

4.1 DE-RISKING THE ANNUAL PLAN - SUMMARY OUTPUT FROM IN-COMMITTEE BOARD- TO FOLLOW

10:45, 15 min
Huw Thomas (Hywel Dda UHB - Director of Finance)

5 FINANCE

11:00, 0 min

5.1 FINANCIAL PERFORMANCE ASSURANCE REPORT

11:00, 15 min
Andrew Spratt (Hywel Dda UHB - Deputy Director of Finance), Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)

5.2 FINANCE DEEP DIVE: ALERTS (MEDICAL)

11:15, 15 min
Mark Henwood (Hywel Dda UHB - Executive Medical Director)

5.3 FINANCE DEEP DIVE: ALERTS (CONTINUING HEALTHCARE)

11:30, 15 min

Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

5.4 FINANCE DEEP DIVE: ALERTS (CLINICAL CARE GROUP SAVINGS PLANS): Request to Defer

11:45, 15 min

Keith Jones (Hywel Dda UHB - Director of Operational Planning & Performance)

5.5 INVESTMENT AND BENEFITS REALISATION REPORT

12:00, 5 min

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

5.6 PLAN FOR CLOSING THE RESIDUAL DELIVERY GAP TO £41M

12:05, 0 min

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

5.7 BAND 2 AND 3 HEALTHCARE SUPPORT WORKER PAY RE-BANDING UPDATE

12:05, 10 min

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

5.8 PROCUREMENT REPORT

12:15, 5 min

Lee Morgan (NWSSP - Procurement)

5.9 PROCUREMENT PLAN

Lee Morgan (NWSSP - Procurement)

5.10 PLANNING GOALS UPDATE REPORT Q1 2026/27

5 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6 FOR INFORMATION

0 min

6.1 ALL-WALES CAPITAL PROGRAMME 2026/27, CAPITAL RESOURCE LIMIT AND CAPITAL FINANCIAL MANAGEMENT UPDATE

0 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6.2 JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

0 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6.3 NWSSP PROCUREMENT SERVICES 2025-26 SUMMARY REVIEW

0 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

6.4 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27

0 min

Michael Imperato (Hywel Dda UHB - Independent Board Member)

7 ANY OTHER BUSINESS

0 min

8 DATE OF NEXT MEETING

0 min

9 IN COMMITTEE SESSION

0 min

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1 - GOVERNANCE

1.1

09:30, 0 Mins

1.1 - WELCOME AND APOLOGIES

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

1.2

09:30, 0 Mins

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 30
APRIL 2026

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

| For approval

Attachments

Unapproved Minutes FPC 30 April 2026.pdf

UNAPPROVED MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE MEETING

DATE OF MEETING: 9:00 AM, Thursday 30 April 2026

VENUE: Microsoft Teams Meeting

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

IN ATTENDANCE: Shaun Ayres (Hywel Dda UHB - Director of Delivery)
Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer)
Gemma Deverill (NWSSP – Procurement) (part)
Lisa Gostling (Hywel Dda UHB – Director of Workforce & OD/Deputy CEO) (part)
Siân Jenkins (Hywel Dda UHB - Deputy Director of Finance) (part)
Keith Jones (Hywel Dda UHB – Director of Operational Planning & Performance)
James Severs (Hywel Dda UHB – Executive Director of Allied Health Professions and Health Science)
Andrew Spratt (Hywel Dda UHB – Deputy Director of Finance)
Huw Thomas (Hywel Dda UHB - Director of Finance)
Jennifer Thomas (Hywel Dda UHB - Head of Corporate Reporting and Planning)
Joanne Wilson (Hywel Dda UHB - Director of Corporate Governance/Board Secretary)
John Jenkins (Hywel Dda UHB - Committee Services Officer) (Secretariat)

MINUTES REF.	ITEM	ACTION
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FPC(26)024	WELCOME AND APOLOGIES
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Mr Michael Imperato welcomed all to the Finance and Performance Committee (FPC) meeting.

Apologies had been received from:

- Mr Mark Henwood, Executive Medical Director

FPC(26)025	DECLARATION OF INTERESTS
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There were no declarations of interest.

FPC(26)026

**MINUTES OF FINANCE AND PERFORMANCE COMMITTEE
HELD ON 24 FEBRUARY 2026**

The minutes of the FPC meeting held on 24 February 2026 were reviewed and agreed as an accurate record of proceedings.

Decision: The minutes of the Finance and Performance Committee meeting held on the 24 February 2026 were **APPROVED** as a correct record of proceedings.

FPC(26)027

**TABLE OF ACTIONS FROM FINANCE AND PERFORMANCE
COMMITTEE HELD ON 24 FEBRUARY 2026**

The Table of Actions from the FPC meeting held on 24 February 2026 was reviewed. The following updates were provided to the meeting:

FPC(26)006 ('Assurance and Risk Report'): Mr Shaun Ayres advised that he would discuss with the Operations Team and Service Directors to use the same data sources for the projection of performance trajectories and that the action could be considered closed.

FCP(26)016 ('Integrated Performance Assurance Report'): It was noted that Mr James Severs was the lead for this risk and advised that confirmation on whether the improvement to the Therapies referral to treatment (RTT) performance was as a result of data validation being undertaken would be confirmed at the FPC meeting on 30 June 2026 and that the action would remain open pending confirmation.

Decision: The Finance and Performance Committee **REVIEWED** and **NOTED** the Table of Actions from the Finance and Performance Committee meeting held on 24 February 2026.

FPC(26)028

**FINANCE AND PERFORMANCE COMMITTEE ANNUAL
REPORT 2025/26**

Mr Imperato presented the FPC Annual Report 2025/26 to the Committee ahead of onward submission to the Board meeting on 28 May 2026.

Decision: The Finance and Performance Committee **NOTED** and **APPROVED** the Finance and Performance Committee Annual Report 2025/26 for onward submission to Board.

Mrs Joanne Wilson presented the Assurance and Risk Report to the Committee and noted that there were 3 risks on the Corporate Risk Register (CRR) aligned to FPC and advised that there were 18 outstanding audit and inspection reports with open recommendations outstanding.

Mrs Wilson advised that the three corporate risks, Risk 1350 ('Risk of not meeting the 80% SCP waiting times target for March 2026 due to diagnostics capacity and delays at tertiary centre'), Risk 2326 ('Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding') and Risk 2327 ('Risk to planned care and RTT recovery in 2026/27 due to demand-capacity gaps, estate fragility and non-recurrent funding') would be discussed in greater detail at a later point of the meeting.

Mrs Wilson believed that due to the number of audit recommendations that had exceeded their completion date that the Committee may not be able to take assurance and that the Committee could be minded to request that the audit responses were updated before the FPC meeting on 30 June 2026.

Cllr Rhodri Evans advised that the Audit and Risk Assurance Committee (ARAC) would also be requesting that work to complete the audit recommendations be undertaken and Mrs Wilson noted that ARAC had requested that a representative of the Community and Integrated Medicine (CIM) Clinical Care Group (CCG) attend the ARAC meeting on 23 June 2026 to provide an update on risks and audits.

Mr Thomas highlighted that the three risks on the CRR had been scrutinised and were up-to-date and all the Ministerial Directions (MDs) within the remit of FPC were complete. Mr Thomas believed that this enabled the Committee to take assurance on the risks and the MDs with only the audit recommendations unable to provide the required level of assurance.

Decision: The Finance and Performance Committee, in relation to the areas presented in this paper from the Lead Director or Supporting Officer:

Risk Management

- **RECEIVED ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVED ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will

reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports

- **ADVISED** that due to the number of overdue audit recommendations on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations with any barriers to delivery noted, could not receive assurance

Ministerial Directions

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

Update Report to Board: The Finance and Performance Committee were **ASSURED** on the management of risk and compliance with Ministerial Directions however it wished to **ADVISE** the Board that a significant number of audit recommendations were overdue and that responses to the audit recommendations were requested ahead of the next Finance and Performance Committee meeting on 30 June 2026.

FPC(26)030

ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

Mr Ayres introduced the Escalation Oversight and Highlight Report to the Committee and noted that the Health Board had met its Welsh Government (WG) Target Control Total (TCT) for 2025/26 however advised that this was due to a reliance on a number of year-end adjustments as the run-rate had increased and advised that there would be a consequence to the run-rate within 2026/27 and the risks being carried by the Health Board.

Mr Ayres advised that in 2026/27 the Health Board would be required to make £42m of savings to attain the £41m position articulated within the Annual Plan.

Mr Ayres highlighted the Single Cancer Pathway (SCP) as an area that was previously within escalation however was no longer in escalation with performance having dipped below the targeted intervention (TI) level of 60% in February 2026, to 59.8% however the March and April 2026 position was anticipated to be higher.

Mr Ayres believed that an area of concern was within Delayed Packages of Care (DPoc) with approximately 220 delayed packages remaining static and posed the greatest risk to the delivery of the Annual Plan with a cost of £27m to £28m to the Health Board of having delayed packages of care within the bed base.

Mr Ayres noted that R1 Ophthalmology performance had continued to improve at the projected rate however was still materially below the required level with work being undertaken on clinical validation and a delivery plan that was anticipated to significantly improve performance.

Mr Ayres highlighted that the Health Board was not meeting its urgent care TI criteria target for less than 7% of ambulance waits of 12 hours with a number of plans in place to address the performance and DPoCs through the implementation of a 7-day clinical streaming hub and the extension of the Same Day Emergency Care (SDEC) centre at Withybush Hospital (WGH) however Mr Ayres believed that additional work was required at the back door of acute sites to facilitate discharges as opposed to solely focussing on the front door and admissions.

In response to a question from Cllr Evans on the SPC performance, Mr Andrew Carruthers advised that it had previously been predicted that there would be two months of performance deterioration as part of the improvement works undertaken within the SCP ahead of an upturn in performance as a result of the actions taken within Urology and the Colorectal Pathway to reduce the backlog of patients awaiting treatment and to make the improvements in performance more sustainable in the longer term. Mr Carruthers advised that WG were aware of the action taken, the rationale for taking the actions and the anticipated short-term reduction in performance to enable a longer-term improvement. Mr Keith Jones confirmed that the March performance figure was anticipated to be at least 63%.

Mrs Eleanor Marks expressed concern on the internal escalation of quality and safety as the only domain with an upward movement within the internal escalation framework and requested that the quality and safety concerns be cross-referenced to the Quality, Safety and Experience Committee (QSEC).

SA

In response to a question from Mr Imperato on R1 Ophthalmology performance, Mr Carruthers advised that a plan and additional investment within Ophthalmology was agreed within 2025/26 and noted that a delay to the implementation of the plan had been advised at the FPC meeting on 24 February 2026 however the revised trajectory was expected to exhibit the improved levels of performance anticipated by Autumn 2026 despite some challenges in identifying the appropriate space within the estate at Amman Valley Hospital (AVH) to enable to level of activity required to deliver the projected performance improvement.

Decision: The Finance and Performance Committee:

- **NOTED** the alert-rated criteria (C2 underlying deficit, C15 ophthalmology, C17 12-hour ED at Withybush Hospital) and agree the mitigating actions proposed by the executive leads.

- **NOTED** the assure-rated criteria (C3 TCT delivered, C16 ambulance de-escalation) and endorse continued monitoring.
- **ADVISED** on pace for DPOC (C19) and pathway compliance (C26/28), particularly resource prioritisation for theatre capacity.
- **CONSIDERED** whether the ophthalmology escalation measure (C15) remains appropriate given the revised achievability assessment.
- **NOTED** the internal escalation summary and the concentrated pharmacy de-escalation.

FPC(26)031

HOSPITAL FLOW PROCESSES

Mr Carruthers introduced the deep dive into the Health Board's hospital flow processes and emphasised that the Health Board was not operating at the level of performance, access, and quality and safety experience that it would like to provide however acknowledged that performance had increased significantly over the preceding 12 months and had exceeded improvement trajectories that had been anticipated.

Mr Carruthers believed that significant improvements had been made against ambulance handover trajectories and 1 hour ambulance handover targets that had seen the Health Board over-achieve against its WG TI de-escalation criteria in six of the previous seven months and ahead of where the Health Board projected it would be in its Annual Plan. Mr Carruthers remarked that this was especially notable as improvements had been sustained over the winter period.

Mr Carruthers advised that there had been a 50% reduction in the amount of lost ambulance hours however the level patients waiting over 12 hours within an Emergency Department (ED) was higher than anticipated with the resulting quality, safety and patient experience risk.

Mr Carruthers noted that a key area that WG were focussing on and had received additional attention at the Health Board's Public Accountability Meeting with the Cabinet Secretary for Health and Social Care on 11 December 2025 was the time patients had to wait to see a clinical decision-maker and was an area Mr Carruthers believed the Health Board was struggling to achieve. Mr Carruthers advised that this was a key area within the Health Board's Annual Plan in addition to reducing the number of DPoCs.

Mr Carruthers advised that the number of DPoCs had reduced to below 200 at the start of 2026 however had increased to around 240 recently and engagement was required with the Health Board's constituent Local Authorities as Local Authorities and Regional Partnership Board (RPBs) had received significant

investment from WG, the investment made to increase social worker assessment capacity and to increase package of care availability had only had a short-term impact on performance.

Mr Carruthers believed that sustained longer-term improvements were required to reduce DPoCs to relieve pressure on the back door of the Health Board's hospitals through improved discharges to support patient flow.

Mr Carruthers noted that an Urgent and Emergency Care (UEC) Business Case had been approved to increase the Health Board's clinical streaming capacity, Hospital@Home and SDEC capabilities to a 7-day-a-week service on a phased basis starting this year with plans being progressed for implementation ahead of the 2026/27 winter period.

Mr Carruthers advised that a workshop had been undertaken in April 2026 to progress transformation work within the Health Board on how the Community by Design Strategy could be implemented and believed that service configuration and workforce fragility posed the greatest service risks affecting a number of key performance metrics.

Mr Keith Jones believed that the incremental improvements to performance trajectories had been driven by the on-going UEC Accelerated Transformation Programme and the Six Goals Programme with further improvements predicated on the delivery improvements associated with the UEC Business Case such as the move to 7-day clinical streaming and the expansion of the SDEC at WGH to drive improvement.

Mr Winston Weir questioned whether the 12-hour patient waits in ED were improving and enquired whether there was data showing the mean average patient waits within ED and the median times for patients to see a clinical decision-maker. Mr Carruthers advised that he would collate the requested data for mean patient waiting times within ED and median times for patients waiting to see a clinical decision-maker by acute site.

AC

Mr Carruthers believed that the waiting times operated on a weekly cyclical pattern with the system performing better from Monday to Thursday with the key improvements anticipated from the UEC Business Case was to move to an improved 7-day-a-week system that would improve performance and reduce variation. Mr Jones believed that the WGH site impacted disproportionately on the Health Board's performance and was the reason for the focus on the SDEC expansion within the UEC Business Case being centred on the WGH site.

In response to a question from Cllr Evans on timescales for expected improvements, Mr Carruthers advised that UEC improvement work was not anticipated to be linear with a fixed endpoint, rather a continually evolving challenge that would

always need to adapt and respond to the changing needs of the population and demand on the system.

In response to a question from Mrs Marks on what actions were being undertaken to break the pattern and cycle of challenge within UEC, Mr Carruthers advised that the engagement work with clusters, primary care and community teams undertaken recently sought to reshape the system to deliver the outcomes relating to reduced demand and improved patient flow within the acute setting and advised that work was being progressed with the Clinical Executive Directors to develop a set of internal operational standards and interprofessional standards to establish expectations of how the differing professions and the system as a whole responded to the ED challenge such as managing referrals to support patient flow.

In response to a question from Cllr Evans on whether there were any financial constraints limiting the ability to drive performance improvements, Mr Carruthers believed that the main resource constraints were within having a fragile workforce within the medical workforce, within EDs and within acute medicine with the additional capacity needed to improve flow being unfunded such as the use of surge beds and that the main challenge was how resources could be reallocated as opposed to the need for additional resources.

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Hospital Flow Processes report.

Update Report to Board: The Finance and Performance Committee were assured with the levels of activity and the plans in place to improve hospital flow performance however wished to **ADVISE** the Board that there needs to be more evidence of the impact that the plans are having on hospital flow performance.

FPC(26)032

Q1 2026/27 PLANNED CARE TRAJECTORIES

Mr Jones presented the Q1 2026/27 Planned Care Trajectory update to the Committee and advised that the premise for planning for Planned Care delivery for the year ahead was predicated on prioritising the available resources to address pathways that were considered the most clinically urgent in the first instance as a priority.

Mr Jones advised that the priority was the delivery of the Health Board's cancer delivery ambitions however the consequence of that prioritisation was a challenge for the forecasted delivery of referral to treatment (RTT) performance, especially for the reduction of patients waiting over 104 weeks for their treatment,

the number of patients waiting over 26 weeks for their first outpatient appointment and for patients waiting over 8 weeks for diagnostic measures.

Mr Jones believed that the Health Board would struggle to meet its target delivery expectations without additional support and investment into capacity.

Mr Jones advised that the planned care trajectories for the forthcoming year had been developed to and reflect key assumptions around productivity and efficiency with the core productivity improvement aiding current performance however on its own do not enable the Health Board to deliver the expected performance targets.

Mr Jones cautioned that the trajectory modelled a scenario whereby there could be breaches and a delivery gap against the 104-week RTT target of 5,507 patients and 9,316 26-week RTT breaches across a number of challenged specialities.

Mr Jones advised that the number of challenged specialities had reduced with all other specialities around balance for their demand and capacity levels.

Mr Jones noted that the positive progress in planned care delivery in preceding years had been achieved through the support of additional financial support, with £10m of additional support having been provided by WG in 2025/26. Mr Jones cautioned that the assumption for 2026/27 was that that additional support would not be received resulting in an anticipated significant drop in anticipated delivery levels and that the cost of recovery to bring the forecasted deficit position back to target level was estimated at £12m.

Mr Jones advised that the system improvement measures being implemented within the SCP would result in performance being maintained in 2026/27 at the same level as exhibited in 2025/26 in the mid-60% range and believed that to facilitate further progress towards the 75% performance target a step improvement in the diagnostic capacity was required with no current realistic expectation that the diagnostic improvements were expected to be delivered, with additional investment in radiology required to drive any improvement.

In response to a question from Cllr Evans on clinical validation being a reason for delays to ophthalmology performance improvements, the delivery gap in 2026/27 was envisaged to be almost exclusively related to the cataract pathway that presented a demand and capacity gap due to the workforce required to respond to the level of demand for treatment. Mr Jones advised that there had been a contemporary reliance on additional outsourced capacity within the independent sector supported by

additional recovery financial support from WG, with more than 3,000 cataract treatments procured in 2025/26.

Mr Jones believed that there was a variable landscape within clinical validation with mechanisms in place to ensure timely and regular clinical validation. Mr Jones noted that Hywel Dda University Health Board (HDdUHB) were one of the few Health Boards in Wales to make positive progress in implementing a one-stop cataract pathway in the last two years with patients referred to the Health Board for a presumed cataract treatment effectively bypassing the outpatient stage of treatment as a result of the close working partnership developed between the Health Board and community-based optometrists.

In response to a question from Mr Neil Prior on whether all productivity measures had been maximised, Mr Carruthers advised that in developing the Annual Plan a level of assumptions had been made relating to the deliverability of productivity and efficiency benefits to attain the year-end position. Mr Carruthers advised that while the Committee could request the service to examine how further efficiency and productivity gains could be made, the stated levels were based on what each service had assessed was deliverable to support performance and that the year-end position should be considered a minimum level of what could be delivered.

Mr Jones advised that the productivity and efficiency levels were advised by services as to what could be reasonably achieved with the infrastructure, skills and capacity available within the organisation and should be considered a minimum with an ambition for further improvement wherever possible. Mr Jones cited the example of theatre utilisation where there was considered to be scope for further improvement.

Mr Jones noted that the NHS Wales Planned Care Optimisation Framework had been revised with each Health Board having been asked to undertake a self-assessment appraisal against the framework to assess themselves against the various metrics measured within the framework. Mr Jones advised that the outcome of the Health Board's self-assessment would be circulated to members of FPC to demonstrate how the Health Board measured itself against the framework.

KJ

In response to a question from Mr Prior on what the current level of theatre utilisation was, Mr Jones advised that the Health Board's theatre utilisation performance was currently at 80% with a trajectory to improve towards a target of 85%.

Decision: The Finance and Performance Committee:

- **ENDORSED** the planned care trajectories for 2026/27 as a credible and evidence-based reflection of what can be delivered within the confirmed resource envelope

- **NOTED** and accept the residual Referral To Treatment, Since Cancer Pathway and diagnostic risk, recognising that:
 - The remaining gaps represent structural demand exceeding funded capacity;
 - All mandated enabling actions and productivity measures are already maximised.
- **SUPPORTED** continued prioritisation of cancer and high-risk patients, maintaining Single Cancer Pathway performance above de-escalation thresholds while preventing deterioration in Referral To Treatment;
- **AGREED** to the use the Annual Plan position as a transparent basis for assurance, escalation and future Integrated Medium-Term Plan development, demonstrating organisational grip, realism and patient-safety-led prioritisation.

Update Report to Board: The Finance and Performance Committee wished to **ADVISE** the Board that it felt that the anticipated levels of improvements contained within the planned care trajectories should be considered a minimal level of expectation and that further work was required to achieve the level of performance that would like to be achieved and that there needed to be more ambition expressed within the plans to state that further efficiency and productivity could be realised to drive performance improvement.

FPC(26)033

ENABLING ACTIONS: VALUE OPPORTUNITIES

Mr Thomas presented the Enabling Actions and Value Opportunities report to the Committee and advised that the report was an amalgamation of the work undertaken by Swansea University and the Health Board's internal Value Team to provide a validated evidence base of value opportunities that were considered available to the Health Board to consider the opportunities that were considered high-value that could be prioritised to be enacted and low-value opportunities that should be deprioritised.

Mr Thomas advised that these opportunities were considered in conjunction with the compendium of enabling actions that had been provided by WG for the Health Board to pursue and address.

Mr Thomas advised that he was seeking assurance from the Health Board that the opportunities outlined were being embedded within the organisation and its ways of working and that a programme of self-assessment had been implemented to enable assurance to be gained from the adoption of the value opportunities by the Health Board. Mr Thomas advised that he had discussed with Mrs Wilson the implementation of an audit

programme to ensure that the self-assessments could be tested to provide independent assurance that as many value opportunities were being embedded within the Health Board as possible.

In response to a question from Mr Prior on whether all value opportunities had been considered, Mr Thomas advised that the compendium was a list of items considered best-practice and not an exhaustive list of items that could be tested within the organisation and that when the Board considers more complex issues such as service configuration, the Board would need to satisfy itself that the Health Board was a high-value organisation and that all of the value interventions had been adopted.

Mr Thomas advised that there had been case studies undertaken and provided the example of the heart failure pathway where the Health Board had reduced the demand on secondary care through a one-stop pharmacy-led heart failure clinic and that the development of the fracture liaison service had been implemented resulting in a reduction of 100 to 120 patients requiring treatment resulting in a full-year impact of £2.4m of value savings being delivered in addition to the improved level of patient quality and experience.

In response to a question from Mr Weir on the timings and phasing of the implementation of the value opportunities, Mr Thomas advised that the opportunities formed a part of the Health Board seeking to meet its £41m Annual Plan position with the Chair of the Health Board having been explicit at the Board meeting on 26 March 2026 of the need to explore all options to attain a £22m deficit position and WG expectations to reach a break-even position.

Decision: The Finance and Performance Committee is asked to **RECEIVED ASSURANCE** that there is a clear catalogue of low investment/high value opportunities that now need to be converted into delivery.

Update Report to Board: The Finance and Performance Committee were **ASSURED** that confidence could be taken from the development of a compendium of value opportunities that the Health Board should seek to embed within the organisation and enacted to ensure that the Health Board could consider itself a high-value organisation that sought to maximise its value opportunities.

FPC(26)034

Q1 2026/27 FINANCIAL TRAJECTORY

Ms Siân Jenkins presented the Q1 2026/27 Financial Trajectory report to the Committee and advised that the report was based on

information up to the end of Q4 2025/26 and followed the agreement of the 2026/27 Financial Plan with the target annual deficit total of £41m.

Ms Jenkins advised that a review of the Clinical Care Group (CCG) financial position indicated an additional £18m deficit in addition to the Annual Plan deficit position coupled with the challenge of meeting an annual savings target of £42.8m. Ms Jenkins advised that there was a potential gap of £29m between the savings schemes that had been currently identified.

Ms Jenkins advised that the current trajectory indicated an annual deficit position of £88m.

Ms Jenkins believed that the savings position could be tested in further detail by reviewing the profile of delivery framed for each saving plan in addition to the categorisation status of saving schemes. Ms Jenkins advised that by focusing on the savings that had been declared as Amber and Green, the savings gap could be refined with the profiled savings plans for Q1 2026/27 and both the savings delivery gap should all BRAG schemes be delivered, total £7.3m assuming only the Amber and Green schemes are realised, a £9.0m gap. Ms Jenkins advised that over the course of Q1 2026/27 the expectation was that some of the savings schemes would be converted to Amber and Green or new schemes would be identified.

Ms Jenkins advised that the range for the Q1 2026/27 financial outlook when combining the planned deficit of £10.3m, the year-to-date budget deficit of £4.5m and the savings gap between £7.8m and £10.2m, was currently estimated to be between £22.6m and £25.0m.

Ms Jenkins advised that to support the recovery of the financial outlook, a four-step improvement framework had been developed with the first three steps aiming to enable the delivery of the £41m planned deficit with the fourth step seeking to go further to attain the £22.1m TCT position.

Ms Jenkins highlighted that the proposal to release as much financial opportunity as possible in Q1 2026/27 to provide opportunity to fund performance improvement measures had not yielded any such opportunities and ruled out the third step as being part of the Financial Improvement Framework.

In response to a question from Mrs Marks on how the £42.8m savings delivery plan would be de-risked, Ms Jenkins advised that work was being undertaken with the CCGs to explore the savings challenge and how the run-rate could be reduced and that further information would be contained in the updated financial forecast currently being produced with the focus on reducing spend.

Mr Thomas believed that while CCGs were a large part of the organisation that there were other areas that also had responsibility for the delivery of savings with a need to ensure that there was local delivery of savings that were within the control of CCGs or individual functions with elements that could not be delivered by one CCG or function likely to be difficult configuration issues that would require choices to be presented to Board.

Mr Thomas believed that the first step was to stabilise the run-rate with further work required on the conversion of non-recurrent savings to recurrent.

Mr Thomas expressed disappointment with the lack of engagement to create a level of headroom within Q1 2026/27 to enable performance improvements with the focus shifting towards de-risking the £41m position to accelerate improvements towards attaining the £22.1m TCT.

Mr Thomas advised that there was a process being led by Mr Carruthers that sought to provide assurance over the delivery of the base savings within operations with a separate process being overseen by the Finance and Planning Teams to develop additional choices to present to Board to further reduce the Health Board's deficit figure towards break-even. Mr Jones advised that each CCG had been asked to review their savings plans from actions that could be taken wholly within each CCG and to consider actions and opportunities that could span individual CCGs or functions

Decision: The Finance and Performance Committee:

- **ACKNOWLEDGED** the update in respect of the financial outlook for Q1 2026/27 and the challenge this poses for the Health Board.
- **DISCUSSED** and **SCRUTINISED** the four-step framework posed and the approach to reduce variable pay.
- **AGREED** that the approach being taken to improve financial performance for Q1 2026/27 was sufficient to gain Board support in May 2026.

Update Report to Board: The Finance and Performance Committee were assured by the Financial Improvement Framework to support the recovery of the financial outlook and that the approach being taken to improve financial performance in Q1 2026/27 gave sufficient assurance to receive Board support.

Financial Performance Assurance Report was subject to end-of-year audit however the indicative position was that the Health Board had achieved its 2025/26 TCT position of £22.1m.

Mr Thomas believed that meeting the TCT position reflected positively on the Health Board and would lend a degree of credibility in the Health Board with WG.

Mr Andrew Spratt introduced a brief review of the 2025/26 financial year and reminded the Committee that the Health Board agreed a financial plan at the start of 2025/26 that had a deficit position of £31.5m that the Health Board improved to £30m that following clarity from WG and through further actions enacted by the Health Board ended at a position of £22.1m, meeting the WG TCT position.

Mr Spratt highlighted the three top priority alerts for the Committee's attention. Mr Spratt advised that there had been an unexpected early opening of the SDECs to accommodate 7-day working to accommodate patient demand and that this had resulted in an increase in the level of variable pay.

Mr Spratt noted that the Health Board was experiencing a degree of dual-system running costs within the Radiology Informatics System Procurement system and advised that work was being undertaken with the national team that were implementing the change of systems to understand for how long the dual-running would operate and what the costs would be.

Mr Spratt advised that further to the discussions on the planned care trajectories, there had been additional activity in Q4 2025/26 within planned and specialist care to clear a proportion of patient backlog that had incurred additional cost and advised that there was no unplanned additional activity anticipated within M1 2026/27.

Mr Spratt advised that the Health Board had received a response from WG regarding a rapid assessment of the Health Board's Annual Plan and that WG have deemed the Health Board's Annual Plan as submitted as being unsupportable from both a finance and performance perspective.

Mr Spratt advised that the first step of the four-step improvement framework was aimed at providing clarity on what proportion of non-recurrent savings could be relied upon on a recurrent basis. Mr Spratt noted that the Health Board had finished 2025/26 with a non-recurrent savings delivery of £37.9m, out of a total of £57m savings. However, Mr Spratt cautioned that £7m of the savings total related to one-off accountancy gains that would not be repeated.

Mr Spratt informed that the Annual Plan process being undertaken in 2026/27 assumed that the level of non-recurrent savings in

2025/26 would continue in 2026/27 unless budget holders or Executive Directors consciously rebutted the need to make the savings for operational reasons. Mr Spratt advised that no rebuttals had been received for £10m of the total savings that had been converted into recurrent savings within the new financial year, leaving £20m that has been historically saved now assumed within the Annual Plan to be spent.

Mr Spratt advised that the £20m of spending formed part of the Health Board's underlying deficit, which was £30m higher than the 2025/26 outturn with £20m of the underlying deficit being savings that had not been converted into the 2026/27 savings plan.

Mr Spratt highlighted that the Committee were advised of the Health Board's escalation approach and changes to the Ways of Working. Mr Spratt noted that there were a number of service areas that continued to be in Level 3 of internal escalation with an overview of accountability and escalation framework to be presented to FPC at the 30 June 2026 meeting.

Mr Spratt advised that there was on-going work being undertaken in relation to newly qualified nurse streamlining and recruitment to understand the implications for the Health Board's financial plan of an oversubscription of streamlining students due to be offered posts within the Health Board that the Health Board may not be able to fulfil that could have a financial impact.

Mr Spratt provided an update on the current status of budget delegation accountability letters for the 2026/27 financial plan and advised that 31 letters had been sent to Executive Directions, Function Leads and CCG Directors with 19 signed letters returned and advised that an update would be provide to the FPC meeting on 30 June 2026.

Mr Spratt advised that an update would be provided to the FPC meeting on 30 June 2026 on the Healthcare Support Worker (HCSW) Band 2/Band 3 re-banding dispute and highlighted that the Financial Plan had assumed a financial impact of £2m however advised that there was a risk that the full implication could be in excess of £2m.

In response to a question from Mr Weir on whether the budget delegation accountability letters contained a commitment to delivering savings, Mr Spratt advised that the manner in which budgets and savings were delegated was undertaken in a similar manner with the signing of the budget delegation accountability letter being a commitment to remain within budget and to implement the savings reductions with savings only being transacted once a robust and assured savings plan was approved.

In response to a question from Mrs Marks on the cost of CHC, Mr Thomas believed that the Health Board had not anticipated the

level of change within CHC following the Internal Audit report providing assurance over the robustness of the CHC database.

In response to a question from Mrs Marks on what incentives or consequences were attached to budget leads not adhering to their commitments within their budget delegation accountability letters, Mr Spratt advised that the incentives for budget leads to remain within budget and deliver their savings in-year would be that they would expected to deliver less in subsequent years.

Decision: The Finance and Performance Committee:

- **NOTED** that The Health Board's unaudited year-end financial position is £22.1m, slightly exceeding (when roundings are removed) the Target Control Total set by Welsh Government of £22.1m.
- **NOTED** that the Health Board has spent within its Capital Resource Limit (CRL) and achieved the statutory target
- **SCRUTINISED** the top priority alerts for urgent remedial action plans, especially given the risks these could cause to the start of the new financial year.
- **ACKNOWLEDGED** that an underlying deficit assessment has been undertaken and the brought forward deficit into the 2026/27 financial year is £53.8m, significantly higher than the 2025/26 outturn of £22.1m, due to the reliance in-year on non-recurrent actions, reduced by £4.7m with the rebuttal exercise undertaken in March 2026
- **RECEIVED ASSURANCE** that accountability letters for the delegation of budgets for the 2026/27 financial year will be signed by those areas that have not yet done so.
- **NOTED** the WG letter response to the annual plan being unacceptable and unsupportable due to the deterioration of both performance and finance trajectories.
- **ACKNOWLEDGED** the Executive Team actions as set out in the 4 Step Improvement Framework, for the financial aspects, in response to the Board action and WG feedback.
- **NOTED** there may be a requirement to include specific updates on the Chief Operating Officer Ways of Working changes, Newly Qualified Nurse Streamlining and Recruitment, and the outcome of the Band 2/3 Re-banding Recurrent Funding, in the next committee meeting.

Update Report to Board: The Finance and Performance Committee wished to **ALERT** the Board to the concern that the Health Board faced a significant challenge to close its required savings gap within the current financial year and the consequences for the availability of cash towards the latter stages of the current financial year.

Ms Jenkins presented the Investments and Benefits Realisation Report to the Committee for information and noted that the report was a closure report for 2025/26 summarising the investments made and their impact.

There were no questions from members of the Committee.

Ms Siân Jenkins left the meeting

Decision: The Finance and Performance Committee:

- **ACKNOWLEDGED** that investment cases for 2025/26 were being progressed through a review and scrutiny process to inform a final approval decision at Formal Executive Team and all decision outcomes have been determined.
- **NOTED** that benefits realisation feedback for strategic investments has been sought

FPC(26)037

DEEP DIVE: RISK LANDSCAPE OF HEALTH BOARD FINANCIAL POSITION

Mr Ayres presented the deep dive into the risk landscape of the Health Board's financial position to the Committee and advised that it was not possible to examine any one issue in isolation and that when considering multiple areas simultaneously.

Mr Ayres noted that the issue of 5,507 patients waiting 104 weeks for treatment breaches and noted that as of Month 10 2025/26, the Health Board had undertaken 3,600 units of outsourcing activity and coupled with the significant risks within theatre utilisation and the loss of recovery support funding in the current financial year resulted in the need for a plan to articulate what alternative opportunities were available to be pursued that were compatible with the financial plan.

Mr Ayres believed that there was a risk of an impact on performance through the pursuit of the £41m Annual Plan position.

Mr Thomas advised that the purpose of the report was to articulate clearly what actions could not be delivered within the current year to avoid the need to test risks against metrics that the Health Board had never planned to address.

Decision: The Finance and Performance Committee:

- **NOTED** the boundary of the Annual Plan 2026/27 and the classification of excluded items by constraint type

- (affordability, workforce, capacity/infrastructure, dependency, deliberate deferral).
- **SCRUTINISED** the reconciled risk landscape at April 2026, noting the stability of the 63 risks scoring ≥ 20 , the emergence of 18 new risk refs within the month, and the data caveat around per-risk score reconciliation.
 - **RECOGNISED** the consequence framework (operational / quality & safety / financial) as the standard lens for residual -risk scrutiny through 2026/27
 - **ACKNOWLEDGED** that the financial position is a working position. Further savings identification, scrutiny and assurance through Q1 is the principal mechanism for closing the gap between £41m forecast and the £22.1m Target Control Total.
 - **CONSIDERED** that any movement in delivery expectation beyond the approved plan is likely to require either additional resource, re- prioritisation against another funded commitment, or explicit acceptance of increased consequence.

Update Report for Board: The Finance and Performance Committee wished to **ADVISE** the Board that the risk landscape of the financial position of the Health Board and the impact on performance trajectories had been reviewed and the risks that the Health Board would not address in addition to the risks that would be address were acknowledged as a recognition of the limitations of what could and could not be achieved within the current financial year were considered.

FPC(26)038

PROCUREMENT SCRUTINY

Ms Gemma Deverill joined the meeting

Ms Gemma Deverill presented the Procurement Scrutiny report to the Committee and advised that approval was sought for a contract extension to facilitate the Digital Directorate's proposal to extend the Hybrid Print and Post contract.

Ms Deverill advised that the initial contract had previously received Board approval however the extension to the contract took the value of the contract over £1m and was presented to the Committee for transparency and oversight ahead of submission to the Board for approval.

In response to a question from Cllr Evans on whether any actions could be taken to mitigate the costs of the project, Mr Thomas advised that a significant element of the costs related to postage of items that passed through Royal Mail with efforts being undertaken to divert as much patient communication through digital methods to reduce the cost of postage to the Health Board.

Ms Gemma Deverill left the meeting

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

- **APPROVE** the extension of the Hybrid Print and Post contract with PSL Print Management Limited from the 1 June 2026 to the 31 May 2028 at a value of £612,000.00 ex VAT taking the total contract value to £1,343,214.70 ex VAT. This contract will have onwards submission to HDUHB Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.

FPC(26)039

PLANNING OBJECTIVE UPDATE REPORT Q4 2025/26

Mr Thomas presented the Planning Objective (PO) Update Report for Q4 2025/26 to the Committee and advised that the report provided assurance over the PO position of the Heath Board for the POs assigned to the Committee.

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

FPC(26)040

INTEGRATED PERFORMANCE ASSURANCE REPORT

Mr Thomas presented the Integrated Performance Assurance Report (IPAR) to the Committee and highlighted that no patients within HDdUHB had waited over 52 weeks for a new outpatient appointment at the end of March 2026, with the Health Board meeting its national target to do so.

Mr Thomas advised that only 3 patients had waited over 104-weeks for treatment and advised that all three cases were within Trauma and Orthopaedic Services and associated with the issue of a national shortage of bone cement.

Mr Thomas highlighted significant improvement within the number of patients receiving an adult mental health assessment within 28 days.

Mr Thomas acknowledged the significant pressures being experienced within the Radiology Service and the Neurodevelopmental Service and highlighted an improvement in the level of performance in both services however acknowledged that the improvement was from a relatively low base position with a gap remaining to meeting national targets.

In relation to R1 Ophthalmology appointments, Mr Thomas highlighted that the number of patients waiting over 100% of their target date for an outpatient appointment was at the lowest level of delays recorded with significant improvement in both quality and safety measures exhibited.

Mr Thomas highlighted the significant decrease in the number of incidents causing moderate or above levels of harm and the number of medication errors.

Mr Thomas referenced the results of the NHS Wales Staff Survey 2025/26 and advised that within HDdUHB there had been a significant improvement in the number of staff recorded as feeling that they were able to influence improvements within their area of work, satisfaction with the level of staff engagement and the numbers of staff receiving an appraisal. Mr Thomas believed that these measures were significant in the engagement of staff to drive improvements in the levels of performance within the Health Board.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **DISCUSSED** the IPAR – Month 12 2025/2026 report and to **RECEIVED ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as 'alert'.

FPC(26)041

FINANCIAL PROCEDURES

Mr Thomas presented the Financial Procedures report to the Committee for review and advised that the Committee were asked to approve the update to Financial Procedure 069 – VAT.

There were no questions from members of the Committee.

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

- Financial Procedure 069 – VAT

FPC(26)042

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:

- **NOTE** the draft year end outturn against the CRL for 2025/26, subject to audit.
- **NOTE** the project updates.

FPC(26)043

JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

Mr Thomas presented the NHS Wales Joint Commissioning Committee (JCC) Planning, Performance and Finance Sub-Committee Highlight Report from its meeting on 26 February 2026 to the Committee.

There were no questions from members of the Committee.

Decision: The Finance and Performance Committee **RECEIVED** and **NOTED** the Highlight Report from the Joint Commissioning Committee Planning, Performance and Finance Sub-Committee meeting on 26 February 2026.

FPC(26)044

FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27

Mr Imperato presented the FPC Workplan 2026/27 to the Committee.

In response to a question from Mr Prior on the need to schedule an update on the Hospital Flow Processes and Planned Care Trajectories onto the Committee Work Plan, Mrs Wilson advised that the updates would be added to the Committee Work Plan following a discussion at the next FPC agenda setting meeting.

In response to a question from Mr Prior on the need to ensure that the performance-related items receive the same level of attention on the agenda as the finance-related items, Mrs Wilson advised that the FPC agenda would be reviewed at the next FPC agenda

CSO

setting meeting to consider whether the performance items could be considered ahead of the finance items on alternate meetings to give equal consideration between the two areas of finance and performance.

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

FPC(26)045 ANY OTHER BUSINESS

There was no other business transacted at the meeting

FPC(26)046 DATE OF NEXT MEETING

The next meeting of FPC will be held on Tuesday, 30 June 2026.

1.4

09:30, 0 Mins

1.4 - TABLE OF ACTIONS FROM FINANCE
AND PERFORMANCE COMMITTEE HELD
ON 30 APRIL 2026

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

| For approval

Attachments

Table of Actions FPC 30 April 2026.pdf

FINANCE AND PERFORMANCE COMMITTEE (FPC)/ PWYLLGOR CYLLID A PHERFFORMIAD
30/04/2026

TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AC-Andrew Carruthers; JPJ-John Jenkins; JW-Joanne Wilson; KJ-Keith Jones; SA-Shaun Ayres

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
16/12/2025	FPC(25)111	ASSURANCE AND RISK REPORT • To discuss with Chair to add consideration of long-term risks/Board Assurance Framework to the Committee Work Plan	JW	24/02/2026	Complete Principle risks are included within the assurance and risk report, these are rotated with the corporate risks. All principle risks are being reviewed as part of the BAF refresh and will be realigned to committees.
24/02/2026	FPC(26)016	INTEGRATED PERFORMANCE ASSURANCE REPORT • To confirm whether improvement to Therapies RTT performance was as a result of data validation being undertaken that had previously not been undertaken.	AC	30/06/2026	Complete The overall trend in improvement in Therapies 14 week wait performance noted from December 2025 to Jan/Feb 2026 was primarily driven by improvements in Podiatry breach volumes, reflective of short-term additional capacity solutions over the period. Whilst validation of therapy waiting lists/times continued during the period, this was not the primary influence on reduced breach volumes.
30/04/2026	FPC(26)030	ESCALATION OVERSIGHT AND HIGHLIGHT REPORT • To cross-referece the quality and patient safety aspects of internal escalation to QSEC	SA	11/06/2026	Complete Escalation Update presented to QSEC on 11/06/2026.
30/04/2026	FPC(26)031	HOSPITAL FLOW PROCESSES • To collate and circulate a detailed analysis of mean 12-hour ED waiting times and median time for a clinical decision broken down per acute site.	AC	30/06/2026	Complete Metrics are produced and shared on a monthly basis by the Performance Team showing the latest position compared with the monthly historical run rate. The improvement actions relating to both are reflected in the monthly IPAR updates.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
30/04/2026	FPC(26)032	Q1 2026/27 PLANNED CARE TRAJECTORIES • To present findings of NHS Wales Planned Care Optimisation Framework self-assessment to FPC.	KJ	30/06/2026	In progress 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.
30/04/2026	FPC(26)044	FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27 • To forward plan update on Hospital Flow Processes and Planned Care Trajectories on Committee Work Plan.	JPJ	19/05/2026	Complete Forward planned on Committee Work Plan for FPC meeting on 27/10/2026.

1.5

09:30, 15 Mins

1.5 - ASSURANCE AND RISK REPORT

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

| For assurance

Attachments

[Assurance and Risk Report FPC 30 June 2026.pdf](#)

[Appendix 1 FPC ORR June 2026.pdf](#)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Assurance and Risk Report

Finance and Performance Committee, 30 June 2026

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 the principal risks are being refreshed and will be reported to the Board in July, and that there are processes in place to oversee operational risks to ensure these are being managed effectively, and that recommendations from audits and inspections 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 August 2026.

Principal Risks:

1

Under Review

Operational Risks

22

21 Reportable Risks

Welsh Health Circulars

2

Risk Management - Overview



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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

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



Principal risks and outcome measures have been reviewed and discussed at FET in May, with final amendments being made by Executive Risk Owners ahead of presentation at Board seminar in June 2026, and to the Board in July 2026.

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

Operational Risks assigned to FPC

21 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:

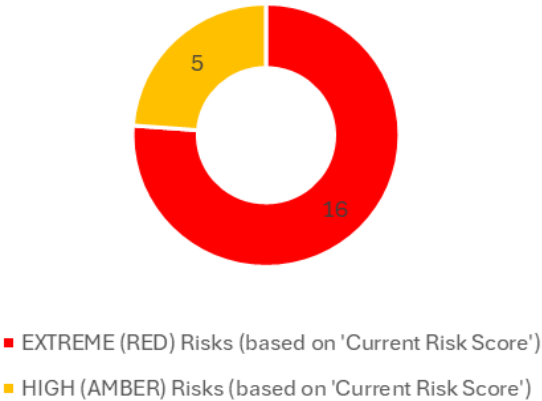
- FPC has been selected by the risk lead as the ‘Assuring Committee’ on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is ‘extreme’ or ‘high’; and
- The current risk score is either equal to or exceeds the target risk score.

The following slide summarises the reportable operational risks aligned to FPC. The Risk Register attached at **Appendix 1**, provides full detail of reportable risks.

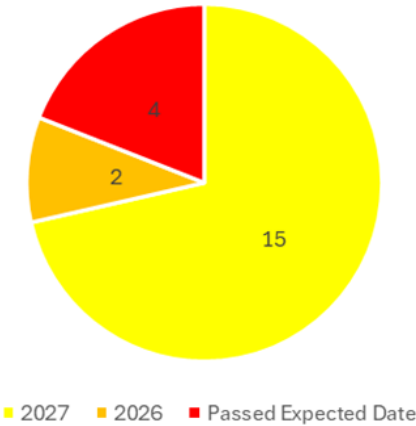
Total Number of Open Risks meeting criteria for reporting	21
New Risks since last reported to FPC	4
Closed Risks since last reported to FPC	2
Increase in Risk Score since last reported to FPC	2
Decrease in Risk Score since last reported to FPC	0
No Change in Risk Score since last reported to FPC	15
EXTREME (RED) Risks (based on ‘Current Risk Score’)	16
HIGH (AMBER) Risks (based on ‘Current Risk Score’)	5

The following slides summarise the operational risks aligned to FPC at 27 May 2026.

Current Level of Risks assigned to FPC



Risks by Target Risk Score Expected Date (Year)



New Risks Added Since Last Report



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2294 - Risk of inability to provide community based dietetic services closer to home due to increasing service fragility	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	3	01/02/2027	21/05/2026
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	08/05/2026
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	08/05/2026
2316 - Risk of being unable to identify recurrent savings required due to ad-hoc pay and non-pay	Planned and Specialist Care	Chief Operating Officer	12	8	04/04/2027	28/05/2026

* Risk 2175 realigned from Quality, Safety & Experience Committee

** Risk 2174 realigned from Strategy & Planning Committee

Risks Closed Since Last Report



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Rationale for risk closure	Date Risk Closed
2110 – Risk of not achieving savings targets for 25/26 due to significant, strategic change required across whole CCGs	Community & Integrated Medicine	Chief Operating Officer	Risk closed as related to 2025/26. Risk relating to 2026/27 financial year savings targets being considered.	21/05/2026
2124 – Risk of being unable to identify recurrent savings required due to spend on ad-hoc pay and non-pay	Planned & Specialist Care	Chief Operating Officer	Risk has been closed and superseded by new risk 2316 (summarised on previous slide).	27/03/2026

Risks With Increased Current Risk Score



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2131 - Risk of overspend due to cost pressures related to Everlight radiology	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25 ↑ (Previous Risk Score 20)	15	31/03/2027	27/04/2026
975 - Risk of inability to achieve the financial target savings set for 2026/2027 due to aged estate and infrastructure	Estates & Facilities	Executive Director of Allied Health Professions & Health Sciences (AHP&HS)	20 ↑ (Previous Risk Score 16)	10	31/03/2027	28/05/2026

Risks With No Change in CRS (Slide 1 of 2)



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve TRS	Date of last risk review
2167 - Risk of increased service fragility and non-pay cost pressures in Podiatry due to overspending as a result of inflation	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	25	5	30/06/2027	01/06/2026
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	27/04/2026
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	08/05/2026
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	27/04/2026
2148 -Risk of significant financial pressures impacting on service delivery due to reliance on RIF funding for key clinical roles	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	10	31/03/2027	29/04/2026
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	08/05/2026
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	05/05/2026

Risks With No Change in CRS (Slide 2 of 2)



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Risk Reference and Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve TRS	Date of last risk review
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	27/04/2026
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	02/06/2026
2184 - Risk that budget code 1962 will have a cost pressure of £144K from April 2026	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	16	6	31/03/2027	29/04/2026
2040 - Risk of decommissioning of current FCP Physio Primary care service due to funding uncertainty from April 2026	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	15	4	31/03/2026	01/05/2026
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	09/04/2026
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	27/04/2026
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	22/05/2026
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	13/05/2026

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 May 2026:

Theme	Definition	Number of risks	Date themed Risk Register last shared
Finance	Risks associated with the possibility of financial loss and uncertainty	90	08/05/2026

Implementation of Welsh Health Circulars



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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 27 May 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.	1
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.	1
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	0
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	2

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.



WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Next steps
008-26: NHS Research and Development Finance Policy 2026	10/03/26	Director of Finance	Director of Finance	30/04/2026	Overdue	The localised policy is being presented at the next Research and Innovation Sub Committee, scheduled for June 2026.



WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
022-26: 2026/27 NHS Wales Financial Monitoring Return Guidance	30/04/26	Director of Finance	Director of Finance	31/03/2027	In Progress	The Corporate Reporting Team coordinate the monthly MMR submission on behalf of the function as an output from the month end reporting cycle. The WHC will be noted as complete following upload of evidence to AMaT.



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

WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status
045-25: Revisions to the Standing Orders for the NHS Wales Joint Commissioning Committee	28/10/2025	Corporate Governance	Director of Corporate Governance	31/12/2025	Complete
055-25: 2026-27 Health Board allocation	22/12/2025	Director of Finance	Director of Finance	March 2026	Complete

Recommendations



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

RISK MANAGEMENT

- **RECEIVE ASSURANCE** that the principal risks are being refreshed and will be reported to the Board in July; and
- **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 Welsh Health Circulars within their area of responsibility, particularly in respect of understanding when the Welsh Health Circulars will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.



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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
2167	Operational Allied Health Professions & Health Sciences	AHP&HS: Podiatry & Surgical Appliances	AHP&HS: Podiatry and Surgical Appliances	Carruthers, Andrew	Quarrie, Sara	Mulroy, Mike	Mulroy, Mike	02-Jul-22	There is a risk of of increased service fragility and increasing non pay cost pressures. This is caused by the Podiatry/Orthotics non-pay budget becoming approximately £200,000 overspent since 2023. This is primarily due to a 33% increase for contract Orthotic products unit price as a result of inflationary pressures. This will lead to an impact/affect on being able to purchase Orthotic products and appliances, provide interventions and timely treatments for patients leading to increased morbidity and a decline in patient well-being if the service is no longer able to continue overspending. This could lead to increased complaints, litigation, patient safety incidents, decrease of flow of patients through the health care system, increasing waiting times, knock-on effects for other services, potential reputational damage and inability to safeguard people with disabilities.	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. Orthotics contracts currently being renegotiated could potentially result in reduction of spend. 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. Effective triaging reduces spend by employing strict eligibility criteria. Effective financial management in service has resulted in consistent overspend from year to year, with a focus on cost-effective solutions for patients.	Finance inc. claims	5	5	25	The overspend of £200,000 is consistent across year. As at October 2025, there are currently 2 Orthotics contracts being negotiated which could reduce spend marginally, but at best this will only prevent further overspend. Further restrictions on budget would present some difficult financial challenges to the service. If the Podiatry service were no longer permitted to overspend, the impact to the quality of service offered and the knock-on effect on patient care could be very high. If the service are required to reduce this overspend it could be catastrophic (Inherent impact = 5). Finance inc. claims = 5 (Finance inc. claims = (Impact - Loss of >1 per	Ensure submission to 2026/27 Annual Planning cycle for uplift of Orthotics budget by £200k.	Mulroy, Mike	Completed	Awaiting outcome of previous action. 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	The best possible outcome for this risk would be an increase in Podiatry of Â£200K in year to offset the overspend and reflect the annual costs of the service. This would reduce the likelihood of noted risks that would be caused by further overspend. 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. 17.02.26: TRS date extended from 31.03.26 to 30.06.26 to allow for decision from Annual plan funding submission 26-27.	Treat	01-Jun-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			
									Increased pressure on staff, workforce challenges (e.g. complexity of patients has increased as lower complexity patients are not being referred into the Health Board), having to deal with an increasing level of complaints and litigations and increased amputation rates, increased workload for administrative staff and loss of key staff to private practices (with less stressful working environment), future recruitment challenges. If further overspend is not permitted, the risk will become further exacerbated which will affect the Podiatry service from providing the necessary quality of care, with difficult decisions having to be made about which cohorts of patients will be prioritised for treatment (emergency patients vs those with long-standing disabilities, younger vs older patients etc). Finance inc. claims = 5 (Impact - Loss of >1 per cent of budget) Likelihood = 5 (It will undoubtedly happen/recur, possibly frequently) Risk location, Health Board wide.							cent of budget) Probability = 5 (95% +)	Risk to be escalated via CCG to Executive risk meeting for steer on financial challenges	Mulroy, Mike	28/11/2025-31/03/2026 31/03/2026 30/06/2026	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									
															SBAR to be presented to OpAH CCG	Mulroy, Mike	Completed	Included on agenda at October 2025 CCG 2/12/25 - SBAR updated and resubmitted on 27/11/25 by request. Next CCG meeting 17/12/25.											
															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.											

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. This is caused by reliance on outsourcing of reporting to provide emergency 24/7 CT and MRI. 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. Risk location, Health Board wide.	Use of locum radiologists to provide partial out of hours service Stabilisation fund - two consultant posts are being advertised in September.	Finance inc. claims	5	5	25	Impact: 5 overspend of 3% of budget 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 Forecast based on current demand of financial impact Work with hospital director to try and reduce demand by clear pathways and restriction of referral rights for lower grades of staff. Meetings ongoing.	Procter, Sarah	Completed	completed not included in annual plan - cost pressure identified initial meetings have taken place ToR drafted awaiting approval prior to start of formal Radiology Referral Management Group	Finance and Performance Committee	3	5	15	Impact - risk of overspend of 3% of budget Likelihood/probability = 3 - increases in demand and costs of outsourcing may change.	Treat	29-May-26
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. This is caused by staffing establishment not sufficient to meet the working hours of the service 24/7. 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. Risk location, Health Board wide.	Radiology Stabilisation plan Annual Planning Clinical service Plan	Finance inc. claims	5	5	25	Impact - The overspend is 3% of the 29.8 million radiology budget. 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 Annual planning submission - £5.1m (as of April 2025) gap in demand vs capacity remains as per agreement in 2025/26 Annual Planning Receive funding for annual plan and split into individual site cost codes. then risk can be closed	Procter, Sarah	Completed	recruitment of staff is ongoing. Recovery of backlog is on target which will release funding for staff in 26/27 Annual plan funding confirmed for 2026/27 Awaiting funding to be split into cost codes.	Finance and Performance Committee	3	5	15	Impact - The overspend is 33% of the 29.8 million radiology budget. Probability- The overspend happens each year as it funds the radiology out of hours service on all sites which has become busier.	Treat	29-May-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	
2294	Operational Allied Health Professions & Health Sciences	AHP&HS: Dietetics & Nutrition	AHP&HS: Dietetics and Nutrition	Carruthers, Andrew	Quarrie, Sara	Paul-Gough, Zoe	Roberts, Sarah	19-Feb-26	There is a risk of of reduced efficiency and effectiveness in community dietetic service across the health board . Inability to deliver services closer to home , increase waiting times for patients referred for routine dietetic assessment and intervention This is caused by fragility in the Community dietetic service with 8 wte qualified dietetic staff working in this service able to provide 5.0wte direct clinical time across the whole health board. This is threatened to be reduced to 4wte qualified with 2.5wte provision for direct clinical care due to workforce stability posts over core establishment reducing ability to recruit into vacant positions over then next financial year 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. potentially increasing risk of deconditioning , frailty and poor nutritional status resulting in increased morbidity and need for hospital admissions. 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 service lead for community has been recruited start date 5th May. Revised triage and clinic process will help streamline and more equitable service across HB and increased virtual clinics.	Safety - Patient, Staff or Public	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 April 2026- clinical lead role in pembs vacant , Clinical lead in Carmarthenshire on long term sickness absence and clinical lead in Ceredigion on secondment , Service lead not inpost until may 2026 extreme low management and high caseload demand	SBAR developed to express the risk and what is required to mitigate this	Roberts, Sarah	14/04/2026-17/06/2026	30/06/2026	SBAR drafted needs to be shared in SL meeting May 2026 for comments and sign off May 2026 comments made for SBAR approval and need to meet with Finance and HR in June	Finance and Performance Committee	1	3	3	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		21-May-26
									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															
									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	22/06/2026	new action															

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
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 budget overspend amounting to the cost of approximately £100k 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. This will lead to an impact/affect on inability to manage physiotherapy services within budget and ensure compliance with financial governance standards. 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 Risk location, Withybush General Hospital.	Monitoring of variable pay costs for weekend working Monitoring of vacancy rates in core staffing monitoring of bank staff/ locums within core services Monday to Friday Engagement in RIF gateway review process for next steps funding stream Monthly meetings with finance business partners Monthly review of qlickview system Engagement in Clinical Services Plan orthopaedic service review engagement in annual planning process	Finance inc. claims	5	4	20	There is currently no new budget available to fund additional services. There is currently no decision to withdraw 7 day services. 100k cost pressure equates to 0.83% of the budget Justification against Risk Framework: * Finance and claims - 4 Loss of 0.5â€"1.0 per cent of budget * Likelihood/probability - 5, 95% +	SBAR to be presented to CCG IG to inform financial challenge (and options to mitigate further) Re draft QIA (in new format) for TOCALs cost mitigation SBAR. Review with Angela Bell and submit to corporate QIA panel.	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. QIA development in progress	Finance and Performance Committee	1	4	4	Funding for service 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.	Treat	27-May-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
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 physiotherapy budget overspend. This is estimated to be £100,000 per year which constitutes on call availability payments , hours worked, travel claims. This is caused by the unfunded service delivery of four Emergency respiratory on call services at all 4 DGH sites. 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. 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. on call claims are scrutinised by respiratory and service leads. trends in inappropriate call outs are identified and wards / individuals are educated on appropriate inclusion criteria for the service. twilight shifts are in place in GGH to reduce call out rates as staff are on site in the early evening. work undertaken is now only urgent respiratory work that cannot be left until the next working day. work is underway to explore merging rotas in Carmarthenshire which may reduce costs slightly.	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). 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. Absorbing these costs within the budget will result in further risks to unscheduled and planned care capacity It is not clinically viable to withdraw on call services as this service maintains life. Risk framework justification: * Impact = Loss of 0.5â€“1.0 per cent of budget * Likelihood/Probability = 5 (95% + as cost pressure is occurring)	SBAR to be presented to CCG IG to inform financial challenge (and options to mitigate further)	Griffith, Susan	3440/2025 01/06/2026	08/05/26 Cost mitigation paper re on call services submitted to CCG in April 2026. Feedback recieved. Post review amendments to paper required.	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	28-May-26

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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 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 This is caused by 1. Limited capacity to identify sustainable, realistic & recurrent savings plans. 2. Non-delivery of recurrent savings requirements, resulting in adverse impact on the underlying position. 3. Limited identification and implementation of opportunities that deliver sustainable financial benefits and support recovery and improvement trajectories without adverse safety consequen 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. 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 Monthly establishments reviews within the service to ensure pay position is understood and actions are taking promptly, supported by Finance colleagues where appropriate. Monthly. 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. New Facilities Managers in post focussing on budget control. Rota reviews in Facilities teams to be implemented. Significant focus on variable pay controls.	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 E&F CCG January 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	Treat	01-Jun-26

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									6. Ongoing workforce & resource pressures within Facilities. 7. Escalating Health Board-wide financial pressures. 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 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. Risk location, Health Board wide.						grown 25% in 10 years with no revenue to cover increased space.													

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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 non-delivery of key objective/ Loss of >1 per cent of budget. Failure to meet specification/ slippage Claim(s) >£1 million. Primary Care OT RIF funding will end 31/03/27 This is caused by mainstreaming of RIF Welsh Government Mainstreaming funding post March 2027, will impact on the availability of funds for any subsequent grant schemes. Activities categorised as mainstreaming will be eligible for Welsh Government funding, with a minimum of 50% match funding required in the first year of mainstreaming This will lead to an impact/affect on cost pressure within the Occupational Therapy Budget of approx. £700K from March 2027 Impact on service delivery if we need to pause or stop some services that do not meet WG criteria Risk location, .	Regular (monthly) meetings with finance partners to review budgets. Meetings with RIF project team to review project outcomes Reviewing any vacant posts funded through RIF to consider options	Finance inc. claims	4	5	20	Some control measures in place but risk remains due to no allocated budget for staff currently funded through RIF Risk framework justification: * Impact = Loss of >1 per cent of budget * Probability = 4 (75-95)%	Head of Occupational Therapy attend regular RIF Finance Review meetings Service Leads attend RIF workshops discussing future funding - Dates available 10th, 15th September Pembrokeshire Meeting Meet with system leaders in Pembrokeshire to discuss the RIF funding issues and impact on wider Pembs system and ICN	Adams, Jon	31/03/2026 31/03/27-30/08/26	Ongoing	Finance and Performance Committee	2	5	10	Permanent funding will have been identified for the majority / all staff he Primary Care Occupational Therapy (PCOT) model is advised that RIF funding will end in March 2027. The PCOT roles will likely need to be absorbed into core funding to address these 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€ 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.		28-May-26

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1631	Operational Allied Health Professions & Health Sciences	Allied Health Professions and Health Sciences	Allied Health Professions and Health Sciences	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 This is caused by inadequate budget to meet organisational demands and increasing unit cost prices / SLA costs (£10.77m cost pressures 2026/27 budget break even + £4.88m saving target 2026/27) 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. 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. Finance - Non-delivery of key objective/ Loss of >1 per cent of budget Reputational Risk location, Health Board wide.	Budget holder 1-1 meetings with finance team (monthly) Forecast meetings monthly with CCG leadership and Finance CCG led finance meeting with finance team and each budget holder (monthly) CCG FCG weekly (vacancy control admin and new roles) Formally clarifying and escalation of cost pressures to executives via iQFPDG and Executive Recovery meetings Annual planning 2026/27 and planned 2027/28 engagement and submissions	Finance inc. claims	4	5	20	See audit trail for previous months updates. May 26- ERM completed 18.05.26, Cost pressure mitigating actions resulting in forecast reduction to 1.6M, in addition the gap in remains at 4.1M (0.7 in progress). ERM action to progress in progress mitigating cost pressures at pace/ by 1st week in June: AMDs and county leads re OOO Everlight reporting TAT; and unfunded weekend physio services. Risk score remains unchanged. 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. Therefore scoring remains unchanged as: Finance domain. Impact - 5: Non-delivery of key objective (non-compliance with accountability letter) / Loss of >1 per cent of budget (£7.6m gap	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 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 Risk of delivering our financial control total and required savings plans Risk to be redrafted with guidance from FBP to align with new CCG structure. M4 saving meetings with each HoS to identify further mitigation for cost pressures and savings. Demand and capacity service review Podiatry	Reed, Lance	Completed	Process established at Therapy Operational Group 18.04.23.	Finance and Performance Committee	3	5	15	If the CCG is able to identify and implement cost pressure mitigation schemes and savings schemes. The target scoring: Finance domain. Impact - 5: Non-delivery of key objective (non-compliance with accountability letter) / Loss of >1 per cent of budget (£7.6m gap equates to 8% of £90m budget) Likelihood / Probability - 3: 25-75% (reduced £ gap to £0 through successful mitigation of cost pressures/savings) Target risk score aligned to new financial year and new financial risk profile.	Treat	28-May-26
	Reed, Lance	Completed	All agreed claims with known financial impact to be discussed at Therapy QSEAR meeting and learning disseminated																							
	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																							
	Quarrie, Sara	Completed	Meeting to be scheduled to redraft new risk.																							
	Quarrie, Sara	Completed	11.07.2025 - M4 meetings completed.																							
	Mulroy, Mike	Completed	11/07/2025 - New action 29.09.2025 - D&C work progressing to handover stage from DS to podiatry team.																							

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															equates to 8% of £90m budget). Likelihood / Probability - 4: 75-95% probability (as £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 29/08 - Due to A/I 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							
																M6 saving meetings with each HoS to identify further mitigation for cost pressures and savings.	Quarrie, Sara	Completed	29/08 - new action 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 29.10.2025 - HoS reporting conversation underway with Team regarding this new to follow-up ratio. Extended due date to 31.12.2025. Dec 2025 - Discussions with Service lead continue and ask for alternative solutions (to be generated by Service Lead) after three months of discussions. Extended 31.01.2026 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.							
																M7 saving meetings with each HoS to identify further mitigation for cost pressures and savings.	Quarrie, Sara	Completed	29/9 - new action 29.10.2025 - shortened meetings took place with key services due to A/L in CCG leadership team. Action complete.							

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																Demand and capacity - Hands and Rhum	Adams, Jon	Completed	29.09.2025 - new action 29.10 - D&C work underway not yet completed further work required. Date extended to Nov 2025. 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	28/11/2025-30/04/2026 30/03/2026 30/05/2026	See audit trail for previous updates. 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.							
																Service review - Podiatry	Mulroy, Mike	28/11/2025-30/04/2026 30/04/2026 30/05/2026	29/09 - new action 28/11/2025 - Service review underway extended deadline until Jan 2026 due to new process and team working through data sets. 30/03/2026 - pending final drafting, being chased by CCG leadership, extension of date to align. 27.04.2026 - Draft received at CCG IG April 2026. Feedback given and expected return in May CCG IG. Therefore date extended.							

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																M7 saving meetings with each HoS to identify further mitigation for cost pressures and savings.	Quarrie, Sara	Completed	29/10 - new action 28/11/2025 - meetings took place to continue to work to mitigate cost pressures and identify savings.							
																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: * £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 * 71k cost pressures (mitigation = being developed) Work underway across services to take further mitigating actions.							

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																Demand and capacity - Service review Occupational Therapy	Adams, Jon	31/01/2026-29/02/2026 20/04/2026 30/05/2026	28/11/2025 - Service review commenced in Q3 (updated from HoS due to study leave unable to present to CCG IG in Jan therefore date extended to Feb 2026) Feb 2026 - Delay due to capacity required for winter pressure escalation and annual planning/cost pressure mitigation schemes. Deadline updated to April 2026 April 2026 - due to the amount of time the Stroke CSP work has taken over the last 4 weeks unfortunately this has been delayed and I would like to postpone to May. Extended to end of May 2026.							
																Annual Planning - AH and HS CCG submission to workshop 21/11/2025. The care group has two re-occurring risk themes across the risk profile: * Right sizing budgets (aka unmitigable cost pressures circa £1 731 332) * 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: a decision to decommission FCP Physiotherapy (as risk score 15) future stabilisation funding for demand and capacity imbalance across the CCG (that will adversely affect ability to meet WG targets - circa £9m cost).							

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																Demand and Capacity - Service review SLT	Slaney-Jones, Emma	Completed	29/12/2025 - New action 30/03/2026 - Service review is being completed at a national level for Paeds SLT therefore action places pending national timelines for review.							
																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.							

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																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							
																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 decision from Chief Operating Officer - OoH Everlight reporting TAT (SBAR V1.0)	Carruthers, Andrew	Completed	20.02.2026 - Submitted scheme to COO and Director of Finance							

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																Cost pressure mitigation scheme decision from Chief Operating Officer - Agency reduction - Convert non pay budget to pay budget (recruit specialist posts and decrease reliance on agency) (SBAR V1.0)	Carruthers, Andrew	Completed	20.02.2026 - Submitted scheme to COO and Director of Finance							
																Cost pressure mitigation scheme decision from Chief Operating Officer - Stop unfunded Service (cell path) (SBAR V1.0)	Carruthers, Andrew	Completed	20.02.2026 - Submitted scheme to COO and Director of Finance							
																Cost pressure mitigation scheme decision from Chief Operating Officer -Stop unfunded WLI workload (SBAR V1.0)	Carruthers, Andrew	Completed	20.02.2026 - Submitted scheme to COO and Director of Finance							
																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 breach - 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	30/06/2026	Feb 2026 - Clinic and workshop implementation commenced.							

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																Demand and Capacity - Physiotherapy new patient D&C analysis and tool implementation	Davies, John	30/04/2026 30/05/2026	Feb 2026 - David Sheppard (performance team) update: Work commenced Jan 2026. Service to review capacity and further meetings to be arranged in Feb 2026. Apr 2026 - 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.							
																Demand and Capacity - N&D new patient D&C analysis and tool implementation	Paul-Gough, Zoe	30/04/2026 30/05/2026	Feb 2026 - David Sheppard (performance team) update: Work commenced Jan 2026. Service to review capacity and further meetings to be arranged in Feb 2026. Apr 2026 - 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.							

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																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 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	31/05/2026	April 2026 - New action											
																Unlikely cost mitigation scheme - Radiology - OoH Everlight reporting TAT reduction from 1hr to 4hrs releasing £400k. 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	29/05/2026	April 2026 - Requested Finance Controller (SN) request budget movement from AH and HS CCG to COO budget hierarchy.							
																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.							
																Unlikely cost mitigation scheme - Physiotherapy - Reduce Variable Pay - Stop unfunded weekend Ortho / unsocial intermediate care / Totals 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.							

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																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.							

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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. This is caused by the inability to either: Identify and deliver robust and realistic recurrent savings plans. Manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement. Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. This will lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability. 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. 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. 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. Mechanism in place to draw down funding to service cost codes inline with original bids. Weekly key performance meetings in place for areas working outside of allocated budgets in collaboration with Senior Finance Business Partner. MHLD is in Escalation for Finance due to the lack of a 6.5% recurrent savings plan. Directorate are meeting weekly to progress plans. Directorate also attend Health Boards Integrated Quality Financial Performance Delivery Group (IQFPDG).	Finance inc. claims	4	4	16	As at September 2025, the Clinical Care Group are estimated to remain within budget in terms of the end of year forecast. Presently, this is estimated to be a Â£163,000 underspend, however continuing pressures resulting in the potential use of private beds are noted and need to be factored into end of year trajectory. The Clinical Care Group continue to identify further non recurrent/recurrent saving opportunities. As of April 2026 we are awaiting the end of month 1 position.	Leon Popham to review impact of CHC uplift reserve on position and determine treatment and risk level on an ongoing basis. To provide an update for Executive Team to clarify the budget setting process and allocation for FY 2024/25. 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. Work to identify recurrent savings for 25-26 underway. First phase to be transacted by end of February 2025.	Popham, Leon	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. CHC overspend neutralised for 2024/25 allocation through £1.9M uplift relating to 2022/23 and operational driver funding remaining pressure. 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. 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. Completed	Finance and Performance Committee	1	3	3	Working towards a position where 6.5% savings are identified and to remain within budget.	Treat	02-Jun-26

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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. 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. This will lead to an impact/affect on Poor outcomes for patients who are either admitted to hospital or who have longer length of stay, resulting in deconditioning. Adverse impact on flow through acute and community system. Delays in unscheduled care. Increased avoidable admissions to hospital. Poorer quality discharge with increased risk of re admission. Risk location, Health Board wide.	Funding is currently in place until March 2027. The physiotherapy service is engaged in 'future funding workshop process' 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. develop SBAR and submit to CCG, that outlines exit strategy if comisioning for RIF funded services does not continue from April 2027	Davies, John	Completed	Data collated in Physio service / finance MS team to support SBAR development Initial draft of paper to be submitted to CCG IG forum for May 2026	Finance and Performance Committee	4	1	4	The future funding process is in its early stages. There is not an imminent risk to decommissioning of RIF funded services.	Treat	08-May-26

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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. 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 This will lead to an impact/affect on poor outcomes for patients with pelvic health conditions with increased risk of developing chronic conditions. It could also lead to increased avoidable referral into secondary care consultant led services. Risk location, Ceredigion.	Funding is currently in place until March 2027. 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 30/06/2026	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.	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	08-May-26

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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 of a loss of >1 per cent of budget from April 2026. This is caused by the temporary funding of substantive posts in 3Ps Prehab and Optimisation Service several year ago by Welsh Government (with agreement to recruit into permanent posts) coming to an end. Staff recruited into these posts cost £289K. The recurring budget for the service is £110K, therefore there is a deficit of £180K. This will lead to an impact/affect on not achieving a balanced budget and potentially putting the service at risk due to financial instability. The staff recruited into these posts (who are responsible for providing prehab to patients awaiting orthopaedic waiting list) are not currently at risk as these positions are contracted, therefore the impact of this risk is purely on the budget of the service. The consequences of running the service with a high budgetary deficit include: overall risk to quality of service, ability to treat patients in a timely manner, ability to recruit into vacant posts and inability to achieve savings targets. Risk location, Health Board wide.	Monthly meetings with finance business partners to review budget and horizon planning for next financial year. Scoping other funding sources (see action below to meet with Planned Care to explore options).	Finance inc. claims	4	4	16	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. 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).	Develop an action plan with finance business partners to explore funding options and monitor service budget 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 Escalate risk via CCG management meetings JA to write SBAR for AHP & HS Governance meeting with recommendations. To be tabled at CCG Governance May 2026	Adams, Jon	30/06/26	New action - action to be updated further as we approach next round of annual planning. Meeting to be scheduled. MP to raise with QSIG group 28/04/26. JA to follow up with MP on 12/05/26 Discussed in CCG meeting SBAR Draft in progress	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	28-May-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. This is caused by unidentified savings plans to reduce expenditure in the directorate. This will lead to an impact/affect on the Health Board's overall financial position and ability to adhere to our financial plan. 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 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. 3. Scrutiny of individual budgets by finance and Head of Radiology to capture any erroneous spend 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. 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 £92k underspent (provisional figure)with savings of £669k achieved. As of 09/04/2025 Radiology investment in workforce has been agreed and is currently subject to case scrutiny by the Executive Team. The Allied Health Professions and Health Sciences CCG has an opening savings position of £3.744m to be achieved in 25-26, of this £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. 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. Recruit a fourth locum Radiologist to enact the proposed level of savings from reduction in outsourcing	Roberts-Davies, Gail	04/04/2025-31/03/2026 31.5.26-31/03/2027	Update from VBHC team as of 11/02/2025: We're currently working with Chris James from Data Development to move this piece of work forward. Still ongoing 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. 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 Action complete	Finance and Performance Committee	3	4	12	Likelihood reduce therefore reduce in score	Treat	29-May-26

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																Explore opportunities for income from dental practices referring for OPT examinations	Roberts-Davies, Gail	04/04/2025-31/03/2026 31/03/2026 30/06/2026	Discussed at TI meeting August 2024 and responded to the collective submission for permission from WG on 21/1/2024. Awaiting feedback following this. Feb 2025 update- GRD has received queries from SN- due to discuss on 26/02/2025. 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							
																To formulate savings scheme plans for the 25/26 financial year	Roberts-Davies, Gail	Completed	Savings plan have been reviewed in September 2025							

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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. 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. 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. 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. 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. 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. 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. reduction of in patient beds by 25 since pre RAAC. Puffin ward now closed Recruitment of newly qualified nurses and international nurses. Recruitment of medical staffing to reduce reliance on locums. Review of compendium of variation to identify additional savings Develop a 90 day plan for cost savings Development of PIDs and QIAs for identified areas of opportunities Review scheme of delegation and all cost centre to ensure alignment at the appropriate level Pipeline Cost saving schemes are being worked through to move from red to amber/green	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	05-May-26

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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. 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) 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. Risk location, Health Board wide.	Cluster funding has been continued each year, with Primary care building the case for a permanent funding solution Positive conversations with Primary care RE: continuation Issues escalated through CCG. Escalation meetings being held with Executive Support Funding request submitted to CCG Annual Planning process Funding now extended until March 2027	Finance inc. claims	3	5	15	Until now, the cluster funding has been considered as beneficial to the clusters in terms of increasing their capacity in Primary care. The clusters initially were confirmed on exiting the finding with only a few months notice. However, the conversations have changed in tone recently and the Physiotherapy department and Primary Care are still in discussion regarding whether this will be continued	24/03/25-Assist in development of SBAR with Primary Care 24/03/25-SBAR under development for presentation to CCG 12/06/25 - Development of CCG Business Case within 25-26 financial year for mainstream funding of FCP service Await outcome of Annual planning process	Svets, Jess Evans, Nick Evans, Nick Evans, Nick Evans, Nick	31/07/2026 Completed Completed Completed 04/04/2026 01/04/2027	Added Respiratory pathway, Emergency Medicine, ED Consultant and Medicine Consultant risk 24/03/25-Links made and access to SBAR granted by Jackson Reynolds 24/03/25-SBAR under development. John Davies, Nick Evans and Susie Launders contributing. 23/04/25 - SBAR completed. Pending presentation 15/05/25-SBAR rewritten as situation has changed. Pending presentation 12/06/25 - Funding secured until March 2026, need to develop business plan for mainstream funding for delivery of FCP service built into the 26-27 CCG business plan. 12/06/25-New Action 11/09/25-Plans currently under development ready for Annual planning Workshop 24/10/25-Initial plans supplied and under review as part of annual planning process New action. Annual Plan funding requests submitted. Pending outcome. 30/03/26-No update. 01/05/26-Funding extended until March 2027. Pending decision on permanent funding in next round of annual planning.	Finance and Performance Committee	2	2	4	Mainstream funding meets several local and national requirements, including right person, right place, right time, prudent healthcare, the fundamental principle of "shift left" and benefits to Primary Care capacity (allowing greater access to GP's, Practice Nurses and other Health Care professionals with lower MSK skills, but higher skills in other arenas) and reduced onwards referrals to Secondary care. Service to assign expected date to reach TRS (date below added during administrative update by Assurance and Risk Team to save risk)	Treat	01-May-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
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. 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). 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. 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. 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. The posts are: 1 x 0.8 WTE Specialty Doctor (70k) now substantive and 1.7 Clinical Nurse Band 7 Specialist Palliative Care (80K), 0.8 Band 6 Bereavement Councillor (57k) (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. 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	Closed completed. Review of action undertaken, agreed in risk meeting to extend timeline to the end of the financial year. Awaiting data from finance so SDM and HoN can undertake review.	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. Expected date to achieve TRS extended to 31/03/2026 to allow report from finance business partner. Based on slow progress target risk score has been moved to end of Q1 FY26/27.	Treat	09-Apr-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
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. This is caused by the increase in referrals for diagnostic referrals from the increase in outpatient appointments This will lead to an impact/affect on a financial overspend and mean that trajectories for planned care breaches will not be met. Risk location, Health Board wide.	Monitoring of performance 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 Uncertain delivery of key objective/service due to lack of staff. Low achievement of performance/delivery requirements Likelihood 3- Probability (25-75%*)	Deputy COO discussing with WG that the tariff doesn't meet the cost of outsourcing examinations. Issues with tracking insourcing OP requests due to new RIS subsystem Capacity and demand to establish increase in waiting list due to OPD insourcing.	Jones, Keith -	Completed	assurance by deputy COO that if funding doesn't met tariff cost then the actual cost will be paid Able to track again awaiting final patients who are still progressing through the service	Finance and Performance Committee	2	3	6	Impact 3 -An event which impacts on a small number of patients. Loss of 0.25â€"0.5 per cent of budget. Likelihood 2 - Probability 5-25%	Treat	27-Apr-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
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. This is caused by Multiple contributing factors including Dental Contract Reform impacting the throughput of patients resulting in reducing income. Reduced access to NHS dental services across the Health Board area The current economic climate contributing to an increase in patients who are exempt from charges. 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. Lack of investment will significantly reduce the pace of improvement to NHS General Dental Services Risk location, Health Board wide.	Procurement to replace lost contracts NHS Business Services Authority monitoring of income trends and patient exemption data. The Health Board will endeavour to replace handed back contracts within 9 months of the contracts being handed back. Ongoing monitoring of the impact of newly awarded contracts on patient revenue charges. Welsh Government increase to patient charges from April 2024.	Finance inc. claims	3	4	12	The allocated Dental budget is £20M, with £17M collected from WG directly and the other £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 In 2024/25, the Health Board collected £1.8M in patient charge revenue, leaving a gap of £1.2M. Data suggests that the situation will not improve during 2025/26 - the projected shortfall is estimated at £1.5 million (6.5% of the overall dental allocation). The replacement contracts procured are unlikely to generate enough income to close the gap. Please see risk 1823 for impact on patient care. 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.	Monitor on a monthly basis until 31st March 2025 for improvement and in particular, when the Health Board has been successful in replacing handed back contracts. The Health Board will endeavour to replace handed back contracts within 9 months of the contracts being handed back. 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. To monitor the impact of newly awarded contracts on patient revenue charges. Decision from Finance to progress the Dental Investment Plan and improve access to services Revisit Target Risk score end of financial year. Update based on available information. Consider procurement / direct delivery of additional GDS services. Paper to be submitted to Execs.	Owens, Mary	Completed	Year-end process now underway (figures will be available in June 2025) Year end data will be analysed by 31/08/25 Year end figures show that £1.8million was collected in Patient Revenue Charges which is only 53% of the £3.4million target	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. 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. 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	22-May-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
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 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. 2. further risk of CSG being overspent due to ad-hoc variable pay (current run rate £2.2m in this financial year with). This is caused by 1. fragile services requiring workforce planning and wider Health Board engagement to enact service change within the financial year. 2. fragile services and workforce pressures driving spend on ad-hoc variable pay. This will lead to an impact/affect on a worsening of the overall financial position of the CSG. 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 2. Weekly review of nursing and medical staff rotas 3. Regular job planning reviews 4. Weekly Operational team meetings 5. Monthly Clinical Service Group Business meetings 6. Continual onboarding of substantive locum staff in order to reduce reliance on premium locum staff and spend 6. Reduction in the O&G and Paediatric spend and working with Medical Sustainability project 7. Scrutiny of budget/Savings schemes via TI escalation meetings 8. Re-assessment of streamlining and education commissioning for Nursing and Midwifery services 9. Workstream future-proof Worthybush Creche '	Finance inc. claims	3	4	12	CIP tracker in place and monitored monthly for progress and shared with Clinical Care Group at the Business Planning and Performance monthly meetings and monthly Value For Money sessions with the CCG director. Services Leads working with the Commissioning team to review SLAs.	Continue to progress CIP schemes identified with CW&FH Work to resolve the Medical HR issues across the CSG	Davies, Nick	30/09/2026	28.5.26. 2 schemes currently identified on tracker- Creation of Gynaecology SDEC and implementation of hysteroscopy under sedation. Both "Blue" at present with SDM progressing as owner. Creche services currently subject to executive escalation to identify opportunity/ next steps- outcome of ET is likely to inform Tracker entry- currently in "red" status. Business partner team have generated non-pay ledgers and shared with all SDMs to enable a deep dive of their portfolios to identify all opportunities.	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	28-May-26

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																Review of WGH Creches sustainability	Davies, Nick	31/03/2027	28/5/26- An options paper designed to support decision making in relation to the provision of the creche service at WGH is currently subject to executive escalation to secure decisions/ identifying opportunity/ next steps- outcome of ET will inform Tracker entry and associated timelines- currently in "red" status.							
																Review Midwifery staffing in line with corporate nursing position	Llewellyn, Cerian	30/09/2026	To be reviewed at next update							

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
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. This is caused by increased workload sent for testing and changes in test repertoire resulting in higher costs. This will lead to an impact/affect on financial overspend. Risk location, Health Board wide.	1. Regular SLA meetings to review spend 2. Reviewed external testing sites 3. Clinical Scientist test vetting 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. 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. Review main SLAs to look at repatriating service Standardising clinical haematology processes, reducing send away tests Establish VBHC Steering Group to review demand optimisation opportunities within Pathology. Review Public Health Wales SLA CMR data. To look at test costs and volumes.	Peters, Lee	Completed	On going and linked to the ARCH Regional Solution. discussions ongoing. 05/06/2024 - update, exploring opportunities with SBU in laboratory medicine workstream. ongoing 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 FIT, MPO and PR3 testing being considered for repatriation 5.4.24 - linked to ARCH regional solution 31/1/25 - these tests are now being discussed in CIG meetings by HD and SBU representatives. Continually reviewing opportunities to standardise processes. Looking at subspecialising the service in the future. 30/1/24 - reviewed send away tests. haemoglobinopathy being reviewed to bring house 5.4.24 - new managed service now in place Steering group established and workstreams identified to progress demand optimisation work. 5.4.24 - ongoing. SLAs being scrutinised to check they deliver value for HB etc. Several tests have been challenged.	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. It has been proposed that this risk remains open, but with a tolerated score of 8.	Tolerate	13-May-26

2 - PERFORMANCE

2.1

09:45, 10 Mins

2.1 - INTEGRATED PERFORMANCE ASSURANCE REPORT

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

| For assurance

Attachments

M2 IPAR SBAR June 2026 - Committee - Final.pdf

M2 June 2026 IPAR Overview - Final.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Performance Update for Hywel Dda University Health Board – Month 2, 2026/2027
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance In association with all Executive Leads
SWYDDOG ADRODD: REPORTING OFFICER:	Huw Thomas, Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report relates to the Month 2, 2026/2027 Integrated Performance Assurance Report (IPAR) which summarises progress against a range of national and local performance measures. The IPAR consists of this SBAR and the following supporting documents:

- IPAR overview – includes data, issues and actions for the Health Board's key performance improvement measures.
- IPAR dashboard – provides statistical process control (SPC) charts for each of our performance measures. The dashboard can be accessed via: [Integrated Performance Assurance Report \(IPAR\) dashboard as at 31st May 2026](#). Ahead of the Board meeting, the dashboard will also be made available via our [internet site](#). For help navigating the IPAR dashboard, email the Performance Team: GenericAccount.PerformanceManagement@wales.nhs.uk.

We have adopted the '3As assessment' approach to highlight either an alert, advise or assure status for each of our key performance metrics:

- **Alert (may require discussion):** There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.
- **Advise (to monitor):** There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.
- **Assure (to note):** There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

Cefndir / Background

Welsh Government published the [2026/27 NHS Wales Performance Framework](#) in February 2026. The Performance team are currently reaching out to service leads to establish new data sources and are aiming to report all new metrics to the July Board. New metrics in 2026/27 are:

- Healthcare acquired infections are now focussing on hospital onset.
- Diabetes metrics have been expanded to monitor foot surveillance and urine albumin.
- Percentage uptake of the Respiratory Syncytial Virus (RSV) vaccination for those turning 75 years old.

- Percentage of people to have a heartbeat restored after a period of cardiac arrest which is subsequently retained until arrival at hospital (Return of Spontaneous Circulation)
- Number of patients waiting more than 26 weeks for a new outpatient appointment

The key metric summary table in the section below has been amended to reflect changes to the 2026/27 delivery framework, ministerial priorities and other local key performance metrics.

Following the health board's recent Accountability and Oversight meeting with Welsh Government, the 2026/27 trajectories are being reviewed. The revised trajectories will be included in the IPAR as soon as they are finalised.

Asesiad / Assessment

Performance overview

The key metric summary table below has been revised to reflect changes to the 2026/27 delivery 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
% pts on single cancer pathway within 62 days	75%	Apr 2026	58%	Improving	Missing target	n/a	Alert
Pts waiting 8 wks+ for specified diagnostic	0	May 2026	5,682	Usual	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	May 2026	1,650	Usual	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	May 2026	2,969	Concerning	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	May 2026	66.5%	Usual	Missing target	n/a	Alert
% MH assess within 28 days (age 0-17)	80%	Apr 2026	71.9%	Concerning	Hit and miss	n/a	Alert
Median time ambulance emergency category calls	8	Apr 2026	12	n/a	n/a	n/a	Alert
Median time ambulance arrest category calls	8	Apr 2026	9	n/a	n/a	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Apr 2026	52.9%	Concerning	Missing target	n/a	Alert
% sickness absence rate of staff	6.20%	May 2026	6.80%	n/a	n/a	n/a	Alert
Patients waiting 104 weeks+ RTT	0	May 2026	159	Improving	Missing target	n/a	Alert
Waits over 52 weeks: new outpatient appointment	0	May 2026	105	Improving	Missing target	n/a	Alert
C. difficile: Number of confirmed cases (in-month)	5	May 2026	13	Usual	Hit and miss	n/a	Alert
Financial in month deficit	n/a	May 2026	£5,977,000	Usual	n/a	Trajectory missed by over 5%	Alert
Ambulance handover > 4 hours Hywel Dda	0	May 2026	196	Improving	Missing target	n/a	Advise
Ambulance handovers > 1 hour Hywel Dda	0	May 2026	754	Improving	Missing target	n/a	Advise
Ambulance handover > 45 minutes Hywel Dda	0	May 2026	879	Improving	Missing target	n/a	Advise
% child neurodevelopment assess waits <26 weeks	80%	Apr 2026	28.3%	Improving	Missing target	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Apr 2026	74.2%	Usual	Hit and miss	n/a	Advise
Number of Pathways of Care delayed discharges	n/a	May 2026	186	Usual	n/a	n/a	Advise
Total days delayed for Pathways of Care delayed discharges	n/a	May 2026	6,813	Improving	n/a	n/a	Advise
% R1 eyecare patients waiting within 25% delay to target date	95%	Apr 2026	43.5%	Improving	Missing target	Trajectory missed by over 5%	Advise
Patients waiting over 52 weeks RTT	0	May 2026	10,684	Improving	Missing target	n/a	Advise
Patients waiting 26 weeks+ new outpatient	0	May 2026	4,390	Improving	Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Dec 2025	77.1%	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
% uptake of RSV vacc - 75+ years	70%	Mar 2026	14.1%	n/a	n/a	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Dec 2025	88.2%	Usual	Missing target	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	50%	Apr 2026	45.3%	Improving	Missing target	n/a	Advise
Follow-up appts - delayed >100%	11387	May 2026	14,842	Improving	Missing target	n/a	Advise
S. aureus (MSSA) BSI: Number of hospital onset cases (in-month)	3	May 2026	3	n/a	n/a	n/a	Advise
E. coli BSI: Number of hospital onset cases (in-month)	5	May 2026	6	Usual	Hit and miss	n/a	Advise
% MH assess within 28 days (age 18+)	80%	Apr 2026	98.1%	Usual	Hitting target	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Apr 2026	93.4%	Usual	Hitting target	n/a	Assure
Coding: % clinically coded - 1 month post discharge	95%	Mar 2026	97.6%	Improving	Hit and miss	n/a	Assure

Triangulating our data: 1st April 2022 to 31st May 2026.

- Quality safety and risk** – the number of incidents causing moderate harm or above reported by month is 130 in May 2026, lowest value since April 2025. May showed an improving trend in the number of patient falls (189) since March 2026 (240). Medication errors have decreased for a second month to 73 in May 2026. Cases of pressure damage increased from April (61) to May with 74 cases. We continue to have significant numbers of high and extreme risks on the risk register with 569 in May 2026. There has been a significant decrease in the number of new complaints received since September 2025 (249) with 38 in May. The number of new infections increased in May reporting 62 cases (S. aureus = 13 cases, E. coli = 30 cases, C. difficile = 13 cases).
- Workforce** – In month, staff sickness increased slightly with 6.6% in May. Short-term sickness remained as the previous month at 2% whilst long-term sickness increased slightly to 4.6%. Note: The sickness metric reported in the alert section of this SBAR includes 12 month rolling data. Nursing and midwifery agency usage continues to decrease since March 2024 (255) with May recording 47.56 whole time equivalent (WTE). Rolling 12-month staff turnover percentage has decreased slightly to 6.3%, lowest recorded.

Quality, safety and risk	Best	Worst	Latest	Trend
Reported incidents causing moderate harm or above	130	305	130	
Patient falls	189	301	189	
Medication errors	61	148	73	
Pressure damage developing or worsening during care	54	215	74	
New complaints by month received	38	249	38	
Number of high and extreme risks (health board & function only)	381	569	569	
Infections: new cases	51	81	62	
Infections: C. difficile cases	8	23	13	
Workforce				
Number of staff/contractor related incidents	98	186	131	
Sickness - short term	1.7%	2.6%	2.0%	
Sickness - long term	3.8%	4.9%	4.6%	
Number of vacancies	To follow			
Staff turnover (12 month rolling)	6.3%	9.8%	6.3%	
Nursing and midwifery vacancies	To follow			
Nursing and midwifery agency (WTE)	47.56	379.79	47.56	
Bank (WTE)	212.99	352.85	233.06	

Argymhelliad / Recommendation

The Committee is asked to **DISCUSS** the IPAR – Month 2 2026/2027 report and to **RECEIVE ASSURANCE** on the operational delivery of mitigating actions to improve performance in the areas that have been categorised as ‘alert’.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.1 The financial performance and delivery against Health Board financial plans and objectives and • give early warning of potential performance issues, • make recommendations for action to continuously improve the financial position of the organisation, • focus on the financial impact of in-year and medium-long term plans, the impact of financial issues on service delivery, quality and patient experience, and any specific issues where financial performance is showing deterioration or there are areas of concern. 2.1.2 The overall performance and delivery against Health Board plans and objectives, including delivery of key targets, giving early warning on potential performance issues and making recommendations for action to continuously improve the performance of the organisation and, as required focus on specific issues where performance is showing deterioration or there are issues of concern
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Risks are outlined throughout the report
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Choose an item. 6. All Apply Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply Choose an item. Choose an item. Choose an item.

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply Choose an item. Choose an item. Choose an item.
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Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2025/2026 NHS Performance Framework
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Contained within the body of the report

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Better use of resources through integration of reporting methodology
Ansawdd / Gofal Claf: Quality / Patient Care:	Use of key metrics to triangulate and analyse data to support improvement
Gweithlu: Workforce:	Development of staff through pooling of skills and integration of knowledge
Risg: Risk:	Better use of resources through integration of reporting methodology
Cyfreithiol: Legal:	Better use of resources through integration of reporting methodology
Enw Da: Reputational:	Yes

Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Integrated Performance Assurance Report (IPAR) Overview

As at 31st May 2026

For further details see the latest [IPAR dashboard](#).



Overview

[Key improvement measure summary](#)

Planned care

[Delayed Follow-up appointments](#)

[New outpatient waits](#)

[Referral to treatment](#)

[Ophthalmology R1 \(high-risk patients\)](#)

Urgent and emergency care

[Ambulances – Hywel Dda](#)

[Emergency departments – Hywel Dda](#)

[Ambulances – Bronglais Hospital](#)

[Emergency departments – Bronglais Hospital](#)

[Ambulances – Glangwili Hospital](#)

[Emergency departments – Glangwili Hospital](#)

[Ambulances – Prince Philip Hospital](#)

[Emergency departments – Prince Philip Hospital](#)

[Ambulances – Worthybush Hospital](#)

[Emergency departments – Worthybush Hospital](#)

[Pathway of Care Delays \(PoCD\)](#)

Cancer

[Single cancer pathway](#)

Statistical process control (SPC) charts

[Why use SPC charts?](#)

[Anatomy of a SPC chart](#)

Mental Health

[Mental health assessments within 28 days](#)

[Therapeutic interventions following primary mental health assessment](#)

[Psychological therapy waits](#)

[Neurodevelopmental assessment waits](#)

Diagnostics and therapies

[Diagnostic waits over 8 weeks](#)

[Therapy waits over 14 weeks](#)

Infections

[C. difficile](#)

[E.coli cases and S. Aureus](#)

Workforce

[Staff sickness](#)

Finance

[Financial Deficit](#)

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*. For data on all performance measures we are tracking, see our IPAR dashboard: [Integrated Performance Assurance Report \(IPAR\) dashboard as at 31st May 2026](#).

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% pts on single cancer pathway within 62 days	75%	Apr 2026	58%	Improving	Missing target	n/a	Alert
Pts waiting 8 wks+ for specified diagnostic	0	May 2026	5,682	Usual	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	May 2026	1,650	Usual	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	May 2026	2,969	Concerning	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	May 2026	66.5%	Usual	Missing target	n/a	Alert
% MH assess within 28 days (age 0-17)	80%	Apr 2026	71.9%	Concerning	Hit and miss	n/a	Alert
Median time ambulance emergency category calls	8	Apr 2026	12	n/a	n/a	n/a	Alert
Median time ambulance arrest category calls	8	Apr 2026	9	n/a	n/a	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Apr 2026	52.9%	Concerning	Missing target	n/a	Alert
% sickness absence rate of staff	6.20%	May 2026	6.80%	n/a	n/a	n/a	Alert
Patients waiting 104 weeks+ RTT	0	May 2026	159	Improving	Missing target	n/a	Alert
Waits over 52 weeks: new outpatient appointment	0	May 2026	105	Improving	Missing target	n/a	Alert
C. difficile: Number of confirmed cases (in-month)	5	May 2026	13	Usual	Hit and miss	n/a	Alert
Financial in month deficit	n/a	May 2026	£5,977,000	Usual	n/a	Trajectory missed by over 5%	Alert
Ambulance handover > 4 hours Hywel Dda	0	May 2026	196	Improving	Missing target	n/a	Advise
Ambulance handovers > 1 hour Hywel Dda	0	May 2026	754	Improving	Missing target	n/a	Advise
Ambulance handover > 45 minutes Hywel Dda	0	May 2026	879	Improving	Missing target	n/a	Advise
% child neurodevelopment assess waits <26 weeks	80%	Apr 2026	28.3%	Improving	Missing target	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Apr 2026	74.2%	Usual	Hit and miss	n/a	Advise
Number of Pathways of Care delayed discharges	n/a	May 2026	186	Usual	n/a	n/a	Advise
Total days delayed for Pathways of Care delayed discharges	n/a	May 2026	6,813	Improving	n/a	n/a	Advise
% R1 eyecare patients waiting within 25% delay to target date	95%	Apr 2026	43.5%	Improving	Missing target	Trajectory missed by over 5%	Advise
Patients waiting over 52 weeks RTT	0	May 2026	10,684	Improving	Missing target	n/a	Advise
Patients waiting 26 weeks+ new outpatient	0	May 2026	4,390	Improving	Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Dec 2025	77.1%	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
% uptake of RSV vacc - 75+ years	70%	Mar 2026	14.1%	n/a	n/a	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Dec 2025	88.2%	Usual	Missing target	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	50%	Apr 2026	45.3%	Improving	Missing target	n/a	Advise
Follow-up appts - delayed >100%	11387	May 2026	14,842	Improving	Missing target	n/a	Advise
S. aureus (MSSA) BSI: Number of hospital onset cases (in-month)	3	May 2026	3	n/a	n/a	n/a	Advise
E. coli BSI: Number of hospital onset cases (in-month)	5	May 2026	6	Usual	Hit and miss	n/a	Advise
% MH assess within 28 days (age 18+)	80%	Apr 2026	98.1%	Usual	Hitting target	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Apr 2026	93.4%	Usual	Hitting target	n/a	Assure
Coding: % clinically coded - 1 month post discharge	95%	Mar 2026	97.6%	Improving	Hit and miss	n/a	Assure

Alert
(may require discussion)

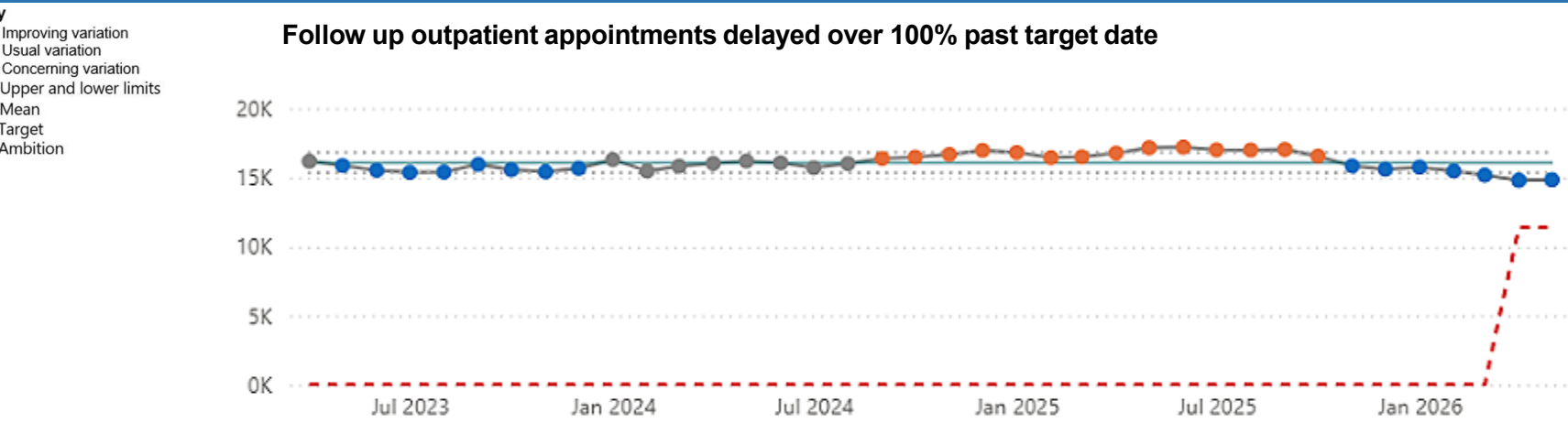
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

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.



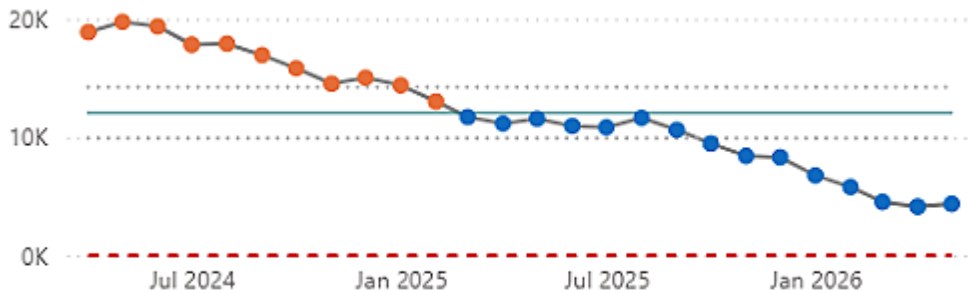
Performance is showing improving variation. In May 2026, 14,842 follow up appointments were delayed over 100% past their target date. The national target for Hywel Dda is 11,387.

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.	Outpatient Transformation Programme in place, with targeted actions for each specialty covering all National Planned Care Programme priorities, including referral management, clinical triage, and maximising the use of self-management pathways like See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).	31/03/27
Reducing follow up waiting lists continues to be challenging in terms of clinical engagement in some specialties.	Further engagement is planned, led by the clinical director with the clinical leads via the Outpatient Transformation programme in July.	31/07/26
Certain specialties have essential follow up pathways and may have additional pressure to reduce significantly due to case mix	Delayed follow-up wait reduction to below 12,000 supported by national clinical leadership and CIN (Clinical Implementation Network) guidelines was not met at the end of March 2026. However, improvements across many specialties are seen in 2026/27 with increased clinical validation, referring mild glaucoma patients back into primary care and use of CIN guidelines continues throughout 2026/27.	31/03/27

Key

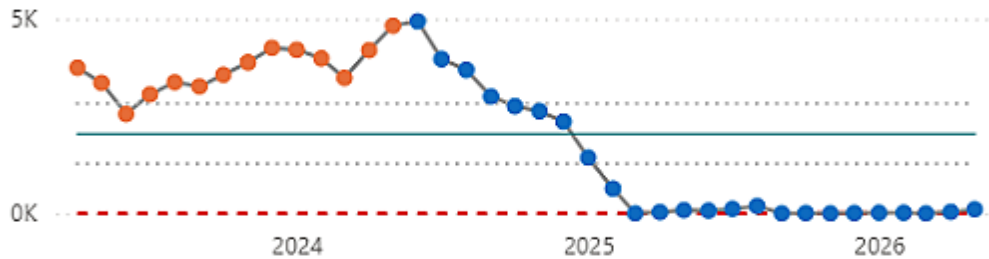
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting >26 weeks for a first outpatient appointment



Performance is showing improving variation. May 2026 (4,390) shows an increase in breaches following 8 consecutive months of improvement.

Patients waiting >52 weeks for first outpatient appointment



Performance is showing improving variation; however, breaches have increased to 105, the highest since August 2025.

Key challenges / issues

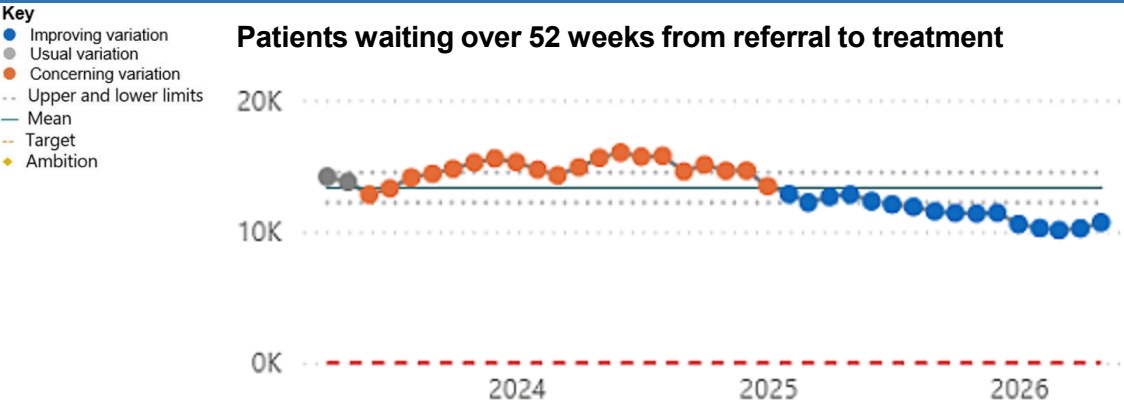
- The Health Board breached the 52-week outpatient target by a total of 105 in May 2026 with breaches recorded in General Medicine (44), Care of the Elderly (25), Rheumatology (22) and Neurology (14).
- Urology, Vascular and Gastroenterology all met the 26-week outpatient target in May 2026; however, 4,390 breaches were recorded in total across all specialties. There is a demand and capacity gap to be investigated for efficiency and productivity actions and until these are identified, we are forecasting this to rise to above 9,000 by March 2027. This is inline with the forecast breach volumes agreed by the Board via the Annual Plan.
- Active management and triage of referrals has resulted in no waiting list growth, whilst a reduction in 36-week new outpatient breaches since June 2024 signifies positive indications for further recovery in the future.

Key actions / initiatives

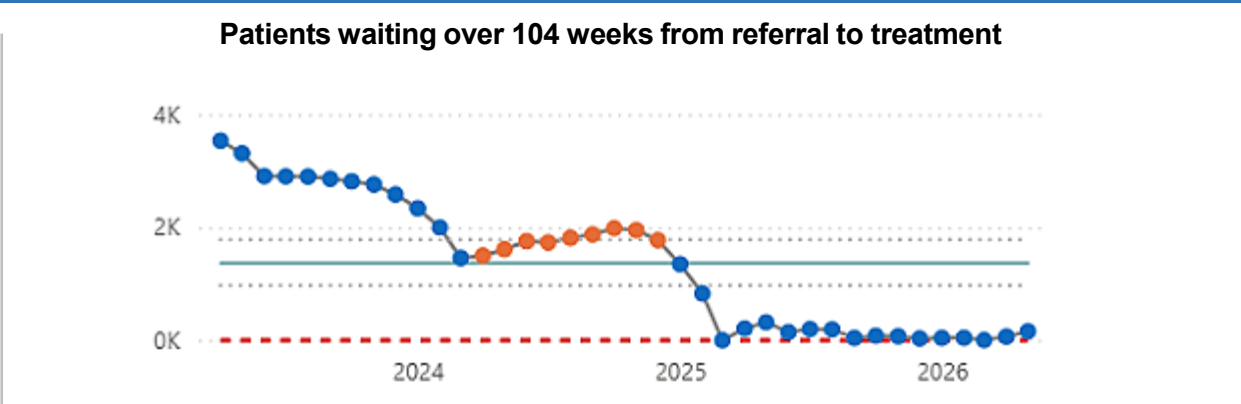
- The Clinical Care Group continues to focus on maintaining waiting time targets in 2026/27 using demand and capacity forecasts to highlight risks and guide funding allocation.
- Performance metrics are reviewed for all outpatient pathways on a weekly basis, with cohorts of 26, 36 and 52 weeks being performance managed across all specialties.
- Outpatient Transformation Programme in place, with targeted actions for each specialty covering all National Planned Care Programme priorities, including referral management, clinical triage, and maximising the use of self-management pathways like See on Symptoms (SoS)/Patient Initiated Follow Up (PIFU).

Due date

- 31/03/27
- 31/03/27
- 31/03/27

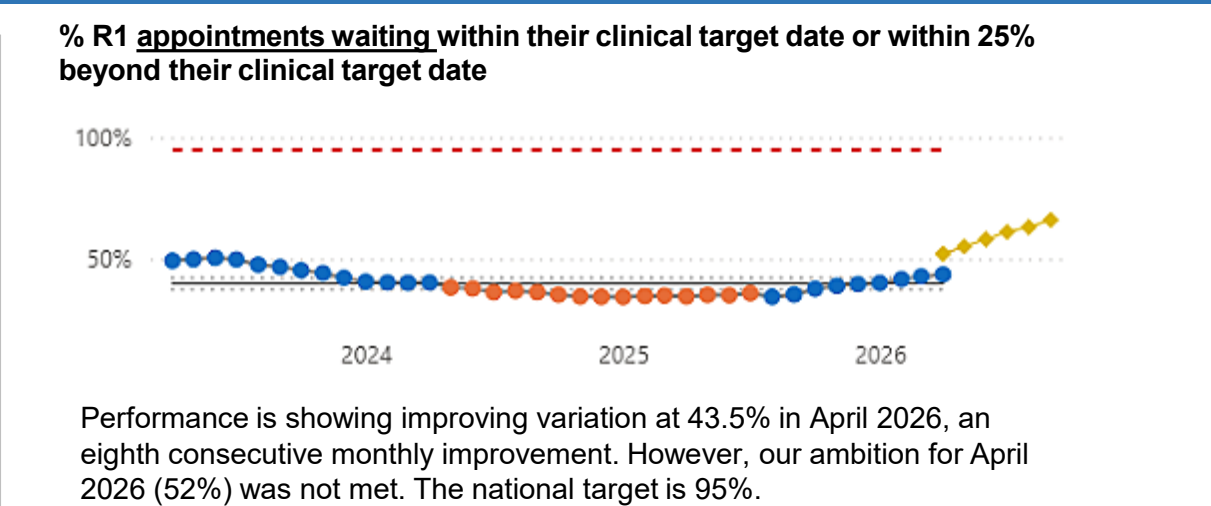
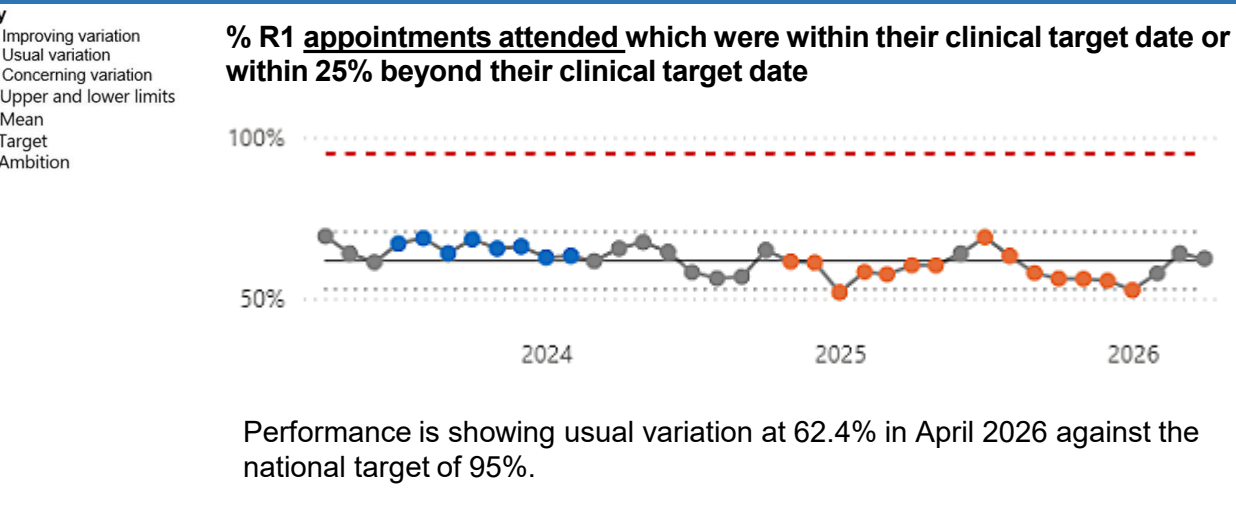


Performance is showing improving variation; however, breaches have increased for two consecutive months to 10,684 in May 2026.

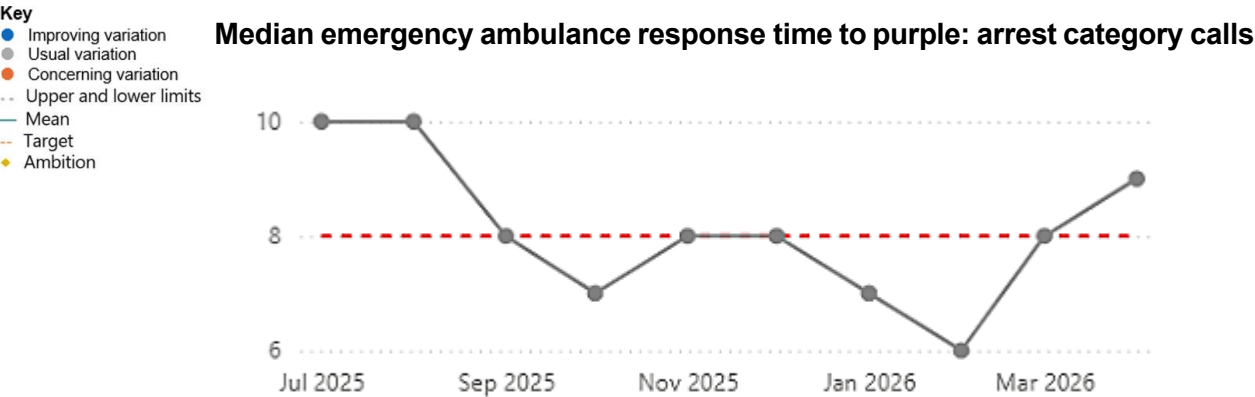


Performance is showing improving variation; however, breaches have increased to 159, the highest since August 2025.

Key challenges / issues	Key actions / initiatives	Due date
- There is a demand and capacity gap to be investigated for efficiency and productivity actions to be identified. The Health Board recorded 159 patients waiting over 104-week at the end of May. Breaches were recorded in Trauma and Orthopaedics (77), ENT (26), Gynaecology (21), Ophthalmology (17), Pain Management (12), Vascular (2), General Surgery (2), Care of the Elderly (2). All other specialties met the target. - We are forecasting 104-week RTT breaches to rise to 5,000 by March 2027 due to the present demand and capacity gap. This is inline with the forecast breach volumes agreed by the Board via the Annual Plan. - Patient complexity and co-morbidities affect suitability for outsourced or day-case procedures, affecting treatment timelines - Getting It Right First Time (GIRFT) ambitions are influenced by clinical confidence and preoperative process variations across specialties. - Additional risks include prioritisation of cancer backlogs, and urgent cases consuming rescheduled theatre slots. - Inpatient/day case activity exceeds pre-pandemic levels, but challenges remain with late starts, early finishes, and fallow (non-utilised) theatre lists due to workforce constraints	- The Clinical Care Group continues to focus on maintaining waiting time targets in 2026/27, as agreed by the Health Board, by using demand and capacity forecasts to highlight delivery risks. - Review of delivery trajectories with NHS National Performance & Improvement support to account for progress during Q1 plus further productivity assumptions - Theatre Optimisation workstream led by the Clinical Care Group and supported by the Medical Director aims to improve productivity and meet GIRFT standards across specialties. This includes a full staffing review and implementing evidence-based guidelines on appropriate staffing and list loading per procedure bundle with a view to eliminating variation between sites.	31/03/27 31/08/26 30/09/26
Embedded improvement actions		
104-week breach volumes were lower than levels forecast in May 2026 due to: - Additional outsourcing in March 2026, lowering overall cataract waiting times in Ophthalmology to below 100 weeks. This outsourcing continued into May 2026 for any cataract pathway procedures commencing initial treatment with outsourcing provider before the end of March 2026, funded from 2025/26 recovery money. - Impact of ROTT (removals for reasons other than treatment) in May 2026 were higher than levels forecasted in the Annual Plan delivery forecasts.		

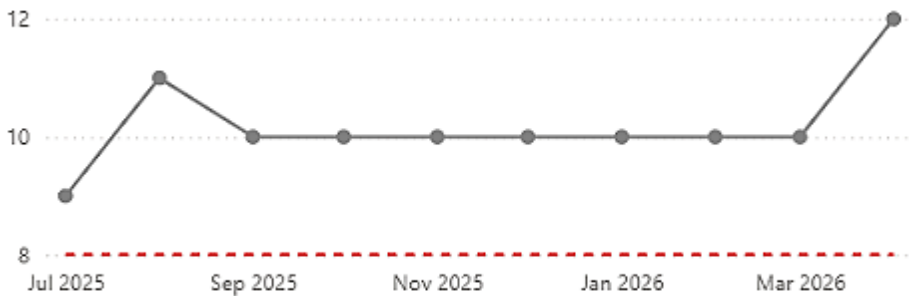


Key challenges / issues	Key actions / initiatives	Due date
- The advice from the Welsh Government is to focus on patients waiting as these are higher risk. Booking these patients, who have already breached, will improve this trajectory but will directly affect the appointments attended trajectory as patients have already breached. Once corrected, R1 appointments attended will improve as capacity grows and the backlog reduces. - Increasing outpatient delivery has been stalled by outpatient staffing and medical records constraints within Carmarthenshire and staff sickness in Pembrokeshire. This has affected approximately seven clinics per week. - Reduced workforce continues to impact delivery, with vacancies for two whole time equivalent (WTE) consultant posts and two WTE Specialist, Associate Specialist and Specialty Doctor (SAS) posts. Recruitment efforts continue. - One SAS doctor took a work break from September 2025 to May 2026 resulting in the loss of 10 sessions per week. - Two regional consultant posts were interviewed but only one applicant was suitable and has been recruited by Swansea Bay University Health Board. This has left a 1 x WTE gap in Hywel Dda. - Due to management absence across both administrative and nursing teams resulting from sickness, our ability to proactively support performance has been temporarily affected; this will be addressed as capacity is restored.	The actions below are to improve performance inline with the forecast volumes agreed as part of the Annual Plan process. During 2025/26, it was agreed that by September 2026, the trajectory of 66% of patients waiting within clinical target, should be achieved. - Monies awarded to reduce waits for Intravitreal (IVT) injections have been used to recruit and train staff, supporting improved performance. Activity is being increased incrementally. A replacement SAS doctor at North Road Eye Clinic (NREC) is currently joining the service and will further increase delivery. A key next step is to expand the IVT service into Amman Valley Hospital (AVH) outpatient settings five days a week, creating a dedicated IVT hub to improve patient flow and overall activity. - Outpatient staff will be increased to support outpatient activity in the blue suite in Glangwili Hospital (GGH). This will allow for the incremental increase in clinic delivery by 11 sessions per week. This requires staff to be recruited and trained in Ophthalmology. - The team are exploring more innovative methods of supporting outpatient activity using Ophthalmology Technicians. This will reduce the nursing resource required and ensure all staff are working to their licence. - Two SAS doctors have been recruited, with a planned start date of August 2026. - Regional Vitreoretinal (VR) Consultant has started, with four outpatient clinics per week and eight theatre lists per month, reducing pressure on the VR service.	01/06/26 01/09/26 31/08/26 01/08/26 01/06/26



In April, the median response time was 09:24 minutes for ARREST (Purple) Calls. There were 122 ARREST calls. Official WAST data is delayed by 1 additional reporting month

Median emergency ambulance response time to red: emergency category calls



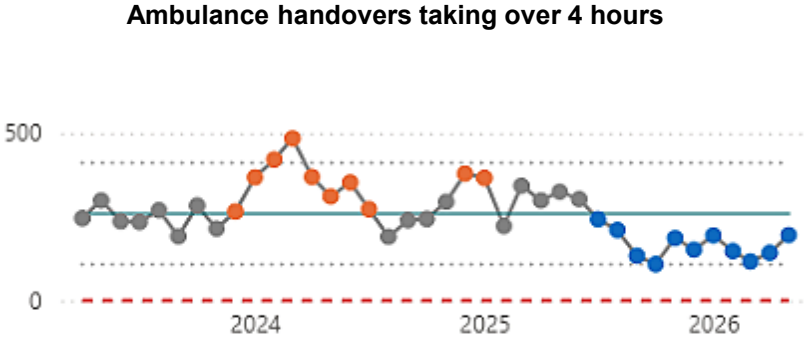
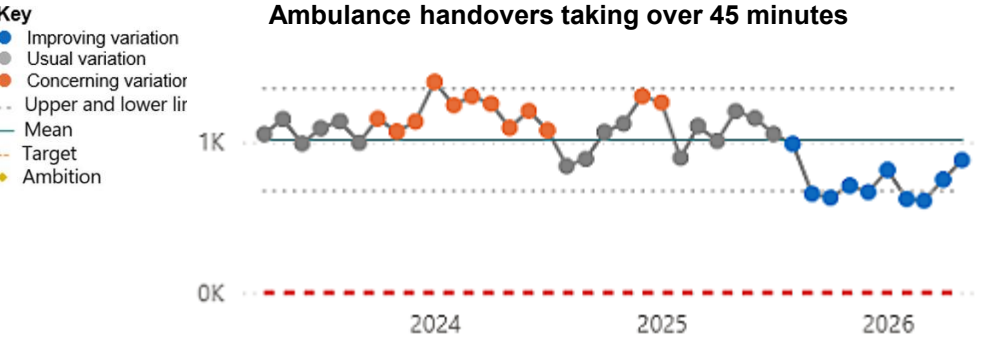
In April, the median response time was 11:52 minutes for RED (Emergency) calls there were 627 calls. Official WAST data is delayed by 1 additional reporting month

Key challenges / issues

- Unverified May performance was 08:21 minutes for arrest (22 incidents) and 10:59 minutes for emergency calls (196 incidents). Overall attended demand in Hywel Dda Health Board area for May 2026 on average has been roughly as forecast fore-cast.
- Hospital delays in ambulance handover for Welsh Ambulance Service Trust (WAST) ambulance crews, 2,470 hours lost at the 4 acute Hywel Dda hospital sites during May 2026, largely the same as April. Notification to Handover within 15 minutes was at 34% in May for the 4 acute general hospitals, showing slight deterioration over April 2026.
- There were 18 immediate vehicle release (IVR) requests of all category of 999 calls in May 2026 of which 15 were accepted. This represents an overall acceptance rate of 83.3%
- WASTs financial picture from April 2026 has seen overtime reduced, resulting in decisions about cover to maximise performance, and reductions short notice in Unit Hour Production (UHP) from staff absences.

Embedded improvement actions

- Ongoing reviews of WAST resource escalation action plan (REAP) which identifies potential service pressures and is a system for managing and mitigating the impacts.
- Dynamic review of demand and area specific pressures using the clinical safety plan. Clinical safety plan provides a framework for WAST to respond to situations where the demand for services is greater than the available resources.
- Same day emergency care (SDEC) access for WAST clinicians. SDEC extended to front door of ED – positive feedback from clinicians. Consultant connect is being in the process of being updated.
- 111 press 2 assisting WAST clinicians to support the management of mental health patients.
- Porth Preseli and Eastgate clinical streaming hubs staffed with Advanced Paramedic Practitioners supporting multidisciplinary approach to admission avoidance and to support equitable coverage in Pembrokeshire and Carmarthenshire. Improvements being made with uplifting cover as additional APPs complete necessary training.
- WAST resourcing reviews and targeted overtime allocation.
- Wait 45 initiative implemented, which will reduce length of ambulance wait times outside emergency departments.
- WAST managers joining 10am Patient Flow call from May 2026 to further support integrated working and furthering joint understanding of risk and flow.

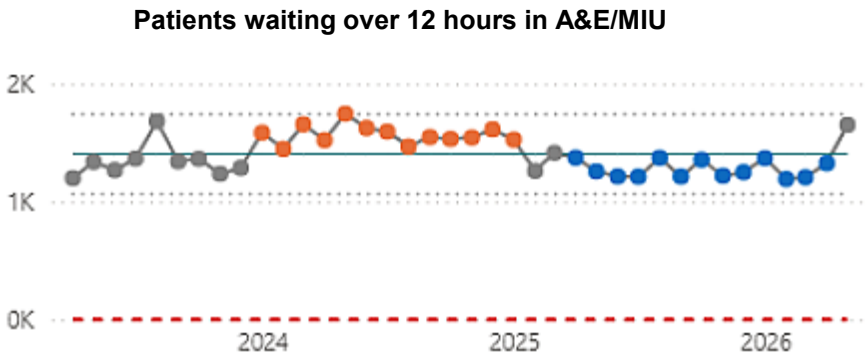
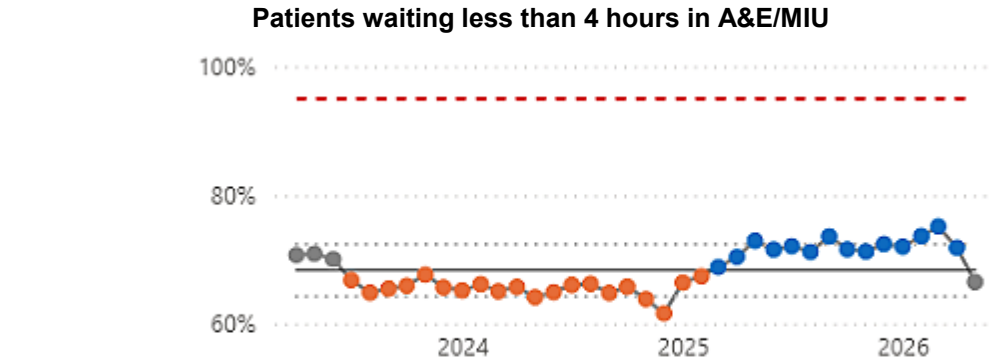


>45 Minutes handovers:

Latest data is showing improving variation, however, handover delays are increasing. 879 handovers > 45 minutes out of a total of 2,171 handovers.

>4 hours handovers:

Latest data is showing improving variation, however, handover delays are increasing. 196 handovers > 4 hour out of a total of 2,171, 9%.



Waits < 4 hours:

Latest data is showing usual variation and performance has deteriorated. 67% of patients were seen within 4 hours, 11, out of 16,591 new attendances.

Waits > 12 hours:

Latest data is usual variation and performance has deteriorated. 1,650 patients waited over 12 hours, out of 16,591 new attendances, 9.9%.

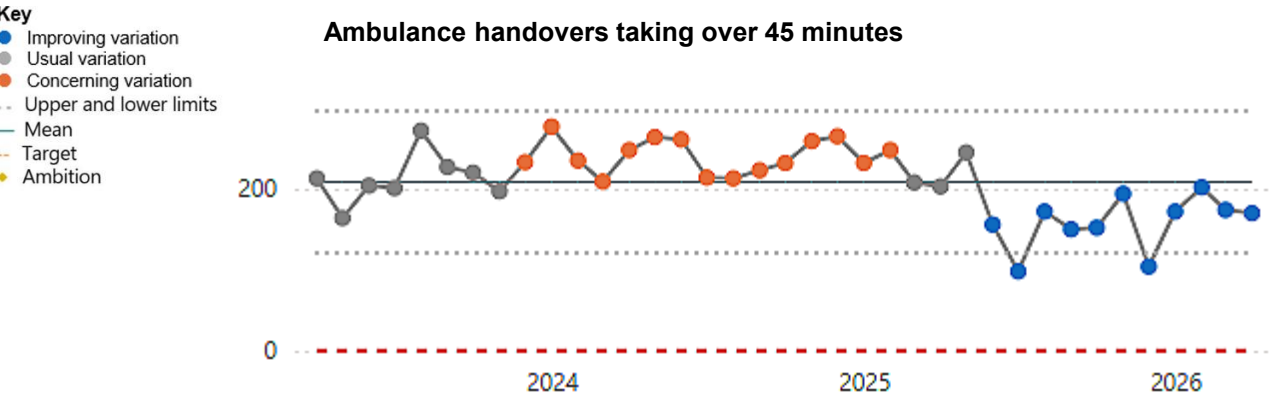
Key actions / initiatives – tactical urgent and emergency programme

The Urgent and Emergency Care (UEC) Programme delivery is focused on implementing the national Six Goals 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 delays. Central to this is the development of the Seven-Day Clinical Streaming, SDEC and Hospital@Home business case, which builds on pilot evidence and national guidance to transition services from weekday to 7-day provision. This 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 October 2026, and a 7-day SDEC service at WGH being December 2026.

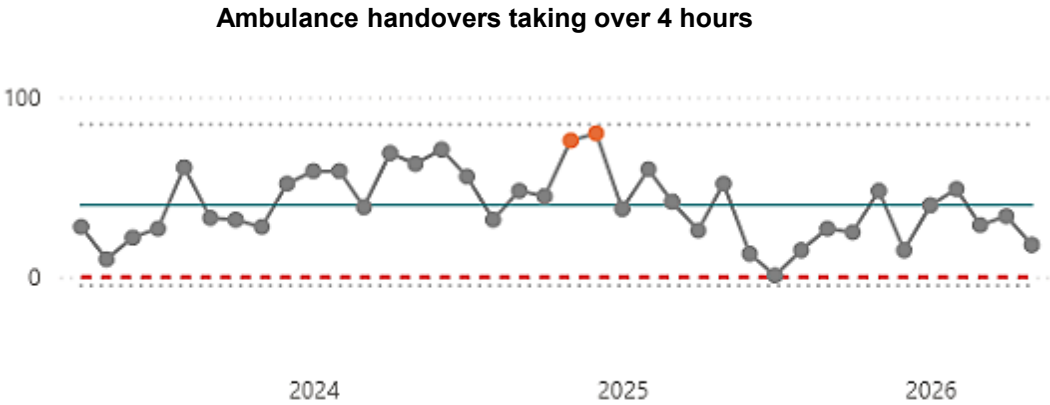
Please see the updates for each of our 4 acute site for the relevant issues faced and key actions we are taking to address:

- [Bronglais Hospital](#) [Prince Philip Hospital](#)
- [Glangwili Hospital](#) [Withybush Hospital](#)

Key actions / initiatives	Due date
Delivery of a formal Ambulance Handover Improvement Plan aligned to national guidance, Health Board hospital ambulance handover 45 plans developed and a Memorandum of Understanding between Welsh Ambulance Service (WAST) and Health Board being currently being undertaken. Trajectory work also being developed for National assurance on performance.	31/10/26
Implementation of the 7- Day business case for 7-day clinical streaming and Hospital@Home services across the Health Board. Occupational Change Process (OCP) completed, job adverts live and Regional recruitment events have been set for early July 2026.	14/10/26
Implementation of 7- Day Same Day Emergency Care (SDEC) services at Withybush Hospital (WGH). Implementation group formed, SDEC staff modelling completed, weekend SDEC consultant rota being developed and OCP papers currently waiting sign off.	01/12/26
Community Falls Programme. Falls prevention and assessment training being rolled out to care home staff across Hywel Dda.	01/08/26
iSTUMBLE – Implementation of iSTUMBLE, a digital tool to support falls decision-making and pathway routing, for care homes and community staff. This will also support falls data in being able to proactively gather community falls activity data, outcomes, and pathway effectiveness from the app. Phase 2 is the building of direct pathways for falls incidents in the community i.e. Care Homes to Clinical Streaming Hubs	31/10/26
Business case for six- and seven-day Frailty Pathway service pilot currently being developed. This will test the impact of extending the frailty pathway service across seven days over the next year. It is expected to increase total discharges and decrease mean length of stay (LoS) for frail patients.	26/06/26
Community Sprint. Delivery of a test-and-learn programme (“Community First Learning Weeks”) to improve community response and reduce emergency department/conveyance. Phase 1 has tested increased engagement with the WAST Remote Integrated Care Service (RICS) desk in starting to progress the principles of “Call before Convey”. The evaluation is currently being undertaken	26/06/26
Deconditioning Early Warning Indicator (DEWI) is being rolled out in phases across acute wards with evaluation informing full adoption across acute and community settings as business as usual. Phase 2 has commenced, with 38 wards currently using DEWI tool.	30/06/26
Continuous implementation of the Optimal Hospital Flow Framework to improve patient flow and discharge planning	31/03/27



Latest data is showing improving variation. 138 handovers >45 minutes reported out of a total of 353 handovers, 39%.



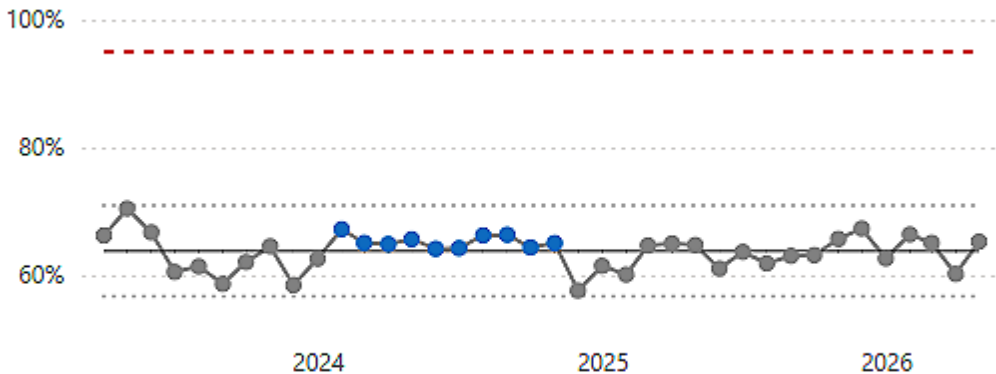
Latest data is showing usual variation. 18 handovers >4 hours was reported out of 353 total handovers 5%.

Key challenges / issues	Key actions / initiatives	Due date
- Physical space limitations within the Emergency Department (ED) footprint including limited assessment and trolley spaces to absorb ambulance arrivals during peak times leading to overcrowding and corridor usage. - Workforce constraints within the senior medical staffing workforce. - High levels of clinically optimised patients occupying inpatient beds impacting timely transfers to wards. - Patients awaiting specialty review, diagnostics or transfer can be delayed. - Community and social care capacity is limited. - Seasonal variation – Bronglais experiences increased demand from visitors and tourists. - Requirement of dual pin to ensure handover times are recorded appropriately.	Proposed reconfiguration of the Emergency and Urgent Care Centre (EUCC) footprint to incorporate more “majors” bays and rapid assessment and treatment (RATT) areas.	30/06/26
	Newly appointed band 7 Team Leaders to be assigned a quality improvement initiative linked to performance.	30/06/26
	ED module for Miya patient flow, to be implemented	31/10/26
Embedded improvement actions		
- Increase in consultant oversight following appointment of 2nd Consultant. - Senior ED Navigator oversight enhanced with appointment of senior sisters. - Site wide ward manager meetings with the ED Navigators to enhance collaborative working. - Shared ownership of the 45-minute ambulance handover performance across the Ceredigion Acute & Community System - Roster review of senior medical staffing to support senior clinical decision making - Daily review of clinical optimised patients - Senior oversight of ambulance handover performance inclusive of real time escalation - Enhanced senior clinical decision making at the front door		

Key

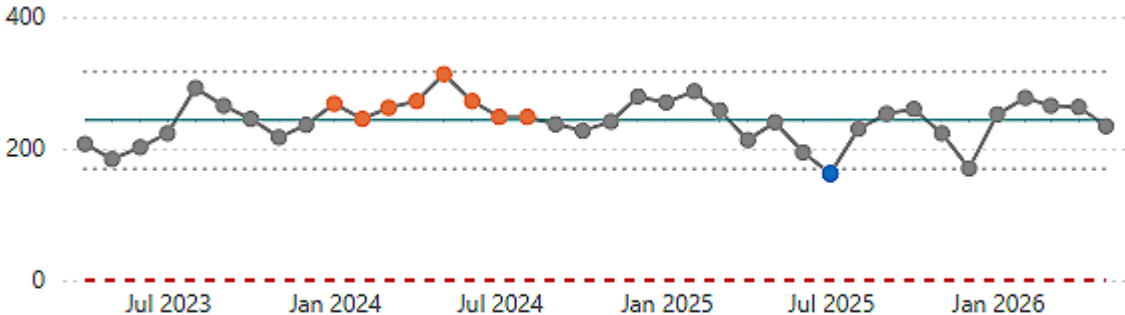
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

Patients waiting less than 4 hours in A&E/MIU



65.3% latest data, 1,009 breaches out of 2,907 new attendances. Chart is showing usual variation.

Patients waiting over 12 hours in A&E/MIU



234 breaches out of 2,907 new attendances, 8%. The chart is showing usual variation.

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.

Key actions / initiatives

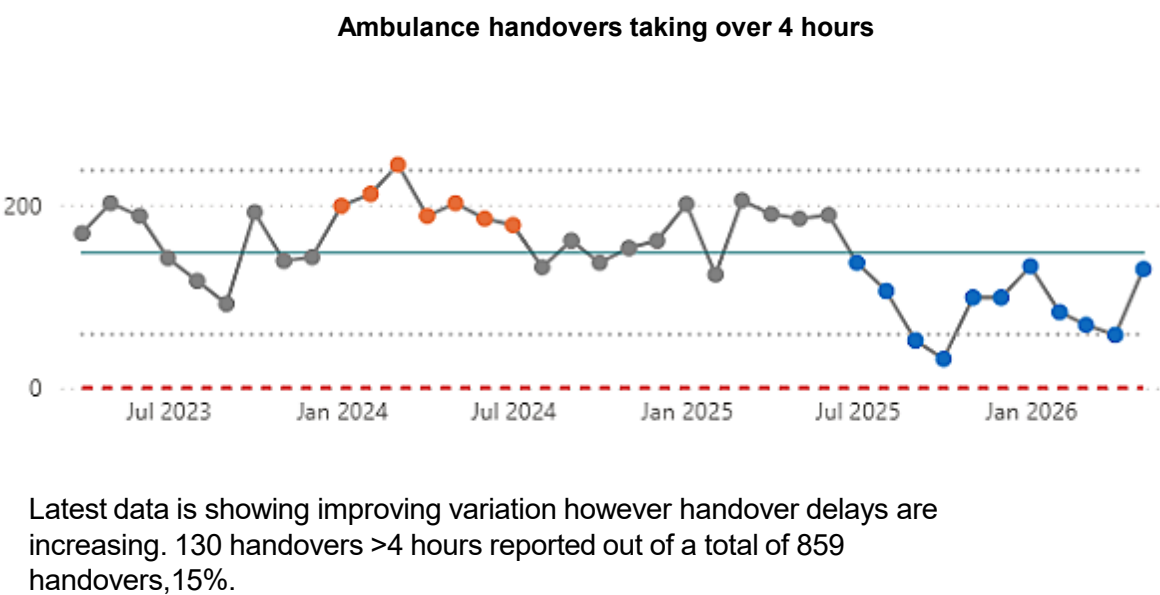
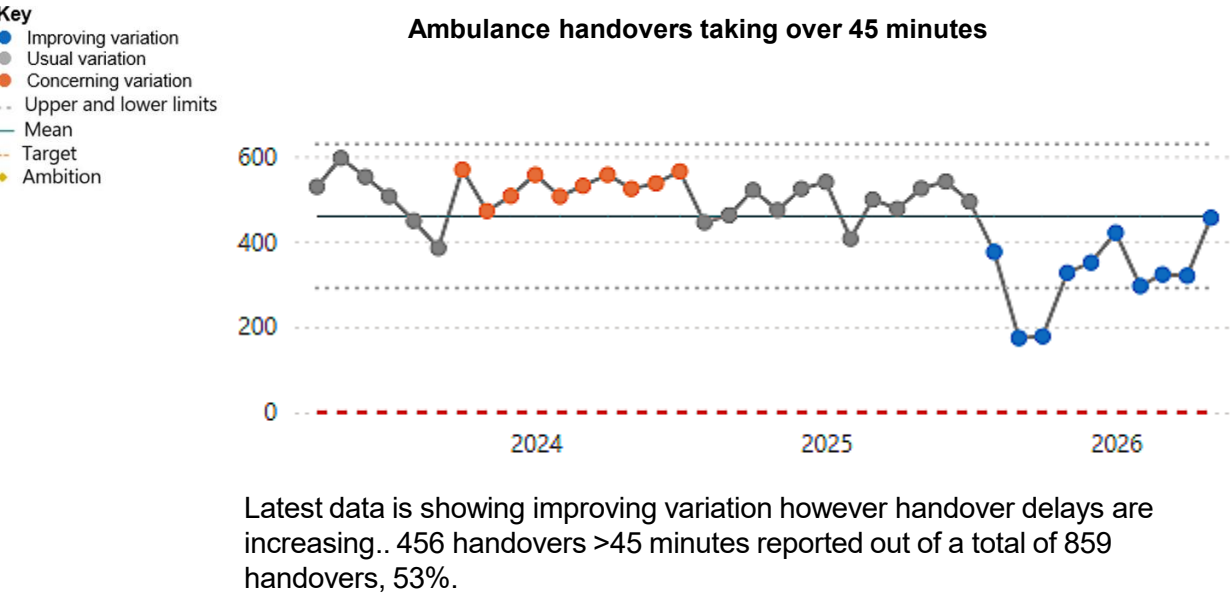
- Reconfiguration of the Emergency Department footprint to enhance flow throughout the department
- Review of clinical pathways across the Ceredigion Acute & Community System
- Quality Improvement Projects to be initiated across the Emergency Department led by the senior sister team.

Due date

30/06/26
30/06/26
30/06/26

Embedded improvement actions

- Successful recruitment of Senior Nurse Manager for the Emergency Department. Start date awaited.
- Increased scrutiny on patients in non clinical areas.
- Review of Your Next Patient
- Daily review of all patients at risk of breaching 12 hours
- Daily review of all clinically optimised patients
- Focus on earlier in the day discharges
- Escalation of delayed pathway of care patients
- Partnership working with Local Authority to minimise delays in discharge



Key challenges / issues

- Improving picture noted.
- Glangwili General Hospital (GGH) is the main Acute site for all medical and surgical pathways, adult and children.
- GGH is still seeing high demand from the ambulance conveyance and the patients presenting at the front door.
- ED remains heavily surged with patients waiting for in-patient beds. This causes lack of physical assessment areas for the patient flow to be timely through the department
- Reliance on agency doctors due to Consultant vacancies within Emergency Medicine and Medicine reduces the impact of senior reviews.
- Demand outweighs bed capacity, which causes slow flow through the system
- Advanced Paramedic Practitioner (APP) navigator rota coverage has been under pressure to staffing issues in the clinical streaming hub.

Key actions / initiatives

- To develop a robust repatriation policy, to return patient back to their local hospitals once the specialist care has ended.
- Active recruitment drive for senior consultants in Medicine and Emergency Medicine
- Re-design the medical take (list of patients needing to see medical consultant or surgeon), not through ED but through SDEC
- To implement 7-day clinical streaming up (directing patients to the most appropriate service or area based on clinical need).
- Strengthen community pathways

Due date

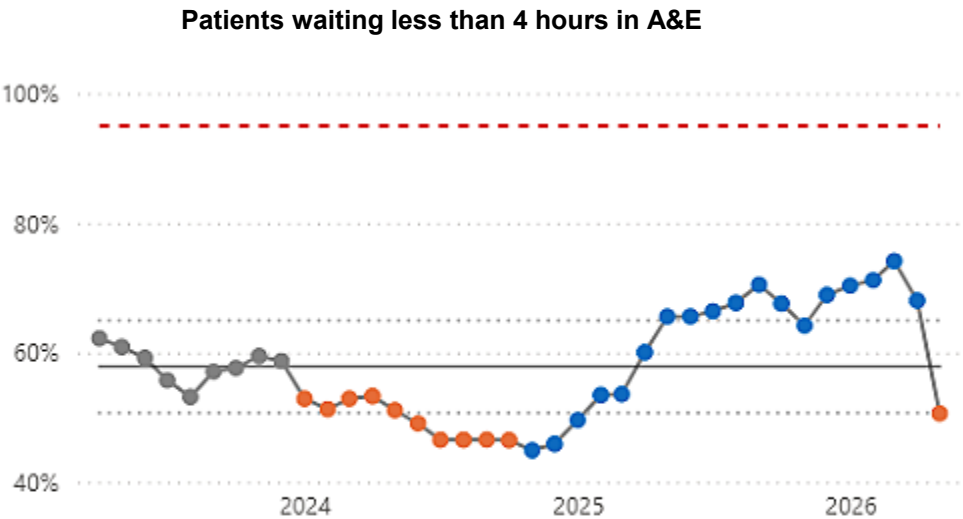
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31/12/26

Embedded improvement actions

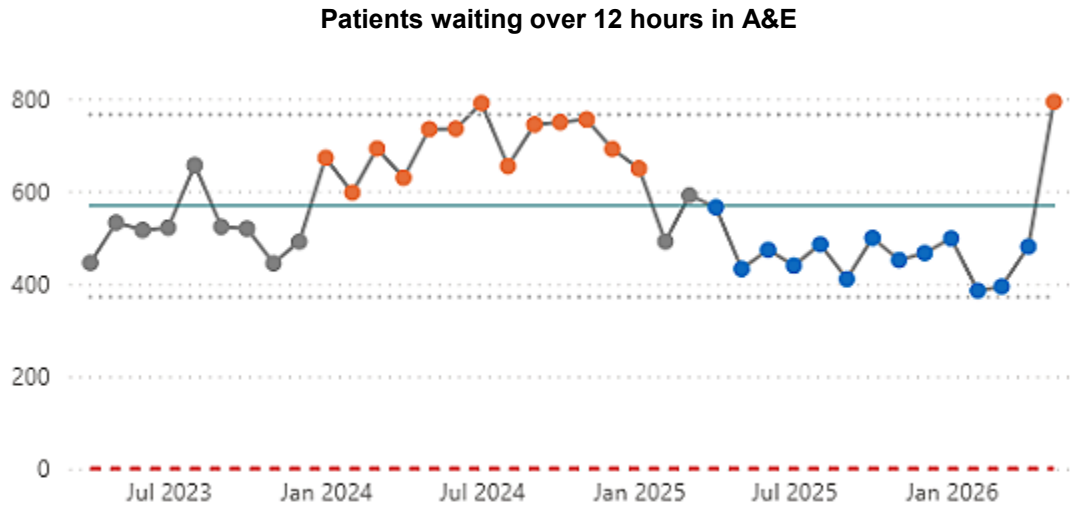
- Engaging with the Patient Flow Unit (PFU), this enables clear communication through the Clinical Care Group (CCG) and systems.
- Local and Health Board level safety huddles are embedded to assure collaboration and shared risk of site escalation.
- Collaboration with Welsh Ambulance Service Trust (WAST) to assure mutual support during elevated risk and escalation of community risk and site risks.
- Proactive "Pull" ethos of patient flow is evident by the high number of "boarding" patients at Glangwili Hospital (GGH). Pull from ED is where wards directly and actively request patients from ED. Boarding protocol (Our next patient) is where patients are moved early to areas where discharges or query discharges have been identified at escalation points via patient flow meeting or the day escalation.

Key

- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition



50.6% reported for May, 2,596 breaches out of 5,257 new attendances. Chart is showing concerning variation.



793 breaches out of 5,257 new attendances, 15%. The chart is showing concerning variation

Key challenges / issues

- Main challenge for GGH is the constant high site escalation (demand and capacity pressure), high demand coming through ED, with a discharge profile that does not match the need for a seamless patient flow.
- In-patient capacity is at its highest, with a constant patient bed surge and boarding noted on all wards.
- ED remains fully escalated and surged, this reduces the space for clinicians to see and treat patient in a timely manner
- GGH ED remains to see over 20 –28 patients waiting for ward beds.

Key actions / initiatives

- Strengthening Community Pathways. Continued collaboration with the community teams to identify patients suitable for community-based care, enabling earlier discharge and reducing inpatient demand.
- To develop a robust repatriation policy, to return patient back to their local hospitals once the specialist care has ended.

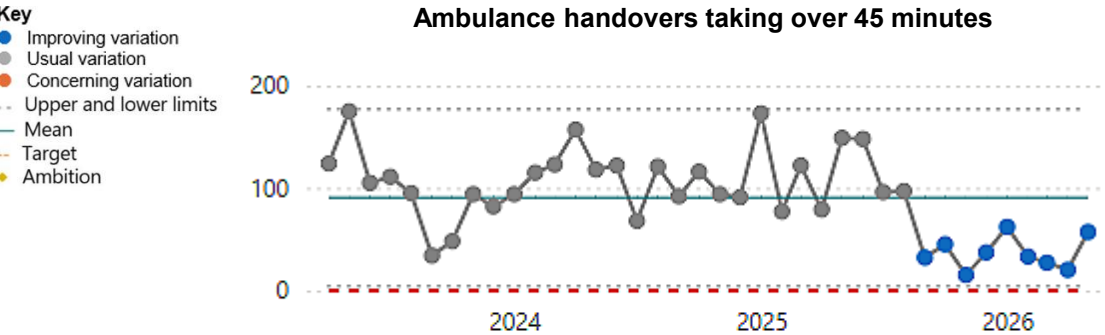
Due date

31/08/26

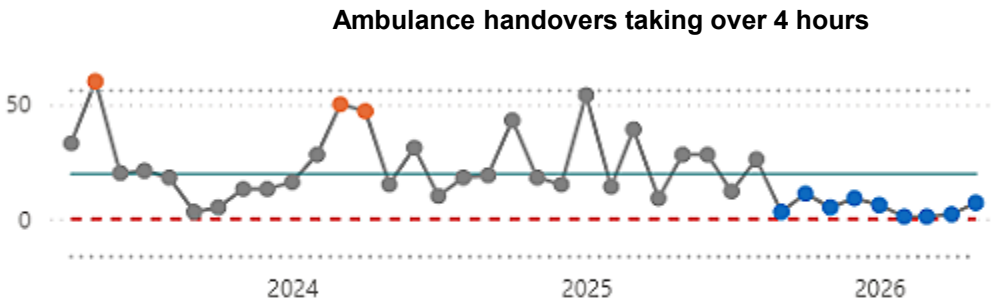
30/09/26

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.
- SDEC team actively "pull" from ED.

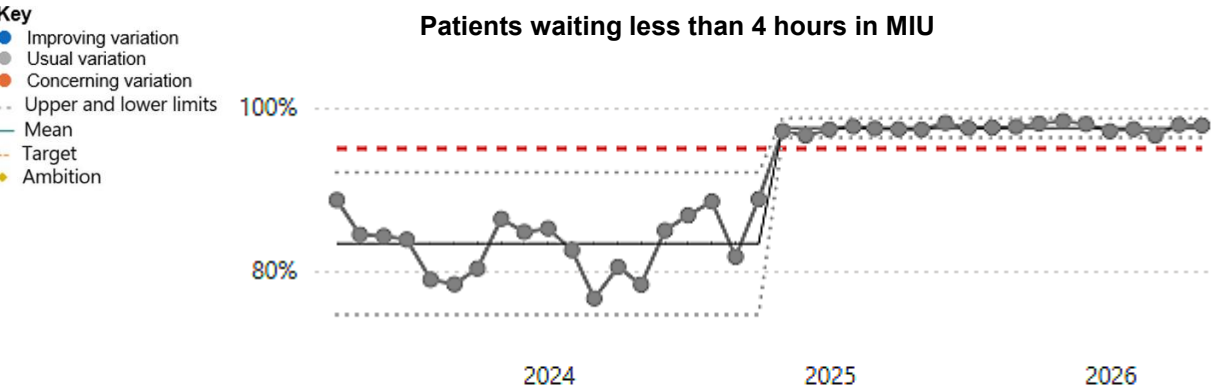


Latest data is showing improving variation however handover delays are increasing. 57 handovers >45 minutes reported out of a total of 322 handovers, 17.7%.

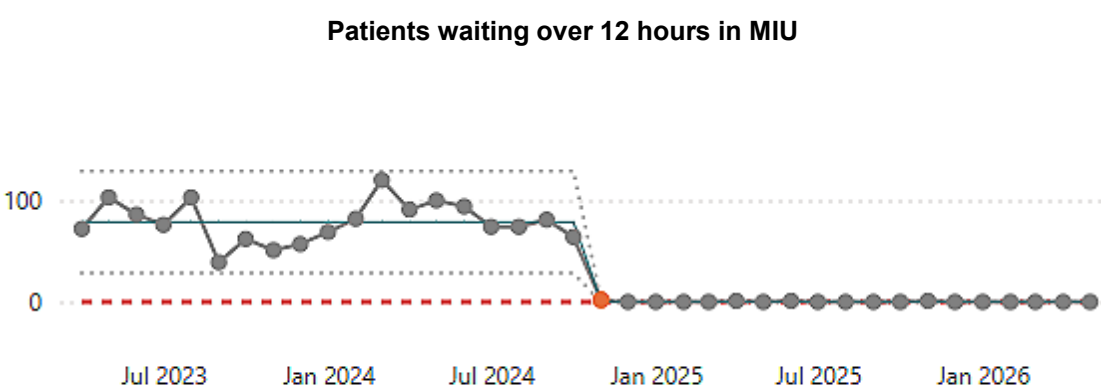


Latest data is showing improving variation. 7 handovers >4 hours reported out of a total of 322 handovers, 2%.

Key challenges / issues	Key actions / initiatives	Due date
- Continued significant pressure at the front door is resulting in very limited capacity at the point of ambulance handover. Substantial incidents of Infection resulting in delays, limited flow and site being unable to support the wider Carmarthenshire system creating limited flow across the health board. Increased patient acuity and volume are intermittently impacting the continuity and efficiency of handovers. - Difficulties in maintaining the 45-minute ambulance handover target this month, due to high demand and infection control issues. However, this continues to create additional internal pressures, particularly across ward areas where surge capacity has been required. Infection Prevention and Control (IPC) requirements are also contributing to delays, as areas require more frequent deep cleaning. - The prioritisation of medical patients transferring from Minor Injury Unit (MIU) to Acute Medical Assessment Unit (AMAU) remains in place. These patients are reviewed daily within site flow calls and tracked until transfer is complete. The boarding protocol continues to support proactive patient movement. Patients are transferred earlier to areas where discharges or potential discharges have been identified, based on escalation discussions within patient flow meetings and decisions made by the Manager of the Day	- Strengthening Community Pathways. Continued collaboration with the Acute Response Team (ART) to identify patients suitable for community-based care, enabling earlier discharge and reducing inpatient demand. Embedded improvement actions - Sustaining Ambulance Handover Performance. Continued focus on maintaining the 45-minute ambulance handover target, with immediate release prioritised wherever possible. Ongoing monitoring of delays linked to capacity constraints and acuity pressures. - A continuation of embedding of the AMAU acute medical model to support early clinical decision-making and discharge at the front door, reducing unnecessary admissions. - Improving Internal Patient Flow Full implementation and ongoing monitoring of the ‘Our Next Patient’ protocol to ensure proactive patient movement and timely transfer to appropriate specialty wards - 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. - Embedded AMAU Front Door Model. The AMAU acute medical model is now fully integrated into front door processes, enabling earlier senior clinical review, promoting same-day discharge, and reducing avoidable admissions - SDEC as a Core Pathway. Same Day Emergency Care (SDEC) is now an established and routine alternative to admission, with consistent utilisation across weekdays and weekends to manage	31/07/26

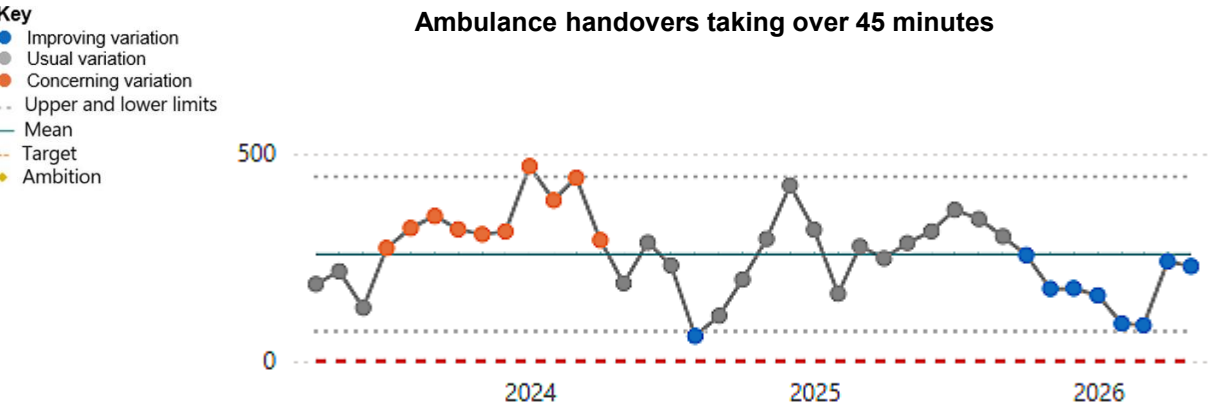


97.8% reported for May, 59 breaches out of 2,703 new attendances. Chart is showing usual variation performance trend. The control limits were adjusted from November 2024 due to change of front door model.

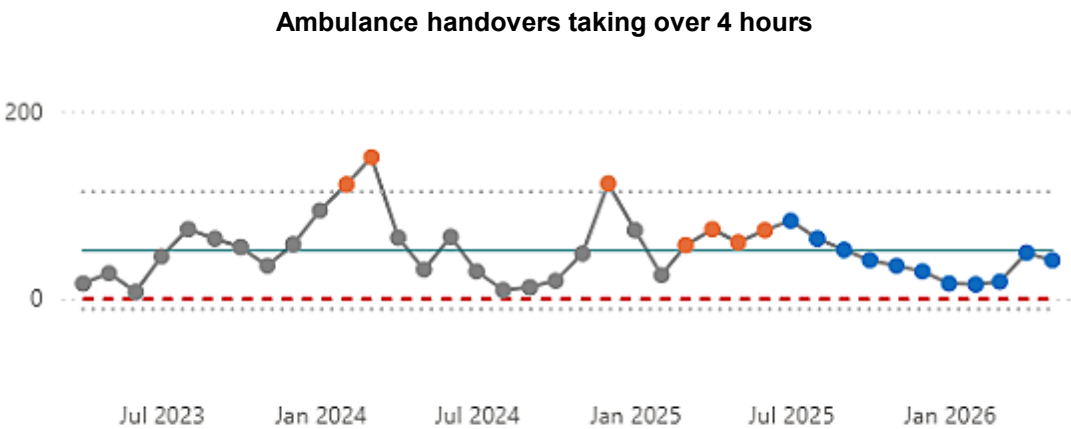


Zero breaches out of 2,703 new attendances. Chart is showing usual variation performance trend. The control limits were adjusted from November 2024 due to change of front door model

Key challenges / issues	Key actions / initiatives	Due date
- Ongoing demand, combined with increased patient acuity, is placing significant pressure on assessment and treatment capacity, impacting flow and timely decision-making. - A rise in oncology patient referrals has risen sharply meaning that modeling work has started to observe trends and action service alterations. - IPC Constraints. Clinical flow across departments has been relentless this year and further challenged by Infection Prevention and Control (IPC) issues affecting several wards. These constraints have reduced available capacity and impacted patient movement, contributing to wider system flow pressures. - Variation in patient streaming and pathway utilisation while pathways such as SDEC and AMAU are in place, inconsistent utilisation at peak times can result in avoidable pressure within core front door areas.	The development of the Urgent Care Centre (UCC) is currently underway, with structured governance and delivery arrangements in place to support implementation. UCC programme activity is progressing at pace, with meetings currently taking place four times per week to maintain momentum, address emerging challenges, and ensure timely delivery of key milestones. This coordinated approach is supporting the development of a robust and sustainable Urgent Care Centre model, designed to improve access, enhance patient flow, and reduce pressure on front door services.	30/11/26
Embedded improvement actions		
- Clear communication channels with the newly named PFU (Patient Flow Unit) team on site to support with hospital flow and patient transfer. - Medical Hot Clinics increased in response to operational pressures. An additional General Medicine hot clinic has been introduced into the rota from January, operating every Monday to support demand and provide an alternative to admission where appropriate - Ongoing work with community colleges in early discharge planning. The use of hospital at home to create a wrap around service enabling community GP's to refer into SDEC out of hours / weekends for SDEC to ti		

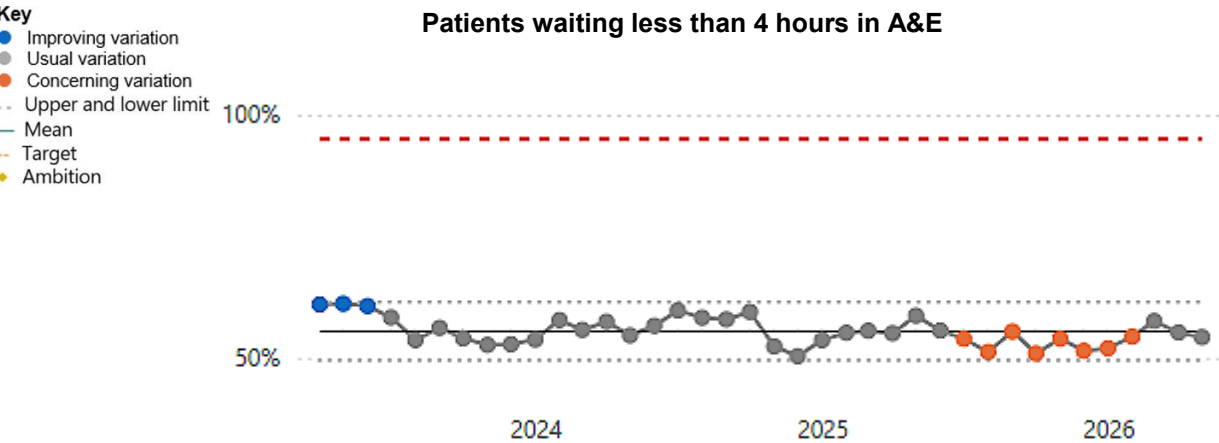


Latest data is showing improving variation. 228 handovers >45 minutes reported out of a total of 637 handovers, 35.8%.

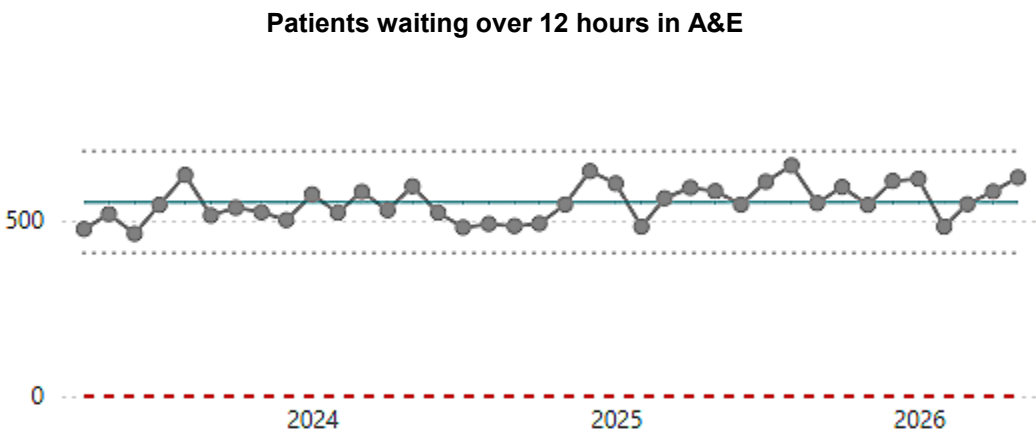


Latest data is showing improving variation. 41 handovers >4 hours reported out of a total of 637 handovers, 6.4%.

Key challenges / issues	Key actions / initiatives	Due date
- Increased monthly conveyances to the Emergency Department (Feb' 542, Mar' 601, Apr' 604, May 637) despite also seeing good use of alternative pathways. This increased demand has contributed to departmental capacity challenges, impacting negatively on ambulance handover performance. - Challenges with wider system flow, in particular during periods of increased demand, has negatively impacted on handover performance. This has been reflected in a period of escalated operational pressure declared at the end of the May. - Due to Welsh Ambulance Service Trust (WAST) staffing challenges there has been some inconsistent cover of the Advanced Paramedic Practitioner Navigator role in our Clinical Streaming Hub.	- Coordinate with WAST regarding Advanced Paramedic Practitioner Navigator support in our Clinical Stream Hub (daily presence required) - Reinforce ring-fenced capacity protocols in the Emergency Department - Increase WAST referrals into alternative to ED pathways	30/09/26 30/09/26 31/12/26
Embedded improvement actions		
- MIYA Patient Flow model - Band 6 permanent presence in Rapid Assessment Triage/Pitstop area to support expedient handovers. - Direct admissions into Frailty Same Day Emergency Care. - Direct admissions into Medical Same Day Emergency Care.		



54.2% reported for May, 1,868 breaches out of 4,080 new attendances. Chart is showing usual variation.



622 breaches out of 4,080 new attendances, 15.2%. Chart is showing usual variation.

Key challenges / issues

- Challenges with wider system flow, particularly during periods of increased demand, has negatively impacted on ambulance handover performance. This has been reflected in a period of escalated operational pressure declared at the end of the May.
- Higher demand experienced month on month, reflected in total attendances: Feb' 3,192, Mar' 3,735, Apr' 3,862, May 4,098.
- This increased demand inhibited improvement with the 4 hour % performance and waiting over 12 hours in the Emergency Department metrics.

Key actions / initiatives

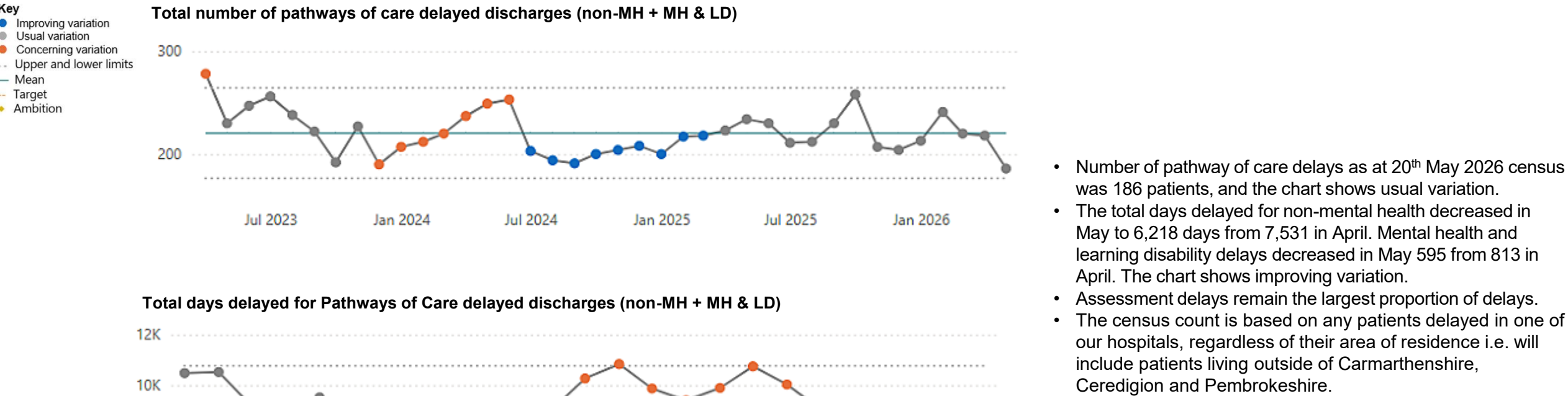
- Embed Home-First discharge model across all inpatient areas (reducing patient length of stay and increasing flow, releasing beds to support the Emergency Department)
- Deployment of senior clinical decision maker to front door to lead on patient streaming.
- Continue to focus on reducing average inpatient length of stay through weekly operational call, targeting 0 cases over 50 days (increasing flow and supporting movement of patients out of ED into inpatient beds)

Due date

30/09/26
31/12/26
31/03/27

Embedded improvement actions

- MIYA Patient Flow model
- Same Day Emergency Care in-reach into the department to support and pull patients from ED
- Pro-active Frailty screening and pull through to Frailty SDEC from ED.



Top 10 delay reasons for census count patients (non-MH + MH & LD)

Delay Code	Delay Reason	Carmarthenshire	Ceredigion	Pembrokeshire	Out of Area	Total Patient Count	Total Days Delayed	Average days delayed
1.01.02	Awaiting completion of assessment by social care	23	5	5		33	866	26
2.03.01	Awaiting start of new community care package funded by social care	3	5	8	1	17	682	40
1.01.05	Awaiting joint assessment	4	8	2		14	368	26
1.01.03	Awaiting completion of assessment Nursing	2	3	5	1	11	281	26
2.04.01	Awaiting reablement community care package	6	3	0	2	11	299	27
1.01.07	Awaiting completion of AHP Allied Health Professional Assessment	4	0	5		9	258	29
1.01.04	Awaiting Continuing Healthcare (CHC) Assessment	3	1	3	1	8	312	39
3.01.13	Identifying Residential Home	6	1	1		8	488	61
1.01.11	Awaiting completion of best interest decision	2	0	5		7	434	62
3.03.03	Home unsafe and requires attention	4	1	1	1	7	242	35
	Other reasons	15	19	22	5	61	2,583	42
TOTALS		72	47	57	11	186	6,813	37

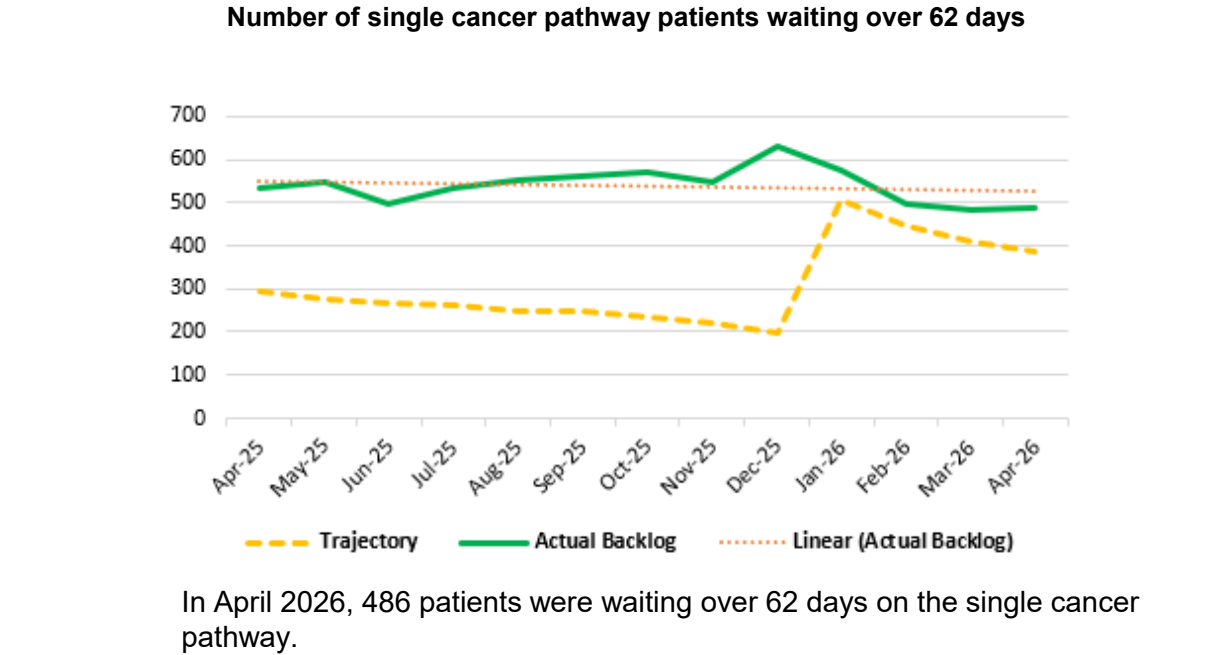
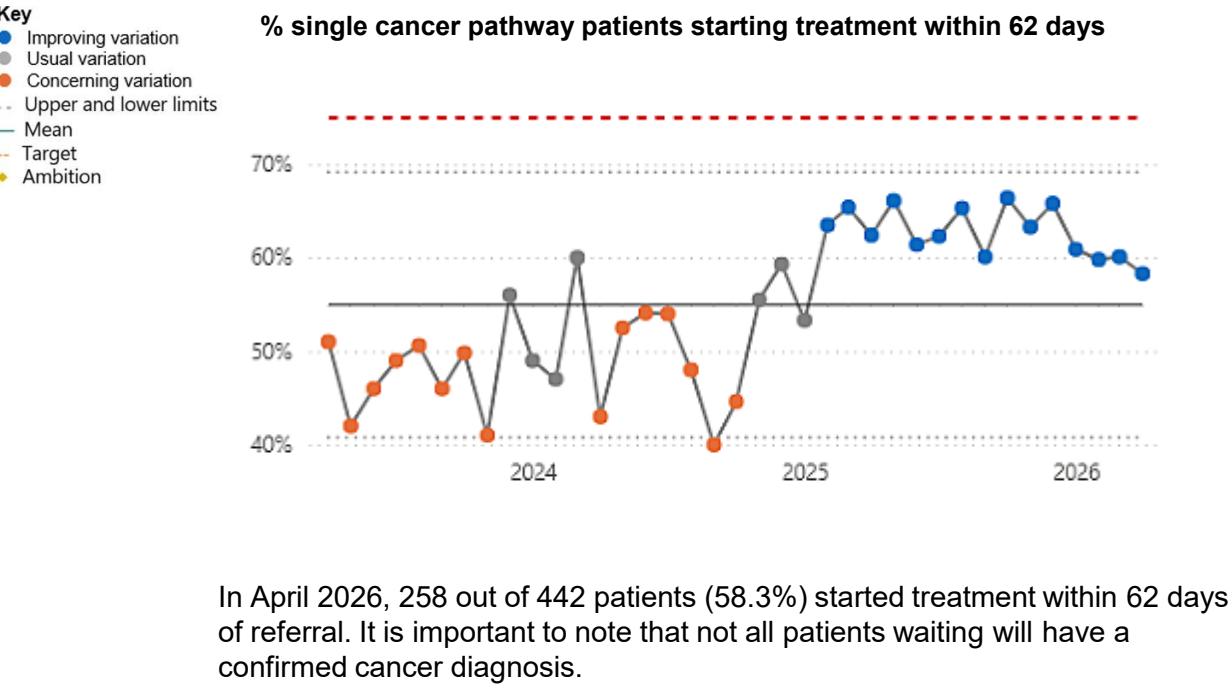
Key challenges / issues	Key actions / initiatives	Due date
Non Mental Health: Widespread infection prevention and control (IP&C) measures across multiple sites affected PoCD census data with patients unable to progress to the next stage of care (either assessments or care home discharge) due to IP&C issues, in addition the number of patients clinically affected impacted on the number of patients declared clinically optimised. This contributed to the reduction in PoCD numbers and days delayed this month. - Staffing challenges across all staff groups and ongoing wider system pressure has negatively impacted on PoCD. - High levels of acuity and frailty across acute and community, patients/family and carers expectations driving the need for nursing, joint and continuing healthcare assessments, as well as social care assessments. - Hospital acquired deconditioning and limited access to appropriate levels of rehabilitation due to the allied health professional (AHP)/ therapy staffing position contributing to delays relating to AHP assessments, re-ablement and packages of care on discharge. - Ongoing challenges related to housing and homelessness, care home manager assessments and care home availability. Mental Health & Learning Difficulties: MH&LD PoCD volumes remain low with a marginal increase from the previous period, driven by a small number of complex Adult Mental Health (AMH) and Older Adult Mental Health (OAMH) cases. Delays continue to be predominantly placement-related, including limited availability of residential, nursing and Elderly Mentally Infirm (EMI) dementia provision, with a small cohort exceeding 90 and 100 days. Housing-related delays persist within AMH, including homelessness and unsuitable accommodation. A small number of delays are linked to community care package initiation and specialist placement availability, reflecting continued reliance on partner agency capacity.	Non Mental Health: - Regional PoCD Action plan updated and submitted to the national team with 5 key actions to progress based on the current system challenges. - Draft Memorandum of Understanding developed between health and local authorities to support PoCD and discharge planning (awaiting final sign-off). - Deconditioning Early Warning Indicator (DEWI) tool being rolled out across all acute and community wards, in addition to other preventing deconditioning initiatives. - Health Board Working Group established to focus on Rehabilitation pathways/ levels Mental Health & Learning Difficulties: - Targeted scrutiny of St Non and Enlli Ward >100-day PoCD an continued improvement plan to strengthen clinical governance process with standardisation across OAMH wards. - System-level engagement with Local Authorities and independent sector providers to address residential, nursing and EMI dementia placement opportunities and social care to expedite community care packages. - Focused management of AMH housing-related delays continues, including strengthened multi-agency liaison with Local Authority housing services. - Continued scrutiny of best-interest decision timelines to ensure proportionality, timeliness and alignment with clinical optimisation. - Focused review of AMH homelessness-related delays continues, with strengthened multi-agency liaison involving Local Authority housing services and policing partners. A multi-agency workshop remains in development to reduce recurrence of PoCD associated with non-clinical discharge barriers for AMH inpatients	31/08/26 30/06/26 31/08/26 31/08/26 31/10/26 30/06/26
		30/06/26 30/06/26 31/10/26

Embedded improvement actions

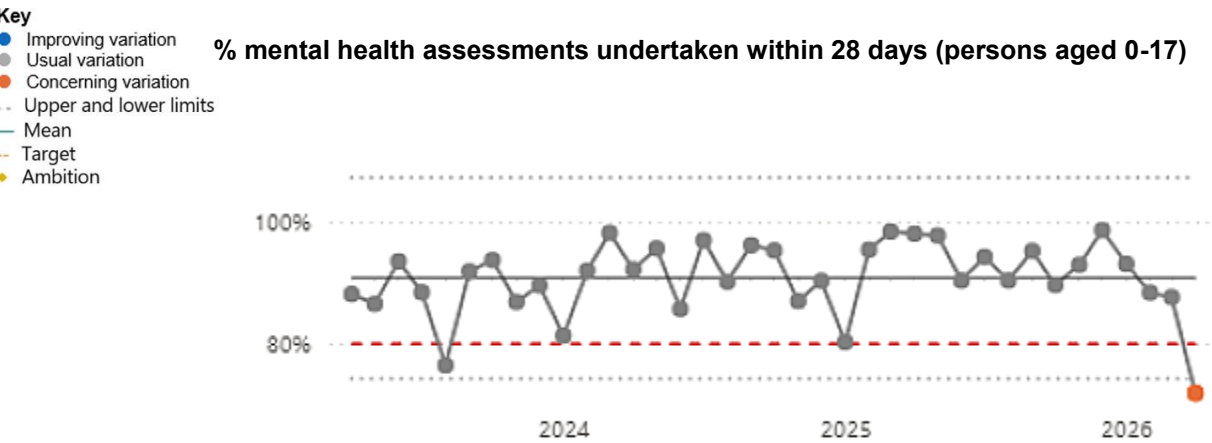
Non Mental health: Regional West Wales Optimal Flow and Discharge Delivery Group overseeing Optimal Hospital Flow delivery, PoCD Action plan and Enhanced Community Care. , Acute frailty action group and action plan developed, Deconditioning Oversight Group in place, Trusted Assessor model in mental capacity developed, long stay review meetings in place, increased social worker and re-ablement capacity from WG funding, strength- based collaborative communication approach being embedded.

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.

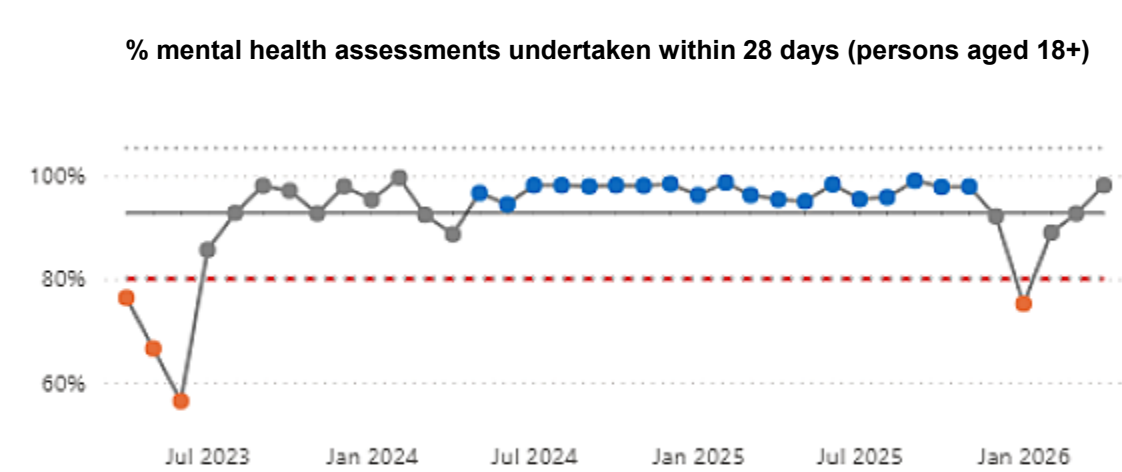
- Weekly PoCD deep-dive and escalation meetings across AMH and OAMH remain established, supporting senior validation and system escalation.
- Discharge to Recover and Assess (D2RA) principles remain embedded, supporting early discharge planning.
- Dementia Wellbeing stepped-care model remains established across regional care home system flow.
- Multi-agency working with Local Authorities remains embedded, including routine validation of PoCD status and shared accountability for delays.



Key challenges / issues	Key actions / initiatives	Due date
Single cancer pathway Whilst overall treatment activity in April 2026 increased, performance was compromised by an increased number of patients (184) treated over 62 days. This impacted breast and lower gastrointestinal pathways, caused by bottlenecks in the diagnostic pathway for both tumour sites in previous months. Additional treatment capacity has been allocated to treat patients that are waiting over 62 days, and this will continue through Quarter 1. Backlog and Diagnostics As reflected in the Annual Plan, the fundamental delivery challenge remains in the overall diagnostic pathway. Performance in May 2026 is expected to recover above 62%.	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. £168k committed via recovery money for Urology Diagnostics for Q1 Residual recovery funds allocated for Pathology turnaround for Q1 Piloting the use of the Galeas Bladder Test from March 2026 – 300 patients, extended for Q1 2026/27 Outsourcing CT equates to 260 scans per month with a 7-day reporting turnaround, extended for Q1 2026/27 As concerns remain regarding resourcing of diagnostic recovery actions beyond Q1, a further deep dive review of SCP performance is being progressed during June 2026.	30/06/26 30/06/26 30/06/26 30/06/26 30/06/26 30/06/26



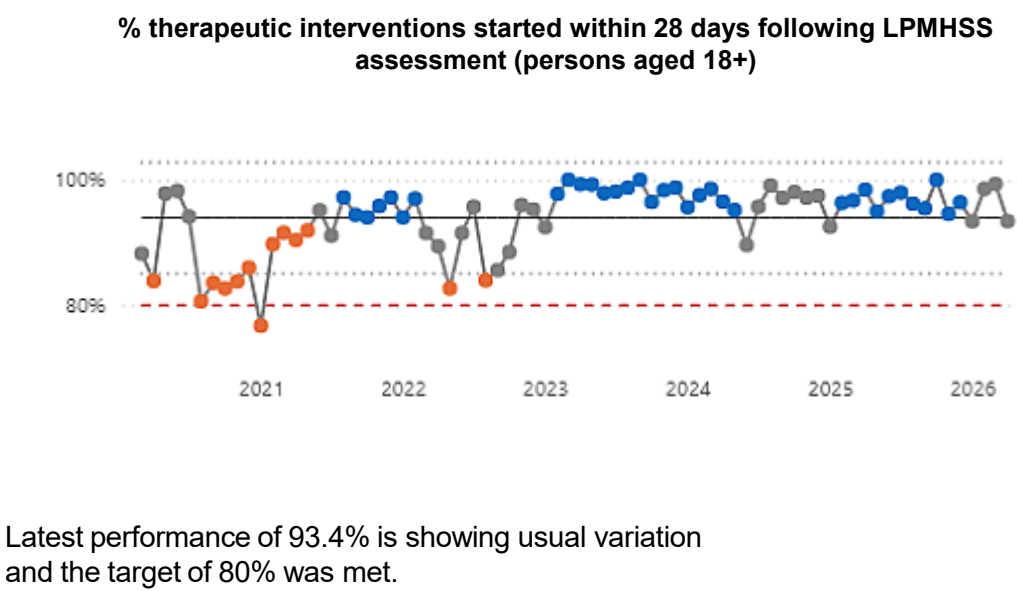
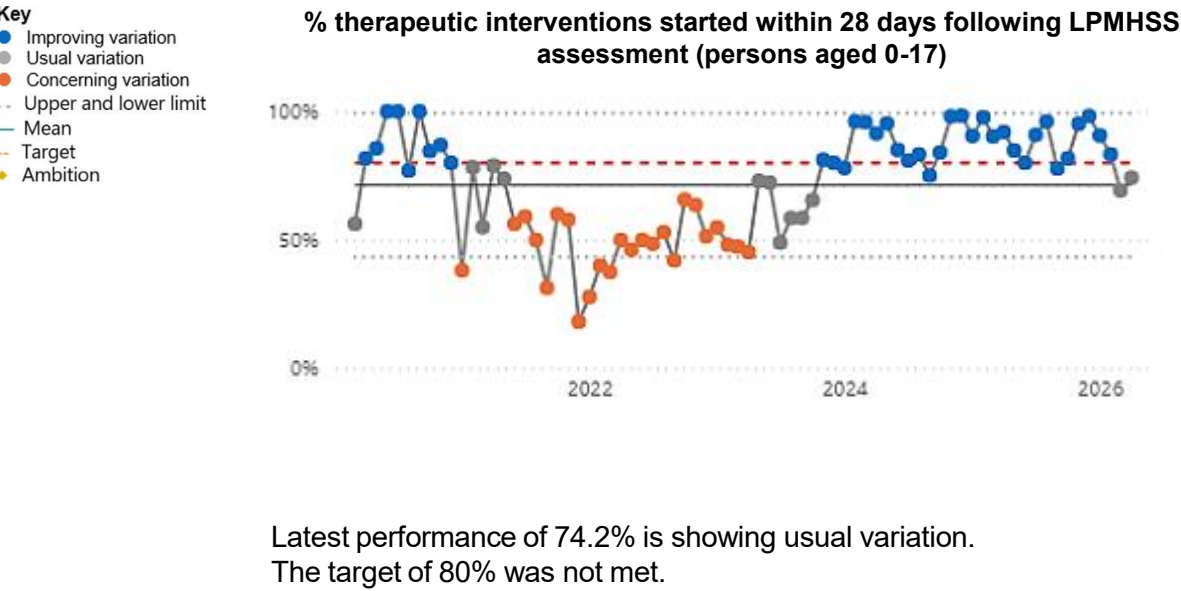
Latest performance of 71.9% is showing concerning variation. The target of 80% was not met.



Latest performance of 98.1% is showing usual variation and the target of 80% was met.

Key challenges / issues	Key actions / initiatives	Due date
% mental health assessments undertaken within 28 days (persons aged 0-17): 71.9% of assessments (64 of 89) were within target in April. The decline in April followed a period of increased demand over the usually quieter winter period. Referrals between October 2025 and March 2026 were up 9.3% compared to the previous year. This coincided with reduced staffing in the largest team (Carmarthenshire). Efforts to improve on our performance for our 28 days treatment target also impacted on our assessment performance. This is expected to improve in the coming two months. % mental health assessments undertaken within 28 days (persons aged 18+): Compliance remains high and the service continues to monitor assessment times which can impact on compliance.	% mental health assessments undertaken within 28 days (persons aged 0-17): Increased frequency of monitoring meetings, with more 'real time' data to inform these and the required actions to improve. Piloting the 'One at a Time' approach to increase responsivity and reduce assessment burden, for which there is an 'Enabling Quality Improvement in Practice' (EQIIP) programme ongoing. Embedded improvement actions % mental health assessments undertaken within 28 days (persons aged 18+): Carmarthenshire remains fragile due to both long term and short-term sickness. All teams are utilising the Primary Care Liaison Service (PCLS) at point of referral supporting reducing pressure on Local Primary Mental Health Support Services at this point of the patient journey.	30/06/26 31/12/26

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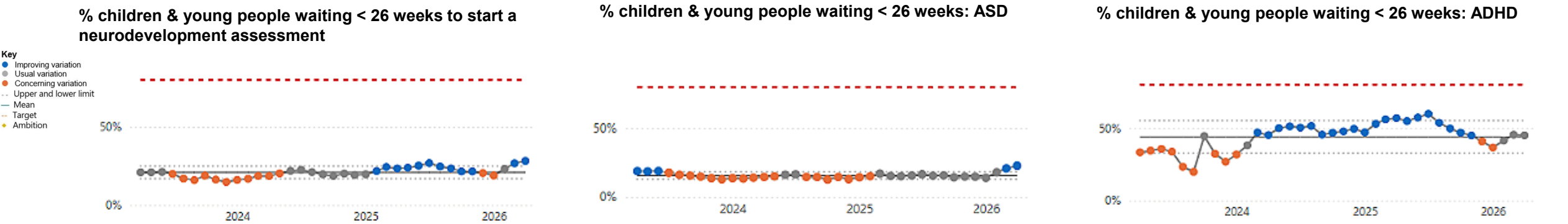
Key challenges / issues	Key actions / initiatives	Due date
% therapeutic interventions started within 28 days following LPMHSS (Local Primary Mental Health Support Service) assessment (persons aged 0-17): April saw a 5% improvement on March performance, with 46 of 62 interventions commenced within target. This follows a period of increased demand over the usually quieter winter period (referrals in October 2025-March 2026 were up 9.3% the previous year). This coincided with reduced staffing in Carmarthenshire, the largest team.	% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17): Increased frequency of monitoring meetings, with more 'real time' data to inform these and the required actions to improve. Piloting the 'One at a Time' approach to increase responsivity and reduce assessment burden, for which there is an 'Enabling Quality Improvement in Practice' (EQIIP) programme ongoing.	30/06/26 31/12/26
% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+): Compliance continues to exceed target which reflects the team's hard work. Estates access continues to be challenging across the three counties with limited access to GP practices resulting in the use of private accommodation in some areas. The current absence of the SPRING trauma intervention programme due to external factors with the provider has impacted on waiting times for single incident trauma work, with staff requiring training in alternatives to support this requirement.	Embedded improvement actions % therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+): Staff endeavour to ensure compliance with the measure by utilising supportive intervention options from third sector, SilverCloud digital options and our Primary Care Liaison Service (PCLS) is operating across the three counties with positive outcomes of reducing potential referrals to LPMHSS. A focus on group interventions remains; however, as a service we will be reviewing the current treatment menu to ensure effectiveness in treatment options. New staff are now in place following recent recruitment to practitioner vacancies in both Ca and Ceredigion.	



Performance in April of 52.9% shows concerning variation and the target of 80% was not met.

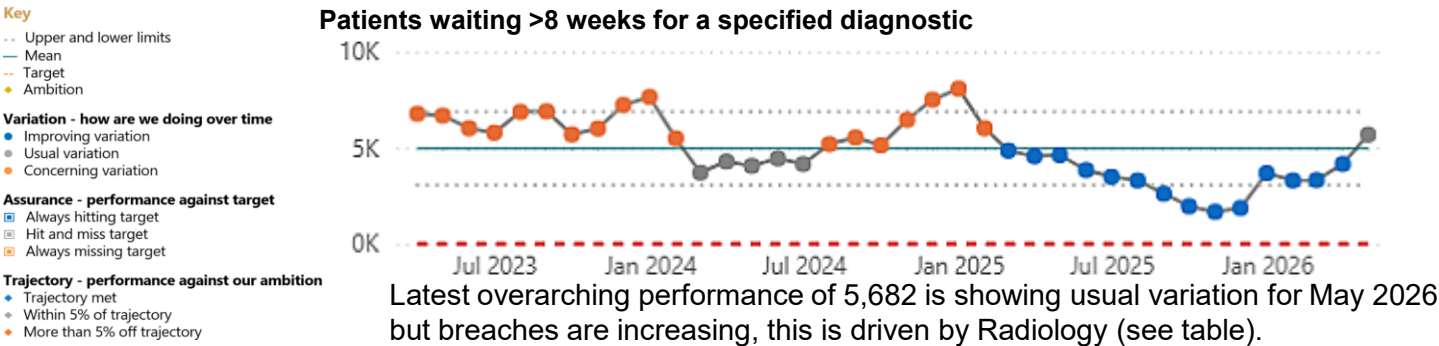
- 429 out of 825 (52%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 5 out of 11 (45.5%) were waiting <26 weeks to start an adult psychology assessment;
- 51 out of 90 (56.7%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

Key challenges / issues	Key actions / initiatives	Due date
Integrated Psychological Therapies Service (IPTS): IPTS has observed a marginal decrease in compliance of 1.2%; however, this is set against a significant overall reduction in the waiting list of 34% over the past 12 months. Referral and discharge rates remain broadly balanced, resulting in a steady-state flow that limits visible improvement in RTT performance despite meaningful backlog reduction. The transition to a stepped-care model has supported sustained improvements in service capacity, patient flow, throughput, and overall pathway management. However, the ability to expand group provision has been constrained by recruitment delays and increasing pressure on the balance between group delivery and 1:1 interventions. In addition, the ongoing digital system transition from Attend Anywhere to Medio has required focused management oversight, which has further impacted operational capacity—particularly in relation to group delivery. 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): The waiting list for patients waiting under 26 weeks for treatment decreased in April. This follows the commencement of a Practitioner Psychologist, based in an area in Carmarthenshire where there was no community provision.	IPTS: - Several staff members have completed training in Dialectical Behaviour Therapy (DBT) for complex post-traumatic stress disorder (PTSD). This will strengthen the service's ability to address the trauma waiting list. 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. Embedded improvement actions IPTS: - A number of high-intensity, evidence-based interventions have now been embedded within the service model and are demonstrating positive patient outcomes. The introduction of caps on therapy sessions is contributing to improved capacity management. - Staff are actively engaged in regular supervision to monitor 1:1 waiting lists, and all therapists have aligned job plans to support increased service capacity wherever feasible. 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 _____' plans are in place.	31/07/26 30/06/26



The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position. Performance in April 2026 of 28.3%, shows improving variation but the target of 80% was not met. Performance is driven by ASD, where 771 of 3,401 (22.7%) patients had an ASD assessment < 26 weeks. 513 out of 1,140 (45%) patients had an ADHD assessment <26 weeks.

Key challenges / issues	Key actions / initiatives	Due date
Attention Deficit Hyperactivity Disorder (ADHD): The longest current wait for an ADHD assessment is 101 weeks, with 326 individuals waiting over 52 weeks. Referrals into the service have increased by 100%, creating significant pressure on the service and a requirement to expand core capacity to meet performance targets. Despite ongoing efforts, demand continues to exceed available provision, even with a fully established medical workforce. Demand for Quantitative Behavioural (QB) testing, a key component of the diagnostic pathway, also exceeds current capacity. Currently, only one device is available across the counties, with a limited number of Healthcare Support Workers trained in its use. In addition, clinic room availability across all sites remains a challenge. Longer-term solutions are being progressed through the Bandi appeal and the proposed reconfiguration of Puffin Ward at Withybush Hospital for children with serious illnesses or injuries.	ADHD: • Increase clinic room capacity through the Bandi appeal and reconfiguration of Puffin Ward. • Expand core capacity by increasing access to QB testing and follow-up appointments. While funding opportunities have been explored, securing investment has been challenging due to the ongoing costs associated with licence fees and per-test charges. Alternative options are being explored. • Continue to optimise clinic utilisation through flexible management and robust job planning. • Explore use of digital solutions, such as Magic Notes, to support assessments and follow-ups and help reduce clinician administrative time. • Options paper submitted to address capacity and demand issues.	31/03/27 31/03/27 31/03/27 31/12/26 31/12/26
Autism Spectrum Disorder (ASD): As of April 2026, there were 3,401 children and young people waiting for an ASD assessment, with 2,630 individuals waiting more than 26 weeks. 136 referrals were received in April. Although this was a reduction from previous months, it is an understandable position given the school holidays during the month which is known to impact referral rates. The service is continuing to streamline pathways in line with national direction towards needs-led services.	ASD: • A week-long visit by the newly appointed national Performance and Improvement Lead for Neurodiversity to observe existing processes, pathways and practice with an aim of offering service development and transformation recommendations that support the delivery of timely, efficient care. • Additional outsourcing contract is being developed to secure a further 300 assessments in year. • Exploring potential digital methods of providing post-diagnostic support to release clinical capacity.	11/05/26 30/06/26 30/07/26
Embedded improvement actions		
ASD: • School cluster project commenced with the initial two days showing potential efficiencies. • Review of website resources to provide signposting and resources to individuals to reduce administrative burden.		



Diagnostic	Latest period	Latest actual	Variation	Assurance
All	May 2026	5,682	●	▣
Radiology		4,708	●	▣
Cardiology		825	●	▣
Endoscopy		58	●	▣
Phys measure		57	●	▣
Imaging		34	●	▣
Neurophysiology		0	●	▣

Key challenges / issues

Radiology

- 4,742 breaches reported May 2026 (radiology & imaging), well above the forecast level of deterioration reflected in the Annual Plan.
- Whilst extended periods of equipment downtime during Quarter 1 (Q1) and higher than forecast levels of diagnostic demand from 2025/2026 national OPA (Outpatient Assessments) insource project have impacted the position, increased CT, MRI and Ultrasound breaches have surpassed projected levels and cannot easily be explained by current demand and activity patterns.
- This has raised concerns regarding the accuracy of the reported breach position via the recently implemented RISP system (Radiology Informatics System Procurement) and the absence of dedicated data analytical capacity to verify data intelligence from the new system.
- The issue has been escalated to the NHS Performance & Improvement Team for support in further interrogating the RISP system which is being rolled out across Wales.

Endoscopy

- Breaches relate to the Urology cystoscopy pathway and continuing capacity pressures noted throughout 2025/26.
- 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 2026/27) has been mitigated during Q1 via continuing of insourcing until end June.

Cardiology

- Breaches primarily attributable to longstanding shortfall of in-house diagnostic capacity, particularly within echocardiography. Position deteriorated in May 2026 due to loss of capacity, via increased levels of short and long-term sickness absence and maternity leave.
- Myocardial Perfusion Scan breaches also increased, due to a two-week system outage in April and reduced service availability during May bank-holidays, noting that the service currently operates on Mondays only.

Key actions / initiatives

Radiology

- NOUS contract extended, with additional capacity being sought. Internal staffing (Insourcing) ongoing funded by vacancy.
- MRI van extended from Apr– Aug 2026 using core funding (vacancy lag). WG funding for second van ended 31 March, reducing capacity by 540 patients per month.
- CT van extended to end Q1 with additional funding (Planned Care). Capacity for 250 additional urgent suspected cancer patients per month.
- Urgent Review Group to be established with support of NHS P&I, Informatics & Data Science teams to investigate the breach position and interrogation of RISP system.

Endoscopy

- Insourcing agreed for May-June 2026 in gastrointestinal endoscopy to bridge baseline capacity deficit in-order-to-maintain the 8-week performance standard. Maintenance of zero breaches reliant on funding to bridge D&C gap of 3 lists/week, as noted in the Endoscopy Annual Plan submission.
- Cystoscopy waits beyond 8 weeks reducing monthly. Galeas Bladder trial for urgent suspected cancer continuing, with funding for 2 additional sessions in June. Maintenance of zero breaches relies on continuation of the program and ability to resource lists appropriately.

Cardiology

- Plans are in place to procure insourcing activity during June and July to support a reduction in the current breach position, however additional funding will be required to achieve full recovery and deliver a sustained breach-free position.

Due date

01/11/26

31/08/26

31/06/26

30/06/26

30/06/26

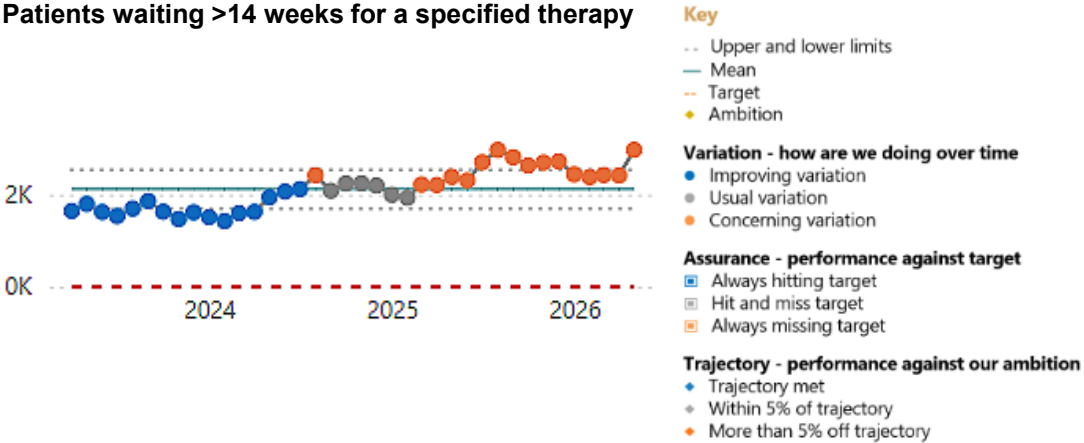
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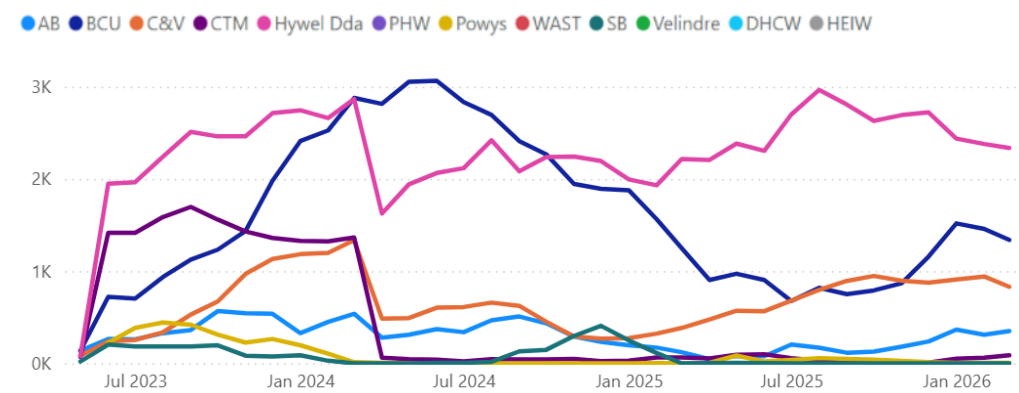
31/07/26

Performance shows concerning variation (May 2026 = 2,969), with breaches rising by over 500 since April 2026.

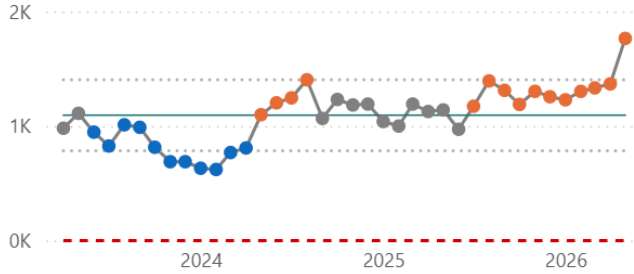
Patients waiting >14 weeks for a specified therapy



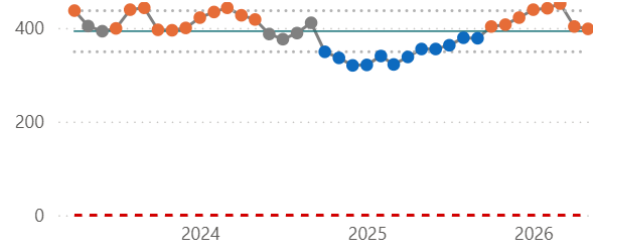
Patients waiting 14 weeks or more for a specified therapy: Welsh Health Boards (March 2026)



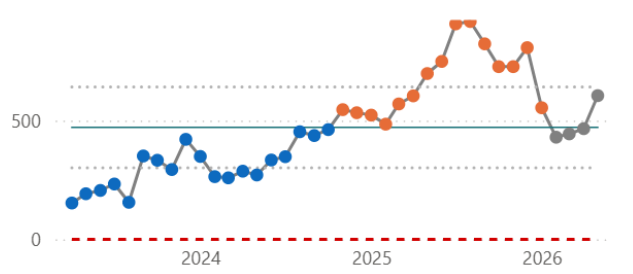
Number of patients waiting 14 weeks plus for Physiotherapy



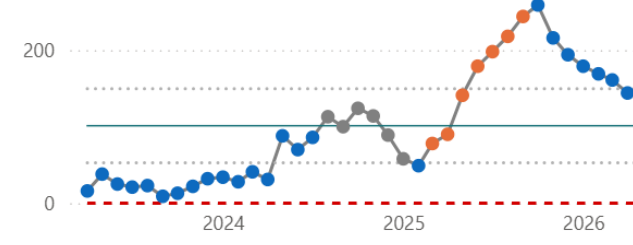
Number of patients waiting 14 weeks plus for Occupational Therapy



Number of patients waiting 14 weeks plus for Podiatry



Number of patients waiting 14 weeks plus for Dietetics (excluding Weight Management)



Therapy	Latest period	Latest actual	Variation	Assurance
All	May 2026	2,969	●	▣
Physiotherapy		1,765	●	▣
Podiatry		605	●	▣
Occupational Therapy		398	●	▣
Dietetics		152	●	▣
Art therapy		30	●	▣
Speech & Language		19	●	▣

Key challenges / issues

Physiotherapy: in month increase in breach position is driven by reduced capacity and corresponding activity. This is caused by two staff on maternity leave, one vacancy, and unavailability of agency to backfill. This is compounded by increased urgency of demand (now 50%), notably in Musculoskeletal (MSK) Physiotherapy specialty (94% of breaches). Demand continues to grow and is greater than capacity, driven by changes to Community Health Pathways and other national pathways (E.g. South Wales Spinal Network Guidance) causing a shift of work from primary and secondary care towards community MSK Physiotherapy services. There is an increase in the proportion of urgent and complex work in community services as pathways have an increased focus on admission avoidance and early supported discharge. The remaining 6% breaches are within community and paediatric services.

Occupational Therapy (Paediatrics)
Performance within trajectory, 79.5% breeches within paediatrics, driven by increases (circa 30%) in new patient referrals over the past 3 years, placing significant pressure on service capacity. Compounded by a rise in urgency and complexity of demand, which continues to impact the service’s ability to meet demand.

Podiatry
Breaches had stabilised until March 2026 due to temporary management-led clinics; however, this is unsustainable and with the temporary clinics ceasing, performance has deteriorated. New patient referrals have risen by around 40% over six years without an increase in capacity, while patient complexity has increased. This has led to longer appointments and fewer patients being seen. Podiatry provides first-contact triage for Orthopaedics and Vascular services and has expanded roles (7 Independent Prescribers and 6 Sonographers) through internal reorganisation without additional funding.

Dietetics
Paediatrics (99% long wait demand): Short-term additional capacity had started to turn the curve of breaches, however further sickness in the team is now impacting negatively on performance. There is a further likelihood of deterioration from September 2026 when short-term additional capacity agreement ceases.

Diabetes & Community: A very small proportion of breaches sit within these specialties; due to fragility in these areas (e.g. any short-term absence is adversely affecting capacity and increasing breach position).

Key actions / initiatives

The agreed trajectory in the Annual Plan for 2026/27 without the required investment in additional posts, forecasts 3,229 breaches by March 2027. Mitigating actions are described below.

Physiotherapy: The actions below will reduce the rate of breach growth but will not off-set the capacity demand deficit.

- A standard operating procedure (SOP) for a targeted telephone triage pilot, for patients who could be signposted towards supported self-management in place with further refinement of this process now planned using PDSA (plan-do-study-act) cycles to test the effectiveness of clinical risk stratification and patient activation tools to broaden the scope of the project.
- 3-month pilot starting on 20/04/26 to validate routine MSK waiting lists using new Microsoft Forms methodology.
- A review of community prioritisation criteria aligned to clinical risk matrix is currently being undertaken

Occupational Therapy (Paediatrics)

- Increasing number of group appointments through the development of a sensory pathway
- Increasing number of clinic appointments to increase service flow.
- Working with estates to minimise any adverse impacts of planned accommodation changes through June and July.
- Weekly performance meetings to review actions and progress on planned service improvements.

Podiatry

- Consultant podiatrist post in development. This will improve treatment flow, governance and waiting times.
- Further action to continually embed successful telephone triage process Health Board wide, which reduces waiting times.

Dietetics

- Service delivery model review underway, access criteria and referral process updated and communicated (timeline dependant on access to Digital / IT support).
- Demand and capacity mapping complete. This will inform the improvement plan which will be presented to the July Clinical Care Group (CCG) business and governance meeting.

Due date

31/08/26

17/07/26

30/09/26

30/09/26

30/09/26

30/07/26

30/09/26

15/08/26

31/07/26

31/08/26

31/07/26

Embedded improvement actions

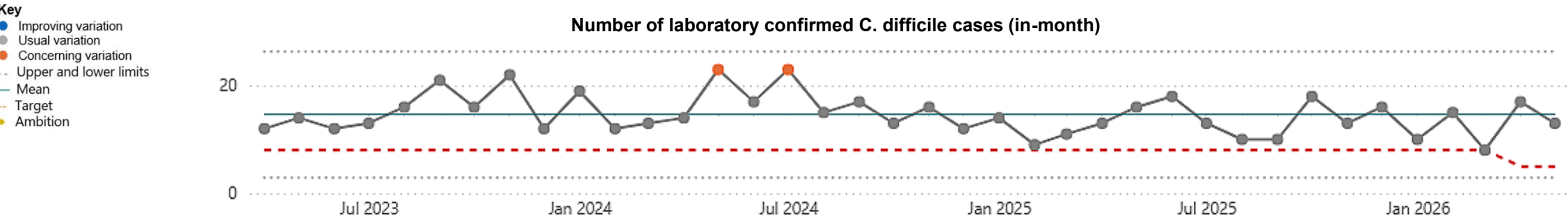
Physiotherapy: Financial Control Group approval given to actively recruit Band 5 bank staff, with 5 job offers made 3rd March 2026. Bank workforce are now in post. Action closed.

Podiatry: New patient demand and capacity modelling found the service to be efficient, with full utilisation of a 10-session template, strong discharge and eligibility processes, and effective skill-mixing. A service review strengthened the management structure, with D&C modelling indicating a requirement for an additional 3.0 WTE to meet demand.

Dietetics: First line resources developed and accessible to referrers via SharePoint ; this is aimed at reducing referral rate

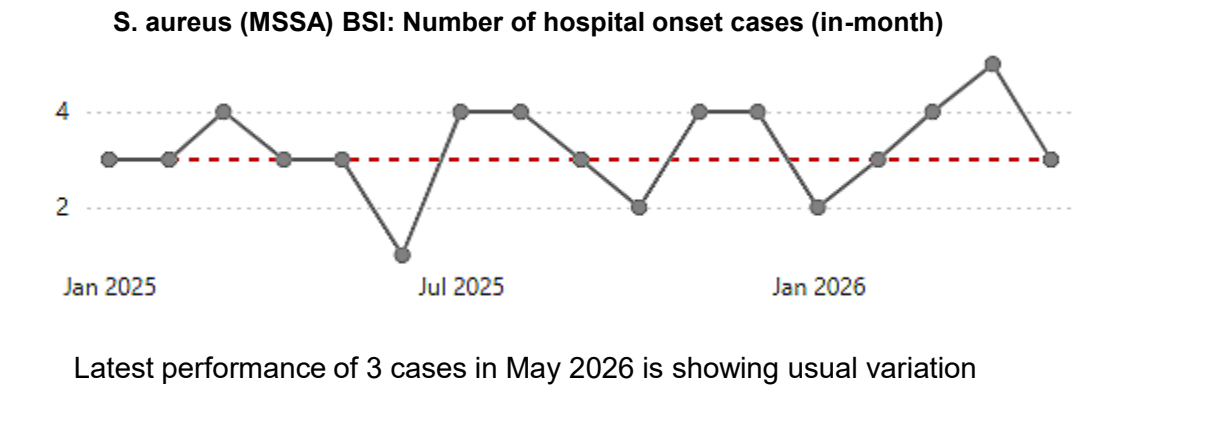
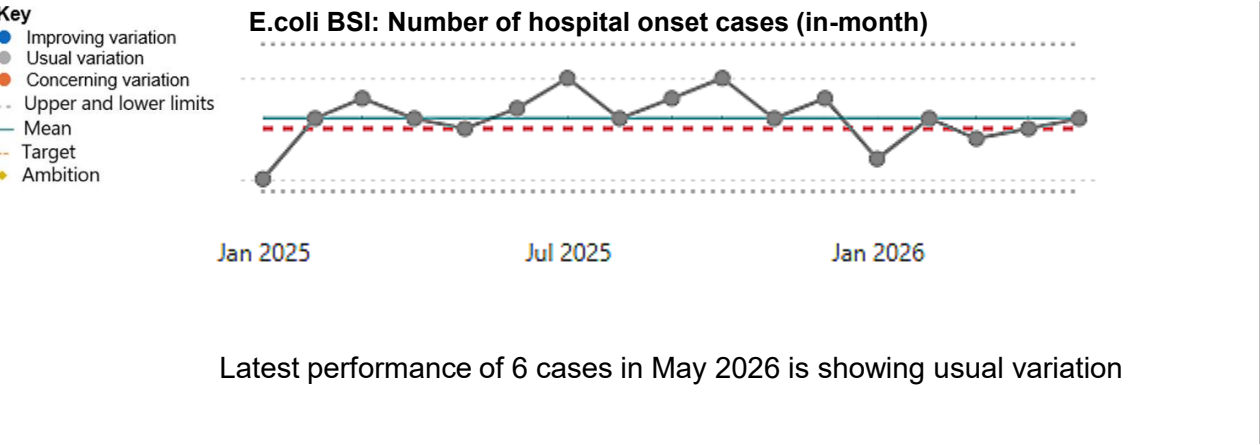
Page 129

st line advice provided and supports early risk management for those waiting.



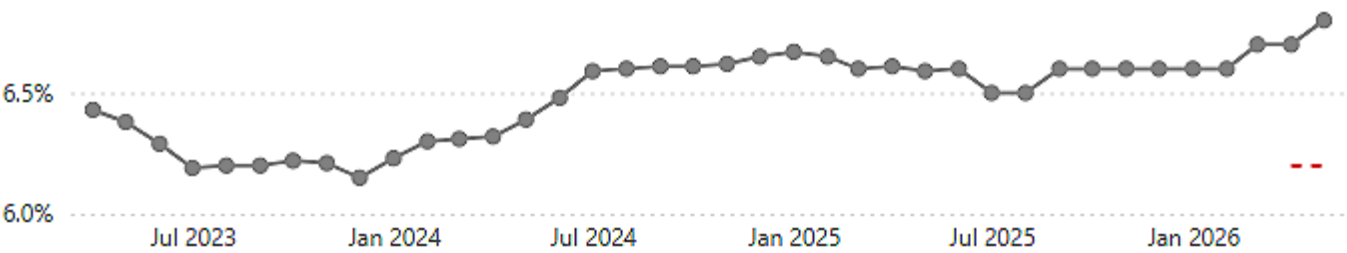
Latest performance of 13 cases for May 2026 is showing usual variation

Key challenges / issues	Key actions / initiatives	Due date
C. difficile: - Hospital onset infections of C. difficile remain to be of concern, several community onset infections have been classified as "community onset, healthcare associated", meaning cases are linked to recent healthcare exposure. - The Welsh Health Circular Anti-Microbial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal: to reduce the overall burden of C. difficile infection by at least 25% against the 2024-25 counts. There were 184 cases of C. difficile in 2024/25, for 206/27 the HB would need to achieve 138 cases or less to meet the improvement goal. - Antibiotic Stewardship: Inconsistent completion of Start Smart Then Focus (SSTF) audits; vacancies in Antimicrobial Pharmacy team risk affecting stewardship. - Delayed Infection Prevention Control Actions: Recognition, isolation, and diagnosis delays noted in some cases. - Environmental Cleaning: Cleaning scores in Glangwili for high-risk wards areas are below the expected standards. - Compliance Gaps: Lapses in bare below the elbow standards across staff groups. - Mandatory Training: Level 2 Infection Prevention Control compliance at 74.37%, below the 85% target and a reduction from the previous month.	C. difficile: C. difficile Improvement Group to progress the work with the C. difficile collaborative and identify improvement projects or shared learning. - Review of cases for May to assess locations, themes and any cleaning implication that could have contributed to the infection. - Support the pilot of electronic prescribing in the health board to promote antimicrobial; stewardship when prescribing and reviewing antimicrobials. Embedded improvement actions for ALL infection types - Learning & Governance: Healthcare associated infections cases reviewed monthly. - Assurance Group; learning shared via Clinical Care Groups. Issues escalated through governance structures. This requires all members of the multi-disciplinary team in attendance. - Monthly hand hygiene audits by Ward Managers, monitored and reviewed. - Self-assessment by Clinical Care Groups against the Quality Statement for Infection Prevention and Control issued by the Chief Nursing Officer. - Clinical Care Groups to monitor Aseptic non-touch technique compliance and assessor training offered to clinical areas from infection prevention.	09/06/26 30/06/26 31/07/26



Key challenges / issues	Key actions / initiatives	Due date
E. coli: • Infections primarily community-onset and linked to urinary tract and some catheter-related. • The Welsh Health Circular Anti-Microbial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal: a reduction of at least 10% in cases of hospital onset E. coli bloodstream infections (BSI) is expected vs the cases in 2024-2025. There were 60 cases of E. coli BSI in 2024/25, for 206/27 the HB would need to achieve 54 cases or less to meet the improvement goal. • Most cases occur in the 80–89 age group. • Non-compliance observed bare-below-the-elbow practices across staff groups. • Health Board aseptic non-touch technique compliance for E-learning is at 85.04%. S. aureus • The burden of S. aureus BSI is seen within the community. • The Welsh Health Circular Anti-Microbial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal for both Methicillin-susceptible Staphylococcus (MSSA) and Methicillin-resistant Staphylococcus (MSRA). • MSSA & MRSA Improvement Goals: A decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards for MSSA and have fewer cases of MRSA in 2026/27 than in 2025/26. There were 122 cases of MSSA BSI in 2024/25, for 206/27 the HB would need to achieve 98 cases or less to meet the improvement goal. There were 11 cases of MRSA BSI for 2024/25. • Health Board aseptic non-touch technique compliance for E-learning is at 85.62%. • Non-compliance observed bare-below-the-elbow practices across staff groups.	E. coli: • Health & Wellbeing booklet has been printed and will be used at public facing forums and impact reviewed • Ongoing review of hand hygiene products and promotional posters - Prince Philip and community hospital complete. S. aureus • Healthcare associated infections cases reviewed monthly at Assurance Group; learning and high-rate areas shared with Clinical Care Groups (CCGs). • Hand hygiene validation and observational audits conducted based on senior nurse monthly audits. • Infection prevention observations fed back to CCGs and staff groups for improvements for hand hygiene and bare below the elbow in June	30/06/26 31/07/26 30/06/26 30/06/26 30/06/26

% staff sickness rate (12 months rolling)



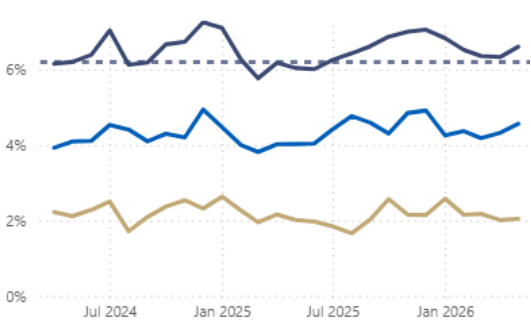
Rolling 12-month staff sickness percentage rate comparisons for May:

- May 2024: 6.4%
- May 2025: 6.6%
- **May 2026: 6.8%**

2026-2027 Rolling 12-month target = 6.2%

% staff sickness rate (in month)

May 2026 (in month) = 6.6%
Short-term sickness = 2%
Long-term sickness = 4.6%



Services with 60+ staff with the highest levels of in-month sickness rates in May 2026:

Team	Staff	R12m	In-month
Immunisation Team	63	12.5%	15.8%
Sunderland Ward	73	14.1%	14.7%
Withybush Domestic Services	139	10.4%	12.7%
Prince Phillip AMAU	77	11.2%	11.5%
Prince Phillip Hotel Services	72	10.5%	10.8%
Glangwilli Domestic Services	136	13.3%	10.8%

Key challenges / issues

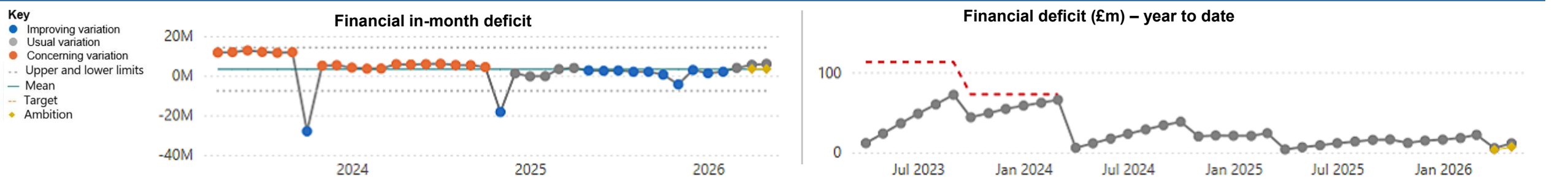
Absence rates attributed to anxiety, stress and depression continues to be the highest reason for absences across the Health Board at 34.2%.

Absences attributed to musculoskeletal problems is the second highest reason at 10.4%.

Embedded improvement actions

Initiatives include; the development of bite-sized training sessions and updated Wellbeing Passport and guidance for managers and a comprehensive review of all sickness absence letters.

- Ongoing support from Workforce Advisors for Attendance Management with a focus on hot spots across all Clinical Care Groups. Outcomes include:
 - Reduction in overall sickness absence rate;
 - Increased percentage of cases managed within policy timescales;
 - reduction in long-term absence cases; improved data quality and reporting accuracy.
- Data analysis and targeted support to address underlying issues, Workforce support aligned to employee relations matters.
- Training sessions on disability and reasonable adjustments have taken place with more planned for the future.
- Work continues to further develop and refresh sickness absence against population health data to improve health promotion and interventions by locality.

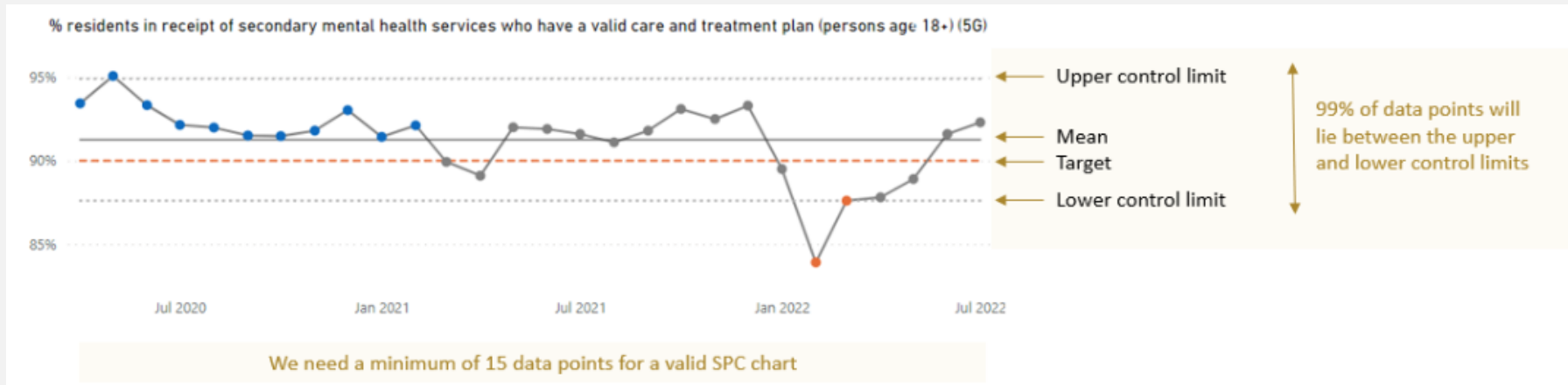


Key challenges / issues	Key actions / initiatives	Due date
The Health Board's Annual Planned Deficit is £41.0m with an Annual Savings Target of £42.8m. Gross forecast position is £61.9m, with unplanned mitigating actions of £20.9m to be finalised, to achieve the reported end of year forecast position of £41.0m. Total savings delivery are £8.7m, leaving a savings delivery gap of £34.1m against the savings target.	Medical pay and rostering additional cover at premium costs. Continuing use of additional medical cover, including premium locum and agency in Bronglais hospital, Withybush hospital, Planned Care and Mental Health. The Medical Rate card has been adopted, and an impact assessment is required of its compliance across the Health Board. The comprehensive use of Allocate (workforce management tool) also needs to be embedded.	30/06/26
The in-month financial position is a deficit of £6.0m, which is an adverse variance against the £3.4m in-month deficit plan due to the savings target of £3.6m has been under identified by £2.4m, and the £1.2m savings identified being fully delivered in-month, and a core operational overspend of £0.2m.	Identification and delivery of robust savings plans. Escalation for the Finance domain is partly due to risk associated with delivering the annual plan equitably across services. Highlighted by Welsh Government and NHS performance and improvement at the escalation meetings of w/c 1 June with requirement of a savings plan with 100% delivery confidence. Outstanding, urgent action required as part of de-risking the annual plan, deadline of 12 June (In-Committee Board 18 June) prior to paper to Finance and Performance Committee.	30/06/26
The in-month core overspend of £0.2m is largely driven by Medical locum agency usage £0.8m, Continuing Healthcare packages within Community and Integrated Medicine and Mental Health £0.5m Digital Strategic Partnership Contract phasing £0.2m, Planned & Specialist Care theatre consumables and insourcing £0.2m and Losses claims increases £0.2m. There are offset by pay vacancies across all service areas £(0.8)m and Dental contract hand back and delay in Cluster projects £(0.9)m.	Robustness of Continuing Healthcare approach. A revised forecast approach introduced in Month 2. Urgent action required - full review of spend levels and mitigating actions to reduce activity demand. Conscious decisions compounding delivery of Annual Plan where known decisions have been made outside of the annual planning process: - Newly qualified streamlining nursing over establishment - Anaesthetist rate card extended, increasing Medical costs - Breast consultant over-established – retiree budget should have offset - Out of area Mental health & Learning disabilities outsourcing beds – Ministerial Priorities conflict - Patient Flow Unit established without business case approval - First Contact Point Physiotherapy service continuation despite cessation of Cluster funding, exit strategy required where funding will cease. - Resident Doctoral 5 whole time equivalents for Medical rotas in WGH	Overdue

Why use SPC charts?

- Plotting data over time can inform better decision-making
- There are many factors that impact our performance and therefore month-on-month variation is to be expected
- RAG data in a table can hide what is happening
- SPC charts enable us to determine if changes are showing special cause variation (concerning or indeed improving) or if the changes are within our expected performance range. They also help us easily compare our performance against target.
- There is a strong evidence base to support the use of SPC charts to inform NHS improvement.
- We started using SPC charts for performance reporting to Board and Committee in March 2021. The feedback has been very positive, with SPC charts helping to change the conversation to focus on improvement.

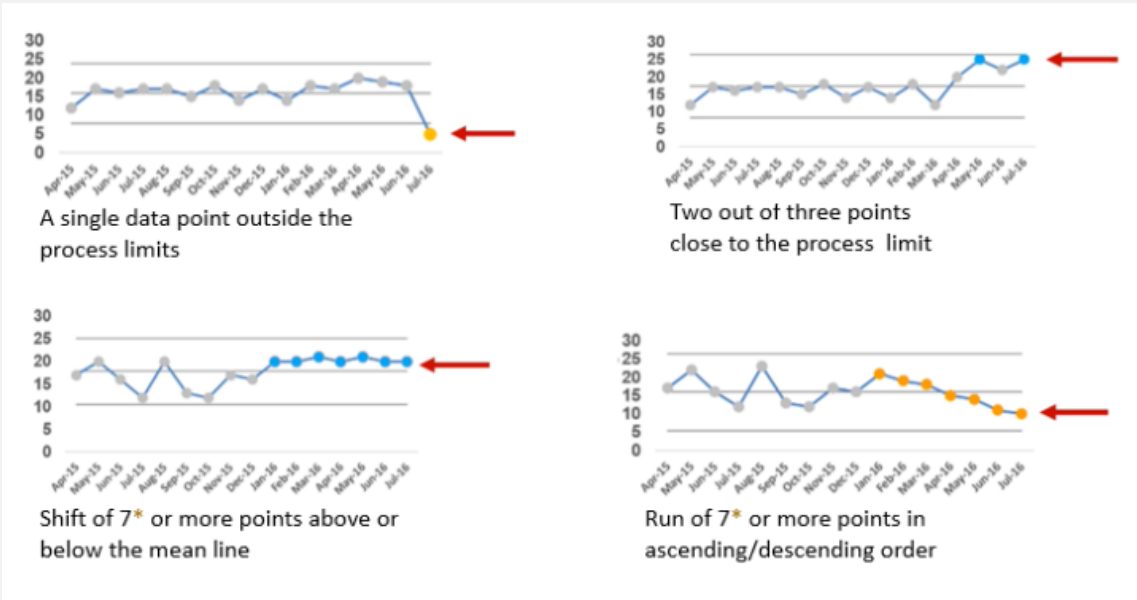
Anatomy of a SPC chart



Rules for special variation within SPC charts

Special variation is change that is unlikely to have happened by chance.

We are using the Making Data Count approach for SPC charts. There are 4 rules:



* A pattern of 7 has a 1 in 128 (0.8%) probability of occurring by chance.

Understanding the SPC icons

Each SPC chart produces 2 types of icons i.e.. one for variation and another for assurance.

Variation How are we doing over time	●	Concerning trend = a decline that is unlikely to have happened by chance
	●	Usual trend = common cause variation / a change that is within our usual limits
	●	Improving trend = an improvement that is unlikely to have happened by chance
Assurance Performance against target	□	Missing target = will consistently fail target without a service review
	□	Hit and miss target = Indicates that the Board cannot have sufficient assurance that the target can be consistently achieved over time, and the delivery of the target is particularly sensitive to external factors
	□	Hitting target = will consistently meet target
Note: remember blue is good, orange is bad		

2.2

09:55, 15 Mins

2.2 - PERFORMANCE DEEP DIVE: ALERT AREAS

Andrew Carruthers
(Hywel Dda UHB -
Chief Operating
Officer)

| For assurance

Attachments

Performance Deep Dive Alerts FPC 30 June 2026.pdf



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Finance and Performance Committee Performance Deep Dive: Alerts

30 June 2026



The Committee is requested to

- consider this deep dive assessment of the performance areas highlighted as ALERTS in the Month 2 2026/27 Integrated Performance Assurance Report (IPAR).

Performance Deep Dive: Alerts Overview



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% pts on single cancer pathway within 62 days	75%	Apr 2026	58%	Improving	Missing target	n/a	Alert
Pts waiting 8 wks+ for specified diagnostic	0	May 2026	5,682	Usual	Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	May 2026	1,650	Usual	Missing target	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	May 2026	2,969	Concerning	Missing target	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	May 2026	66.5%	Usual	Missing target	n/a	Alert
% MH assess within 28 days (age 0-17)	80%	Apr 2026	71.9%	Concerning	Hit and miss	n/a	Alert
Median time ambulance emergency category calls	8	Apr 2026	12	n/a	n/a	n/a	Alert
Median time ambulance arrest category calls	8	Apr 2026	9	n/a	n/a	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Apr 2026	52.9%	Concerning	Missing target	n/a	Alert
% sickness absence rate of staff	6.20%	May 2026	6.80%	n/a	n/a	n/a	Alert
Patients waiting 104 weeks+ RTT	0	May 2026	159	Improving	Missing target	n/a	Alert
Waits over 52 weeks: new outpatient appointment	0	May 2026	105	Improving	Missing target	n/a	Alert
C. difficile: Number of confirmed cases (in-month)	5	May 2026	13	Usual	Hit and miss	n/a	Alert
Financial in month deficit	n/a	May 2026	£5,977,000	Usual	n/a	Trajectory missed by over 5%	Alert
Ambulance handover > 4 hours Hywel Dda	0	May 2026	196	Improving	Missing target	n/a	Advise
Ambulance handovers > 1 hour Hywel Dda	0	May 2026	754	Improving	Missing target	n/a	Advise
Ambulance handover > 45 minutes Hywel Dda	0	May 2026	879	Improving	Missing target	n/a	Advise
% child neurodevelopment assess waits <26 weeks	80%	Apr 2026	28.3%	Improving	Missing target	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Apr 2026	74.2%	Usual	Hit and miss	n/a	Advise
Number of Pathways of Care delayed discharges	n/a	May 2026	186	Usual	n/a	n/a	Advise
Total days delayed for Pathways of Care delayed discharges	n/a	May 2026	6,813	Improving	n/a	n/a	Advise
% R1 eyecare patients waiting within 25% delay to target date	95%	Apr 2026	43.5%	Improving	Missing target	Trajectory missed by over 5%	Advise
Patients waiting over 52 weeks RTT	0	May 2026	10,684	Improving	Missing target	n/a	Advise
Patients waiting 26 weeks+ new outpatient	0	May 2026	4,390	Improving	Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Dec 2025	77.1%	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
% uptake of RSV vacc - 75+ years	70%	Mar 2026	14.1%	n/a	n/a	n/a	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Dec 2025	88.2%	Usual	Missing target	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	50%	Apr 2026	45.3%	Improving	Missing target	n/a	Advise
Follow-up appts - delayed >100%	11387	May 2026	14,842	Improving	Missing target	n/a	Advise
S. aureus (MSSA) BSI: Number of hospital onset cases (in-month)	3	May 2026	3	n/a	n/a	n/a	Advise
E. coli BSI: Number of hospital onset cases (in-month)	5	May 2026	6	Usual	Hit and miss	n/a	Advise
% MH assess within 28 days (age 18+)	80%	Apr 2026	98.1%	Usual	Hitting target	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Apr 2026	93.4%	Usual	Hitting target	n/a	Assure
Coding: % clinically coded - 1 month post discharge	95%	Mar 2026	97.6%	Improving	Hit and miss	n/a	Assure

This assessment covers the following performance alerts:

- %age of patients on a single cancer pathway within 62 days
- Patients waiting > 8 weeks for a specified diagnostic
- Patients waiting > 12 hrs in A&E/MIU
- Patients waiting > 14 weeks for a specified therapy
- % of MH assessments for patients 0-17 within 28 days
- % adult psychological therapy waits < 26 weeks

Performance Deep Dive: Alerts Exclusions:



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

- The following performance areas highlighted as ALERTS in the Month 2 2026/27 IPAR have been excluded from this deep dive report for the reasons specified below:
- **% patients spending < 4hrs in an A&E/MIU**
 - Although this continues to remain an area of focus, UEC performance objectives for 2026/7 prioritise ambulance handover metrics, long (12hrs+) ED waits and delayed pathways of care
- **Median time ambulance emergency category calls**
 - Delivery accountability lies jointly with the Welsh Ambulance Services NHS Trust
- **Median time ambulance arrest category calls**
 - Delivery accountability lies jointly with the Welsh Ambulance Services NHS Trust
- **Patients waiting 104 weeks + Referral to Treatment (RTT)**
 - Although performance has shown a slight deterioration during Q1 2026/27, this is in line with Annual Plan delivery expectations and current breach volumes are significantly lower than levels predicted in the Annual Plan
- **RTT Waits over 52 weeks (first outpatient appointment)**
 - Although performance has shown a slight deterioration during Q1 2026/27, this is in line with Annual Plan delivery expectations and current breach volumes are significantly lower than levels predicted in the Annual Plan

%age of patients on a Single Cancer Pathway within 62 days

Key challenges and improvement actions:



GIG
CYMRU
NHS
WALES

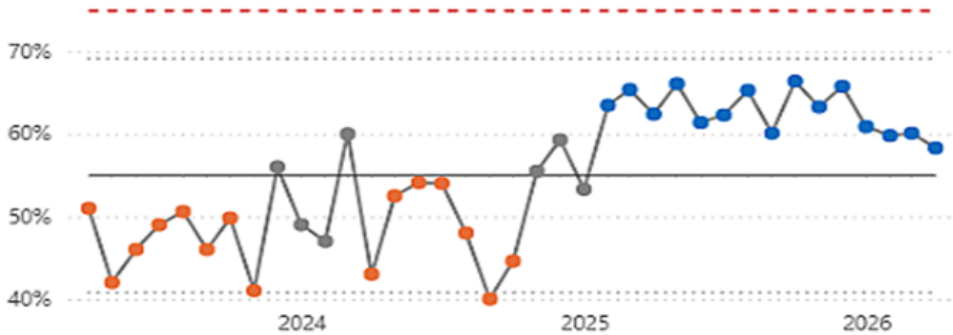
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Hywel Dda
University Health Board

Single cancer pathway (Enhanced monitoring condition and Ministerial priority)

Cancer

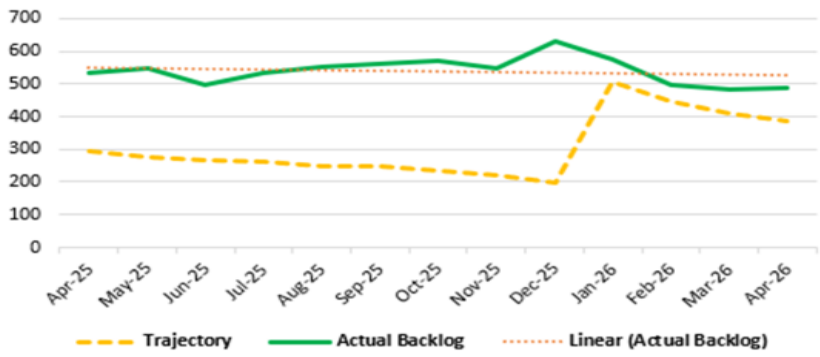
Key
● Improving variation
● Usual variation
● Concerning variation
--- Upper and lower limits
— Mean
— Target
● Ambition

% single cancer pathway patients starting treatment within 62 days



In April 2026, performance was 58.3% against the trajectory of 66%. Performance reduction due to above usual treatment run rate for patients (184) waiting over 62 days, within breast and lower gastrointestinal pathways.

Number of single cancer pathway patients waiting over 62 days



In April 2026, 486 patients were waiting over 62 days on the single cancer pathway.

Key challenges / issues

Single cancer pathway

Whilst overall treatment activity in April 2026 increased by 69 patients to a total of 258 patients, performance was compromised by an increased number of patients (184) treated waiting over 62 days.

This impacted the breast and lower gastrointestinal pathways, caused by bottlenecks in the diagnostic pathway for both tumour sites in previous months. These have since been resolved. Additional treatment capacity has been allocated to treat patients that are waiting over 62 days and this will continue during Q1.

Backlog and Diagnostics

As reflected in the Annual Plan, the fundamental delivery challenge remains in the overall diagnostic pathway

Performance in May 2026 is expected to recover above 62%.

Key actions / initiatives

- 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.
- £168k committed via recovery money for Urology Diagnostics for Q1
- Residual recovery funds allocated for Pathology turnaround for Q1
- Piloting the use of the Galeas Bladder Test from March 2026 – 300 patients, extended for Q1 2026/27
- Outsourcing CT equates to 260 scans per month with a 7-day reporting turnaround, extended for Q1 2026/27

As concerns remain regarding resourcing of recovery actions beyond Q1, a further deep dive review of SCP performance is being scheduled for late June 2026.

Due date

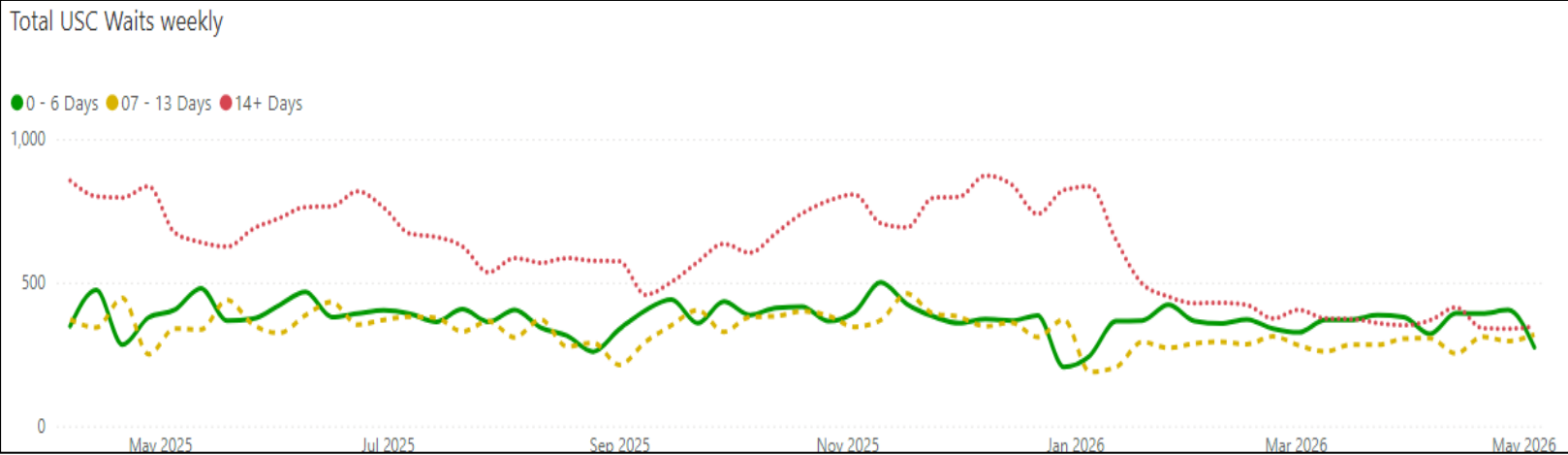
30/06/26
30/06/26
30/06/26
30/06/26



Radiology reporting

Supported by additional investment during Q4 2025/26 and Q1 2026/27, turnaround times for radiology investigations has Improved since January 2026 with the outsourcing of CT and reporting turnaround initiatives.

	Jan-26	Mar-26	Apr-26
0-6 Days	245	263	119
7-13 Days	188	281	116
14+ Days	811	290	178
Total	1244	834	513



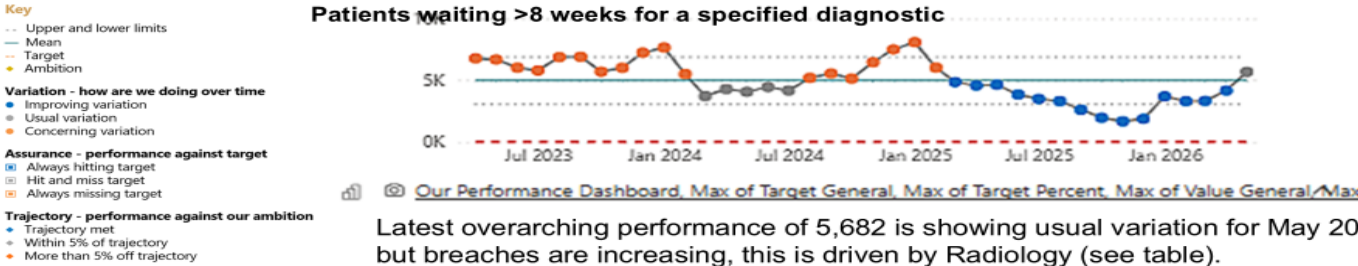
However, of concern is the adverse impact of the cessation of unfunded 48hr radiology reporting initiatives which ceased in March 2026 due to resourcing constraints. The introduction of 48hr radiology reporting initiatives during Q3 and Q4 2025/26 enabled an improvement in the time from scan performed to reported from an average of 6.9 days in Nov 25 to 1.7 days in March 26. Following the cessation of these initiatives, this increased to 2.1 days in April and is at 4.5 days for May.

Patients waiting > 8 weeks for a specified diagnostic

Key challenges & improvement actions:

Diagnostics waits over 8 weeks (Ministerial priority)

Diagnostics



Diagnostic	Latest period	Latest actual	Variation	Assurance
All	May 2026	5,682	●	▢
Radiology		4,708	●	▢
Cardiology		825	●	▢
Endoscopy		58	●	▢
Phys measure		57	●	▢
Imaging		34	●	▢
Neurophysiology		0	●	▢

Key challenges / issues

Radiology

- 4,742 breaches reported May 2026 (radiology & imaging), well above the forecast level of deterioration reflected in the Annual Plan..
- Whilst extended periods of equipment downtime during Q1 and higher than forecast levels of diagnostic demand from 2025/26 national OPA insource project have impacted the position, increased CT, MRI and Ultrasound breaches have surpassed projected levels and cannot easily be explained by current demand and activity patterns.
- This has raised concerns regarding the accuracy of the reported breach position via the recently implemented RISP system (Radiology Informatics System Procurement) and the absence of dedicated data analytical capacity to verify data intelligence from the new system.
- The issue has been escalated to the NHS P&I Team for support in further interrogating the RISP system which is being rolled out across Wales.

Endoscopy

- Breaches relate to the Urology cystoscopy pathway and continuing capacity pressures noted throughout 2025/26
- An underlying capacity deficit in gastrointestinal endoscopy pathway reflected in the Annual Plan (equivalent to additional, 3 lists per week or 5% increase in 2026/27) has been mitigated during Q1 via continuing of insourcing until end June..

Cardiology

- Breaches primarily attributable to longstanding shortfall of in-house diagnostic capacity, particularly within echocardiography. Position deteriorated in May 2026 due to loss of capacity, via increased levels of short and long-term sickness absence and maternity leave.
- Myocardial Perfusion Scan breaches also increased, due to a two-week system outage in April and reduced service availability during May bank-holidays, noting that the service currently operates on Mondays only.

Key actions / initiatives

Radiology

- NOUS insource contract extended, with additional capacity being sought. Internal staffing (Insourcing) ongoing funded by vacancy.
- MRI van extended from Apr– Aug 2026 using core funding (vacancy lag). WG funding for second van ended 31 March, reducing capacity by 540 patients per month.
- CT van extended to end Q1 with additional funding (Planned care). Capacity for 250 additional urgent suspected cancer patients per month.
- Urgent review group to be established with support of NHS P&I, Informatics & Data Science team to investigate breach position and interrogation of RISP system

Endoscopy

- Insourcing agreed for May-June 2026 in gastrointestinal endoscopy to bridge baseline capacity deficit in-order-to-maintain the 8-week performance standard. Maintenance of zero breaches reliant on funding to bridge D&C gap of 3 lists/week, as noted in the Endoscopy annual plan submission.
- Cystoscopy waits beyond 8 weeks reducing monthly. Galeas Bladder trial for urgent suspected cancer continuing, with funding for 2 additional sessions in June. Maintenance of zero breaches relies on continuation of the programme and ability to resource lists appropriately.

Cardiology

- Plans are in place to procure insourcing activity during June and July to support a reduction in the current breach position, however additional funding will be required to achieve full recovery and deliver a sustained breach-free position.

Due date

01/11/26

31/08/26

31/06/26

30/06/26

30/06/26

30/06/26

31/07/26

Patients waiting > 8 weeks for a specified diagnostic

Supplementary information:



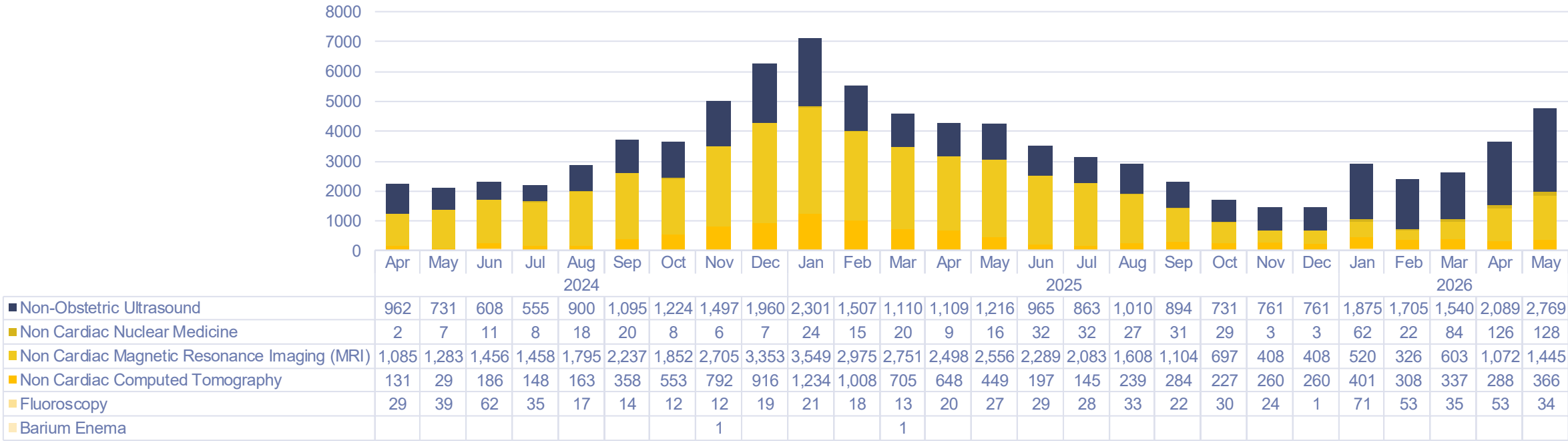
GIG
CYMRU
NHS
WALES

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Hywel Dda
University Health Board

Radiology >8 week breach trend

Radiology breaches showed an improving trend during Q1-3 2025/26 with deterioration noted from January 2026 following implementation of the new RISP system. The rate of deterioration seen in April and May 2026 across ultrasound, MRI and CT modalities significantly exceeds forecast levels reflected in the Annual Plan.

Radiology breaches 8 weeks and over by sub-service



An urgent control group is being established, with support of NHS Performance and Improvement, Informatics and Data Science team expertise to review the reported breach position and interrogate the new Radiology RISP system.

Patients waiting > 12 hours in A&E / MIU

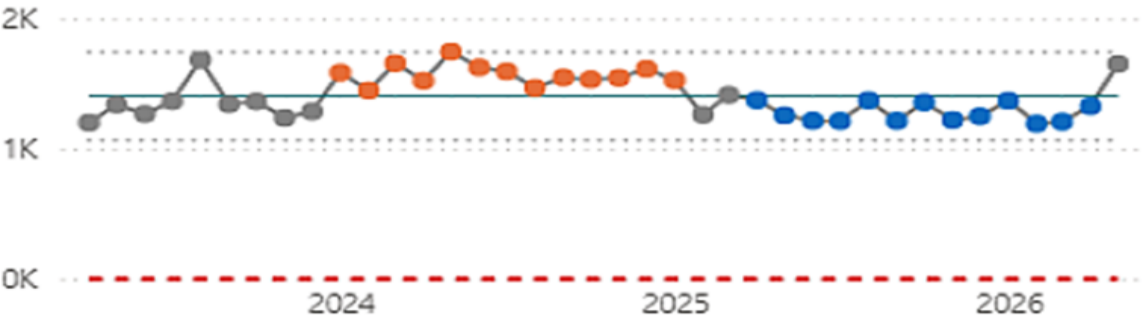
Health Board Overview:

Urgent and Emergency Care – Emergency Departments– Hywel Dda
(Enhanced monitoring condition and Ministerial priority)

Urgent and Emergency Care

- Key
- Improving variation
 - Usual variation
 - Concerning variation
 - Upper and lower limits
 - Mean
 - Target
 - ◆ Ambition

Patients waiting over 12 hours in A&E/MIU



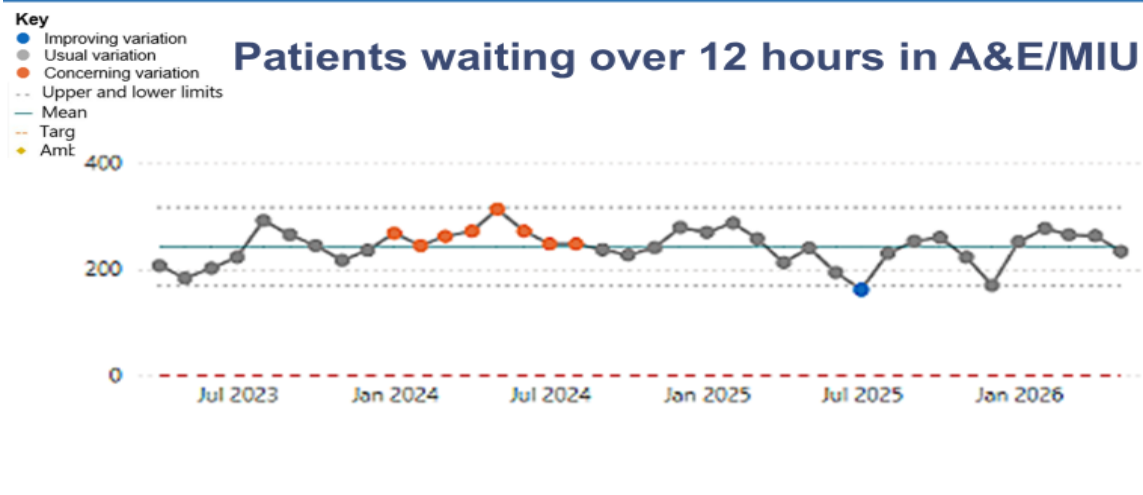
Overview

- Whilst Health Board performance continues to show the usual pattern of variation, 12 hr ED waits increased in April & May. The causal factors are explored in the following site specific slides.
- Improvement actions across all sites / systems focus on 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 delays. Central to this is the planned implementation of the Seven-Day Clinical Streaming, SDEC and Hospital@Home business case, which aims to improve patient flow, enhance outcomes, enabling earlier intervention, reducing emergency department demand, and supporting a sustainable ‘shift-left’ model of care across acute and community pathways.
- The Go-Live date for Seven-Day Clinical Streaming and Hospital@Home is October 2026, and a 7-day SDEC service at WGH being November 2026.

Patients waiting > 12 hours in A&E / MIU Bronglais Hospital:

Urgent and Emergency Care – Emergency Departments – Bronglais Hospital
(Enhanced monitoring condition and Ministerial priority)

Urgent and Emergency Care



Bronglais Overview:

- Performance in recent months has shown a general improving trend as a result of the continuing focus on the embedded improvement actions described below
- The BGH site team are prioritising additional improvement actions during June 2026 designed to drive further improvement

234 breaches out of 2,907 new attendances, 8%. The chart is showing usual variation.

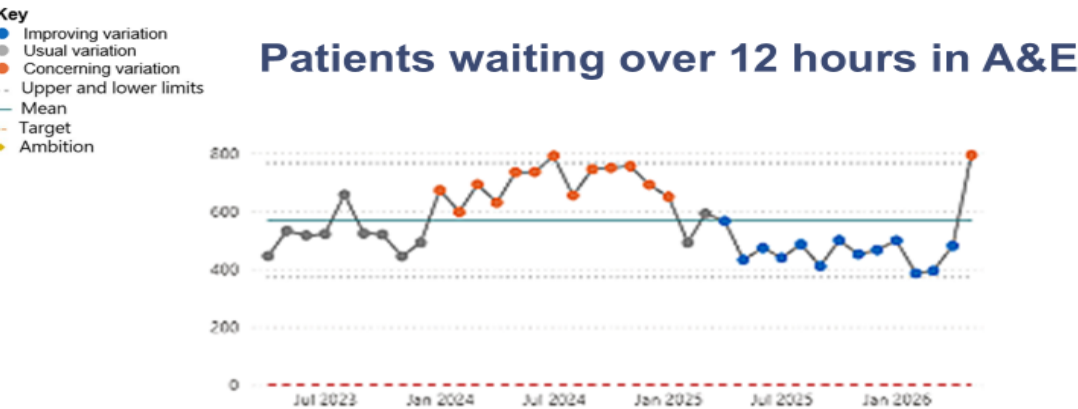
Key challenges / issues	Key actions / initiatives	Due date
- Physical space limitations within the Emergency Department footprint including limited assessment and trolley spaces to absorb ambulance arrivals during peak times leading to overcrowding and corridor usage. - Limited senior medical workforce 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.	- Reconfiguration of the Emergency Department footprint to enhance flow throughout the department - Review of clinical pathways across the Ceredigion Acute & Community System - Quality Improvement Projects to be initiated across the Emergency Department led by the senior sister team.	30/06/26 30/06/26 30/06/26
Embedded improvement actions		
- Successful recruitment of Senior Nurse Manager for the Emergency Department. Start date awaited. - Increased scrutiny on patients in non clinical areas. - Review of Your Next Patient - Daily review of all patients at risk of breaching 12 hours - Daily review of all clinically optimised patients - Focus on earlier in the day discharges - Escalation of delayed pathway of care patients - Partnership working with Local Authority to minimise delays in discharge		

Patients waiting > 12 hours in A&E / MIU Glangwili Hospital:

Urgent and Emergency Care – Emergency Departments – Glangwili Hospital

(Enhanced monitoring condition and Ministerial priority)

Urgent and Emergency Care



793 breaches out of 5,257 new attendances, 15%. The chart is showing concerning variation

Glangwili Overview:

- Whilst improvement actions progressed by the site have driven an overall improvement in ambulance handover metrics, there has been no clear improvement trend in 12 hour ED waits with performance in the past 2 months showing a sharp decline.
- Whilst the site team continue to focus on the embedded improvement actions described below, a number of additional improvement measures are being pursued during Q2 which are designed to alleviate capacity pressure and ED LOS.

Key challenges / issues

- Glangwili General Hospital (GGH) is the main Acute site for all medical and surgical pathways, adult and children, with continuing challenges in the timely repatriation of patients to other sites
- GGH is still seeing high demand from the ambulance conveyance and the patients presenting at the front door.
- ED remains heavily surged with patients waiting for in-patient beds.
- Reliance on agency doctors due to Consultant vacancies within Emergency Medicine and Medicine reduces the impact of senior reviews and timeliness of decision-making
- Advanced Paramedic Practitioner (APP) navigator rota coverage has been under pressure to staffing issues in the clinical streaming hub, limiting opportunities to direct patients to alternative pathways
- In-patient capacity is at its highest, with a constant patient bed surge and boarding noted on all wards.
- ED remains fully escalated and surged,

Key actions / initiatives

- Strengthening Community Pathways. Continued collaboration with the community teams to identify patients suitable for community-based care, enabling earlier discharge and reducing inpatient demand.
- To develop a robust repatriation policy, to return patient back to their local hospitals once the specialist care has ended.

Due date

31/08/26
30/09/26

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 patient care or patient care pathways delays.
- SDEC team actively "pull" from ED.

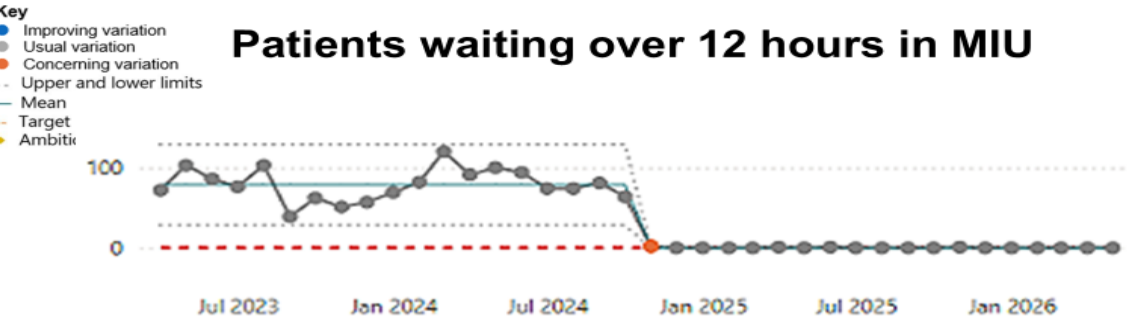
Patients waiting > 12 hours in A&E / MIU

Prince Philip Hospital:

Urgent and Emergency Care – Emergency Departments – Prince Philip Hospital

(Enhanced monitoring condition and Ministerial priority)

Urgent and Emergency Care



Zero breaches out of 2,703 new attendances. Chart is showing usual variation performance trend. The control limits were adjusted from November 2024 due to change of front door model

Prince Philip Overview:

- 100% compliance continues at PPH MIU
- Whilst the MIU does not operate overnight, the site team continue to focus on the embedded improvement actions described below and the additional Urgent Care Centre (UCC) development priorities in readiness for Winter 2026/27

Key challenges / issues	Key actions / initiatives	Due date
- Ongoing demand, combined with increased patient acuity, is placing significant pressure on assessment and treatment capacity, impacting flow and timely decision-making. - A rise in oncology patient referrals has risen sharply meaning that modeling work has started to observe trends and action service alterations. - IPC Constraints. Clinical flow across departments has been relentless this year and further challenged by Infection Prevention and Control (IPC) issues affecting several wards. These constraints have reduced available capacity and impacted patient movement, contributing to wider system flow pressures. - Variation in patient streaming and pathway utilisation while pathways such as SDEC and AMAU are in place, inconsistent utilisation at peak times can result in avoidable pressure within core front door areas.	The development of the Urgent Care Centre (UCC) is currently underway, with structured governance and delivery arrangements in place to support implementation. UCC programme activity is progressing at pace, with meetings currently taking place four times per week to maintain momentum, address emerging challenges, and ensure timely delivery of key milestones. This coordinated approach is supporting the development of a robust and sustainable Urgent Care Centre model, designed to improve access, enhance patient flow, and reduce pressure on front door services.	30/11/26
Embedded improvement actions		
- Clear communication channels with the newly named PFU (Patient Flow Unit) team on site to support with hospital flow and patient transfer. - Medical Hot Clinics increased in response to operational pressures. An additional General Medicine hot clinic has been introduced into the rota from January, operating every Monday to support demand and provide an alternative to admission where appropriate - Ongoing work with community colleges in early discharge planning. The use of hospital at home to create a wrap around service enabling community GP's to refer into SDEC out of hours / weekends for SDEC to treat and refer back into the virtual ward.		

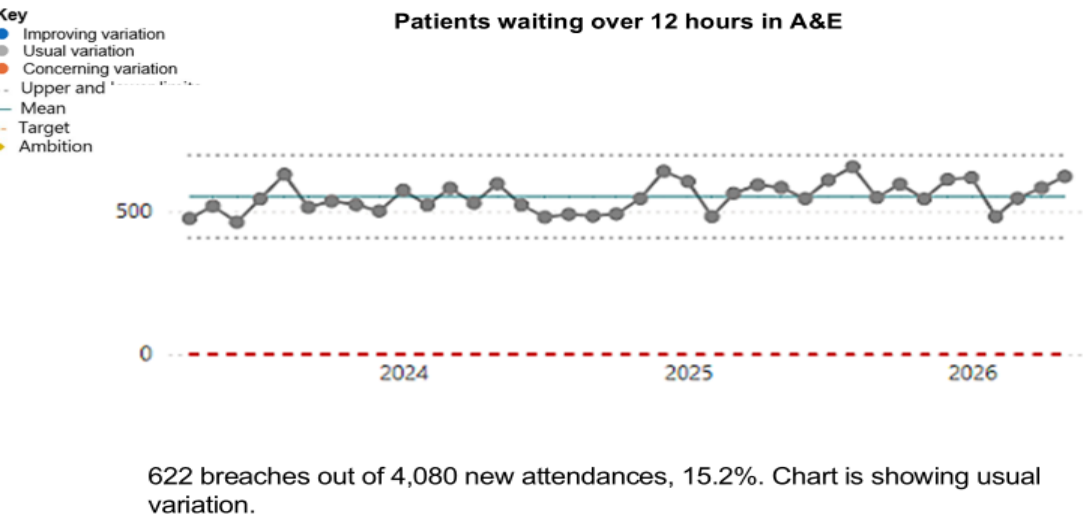
Patients waiting > 12 hours in A&E / MIU

Withybush Hospital:

Urgent and Emergency Care – Emergency Departments – Withybush Hospital

(Enhanced monitoring condition and Ministerial priority)

Urgent and Emergency Care



Withybush Overview:

- Despite a positive overall trend in ambulance handover metrics over the past 6 months, the site has not been able to sustain similar improvement trend in ED waits > 12 hours with a steady deterioration during Q1 for the reasons described below
- In addition to the continued focus on the embedded improvement actions, the site is also pursuing additional improvement actions during Q2 including a 'Home-First' discharge model, LOS improvements and strengthened senior clinical decision maker capacity.

Key challenges / issues

- Increased monthly conveyances to the Emergency Department (Feb' 542, Mar' 601, Apr' 604, May 637) despite also seeing good use of alternative pathways. This increased demand has contributed to site wide capacity challenges, impacting negatively on ED flow.
- Challenges with wider system flow, particularly during periods of increased demand, has been reflected in a period of escalated operational pressure declared at the end of the May.
- Higher demand experienced month on month, reflected in total attendances: Feb' 3,192, Mar' 3,735, Apr' 3,862, May 4,098 leading to increased pressure with the ED
- Inconsistent cover of the Advanced Paramedic Practitioner Navigator role in our Clinical Streaming Hub has limited opportunities to redirect patients to alternative pathways

Key actions / initiatives

- Embed Home-First discharge model across all inpatient areas (reducing patient length of stay and increasing flow, releasing beds to support the Emergency Department)
- Deployment of senior clinical decision maker to front door to lead on patient streaming.
- Continue to focus on reducing average inpatient length of stay through weekly operational call, targeting 0 cases over 50 days (increasing flow and supporting movement of patients out of ED into inpatient beds)

Due date

30/09/26
31/12/26
31/03/27

Embedded improvement actions

- MIYA Patient Flow model
- Same Day Emergency Care in-reach into the department to support and pull patients from ED
- Pro-active Frailty screening and pull through to Frailty SDEC from ED.

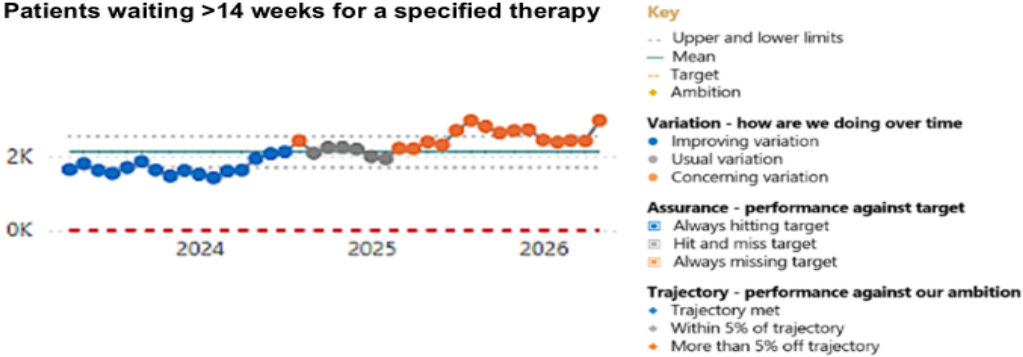
Patients waiting > 14 weeks for a specified therapy

Overview:

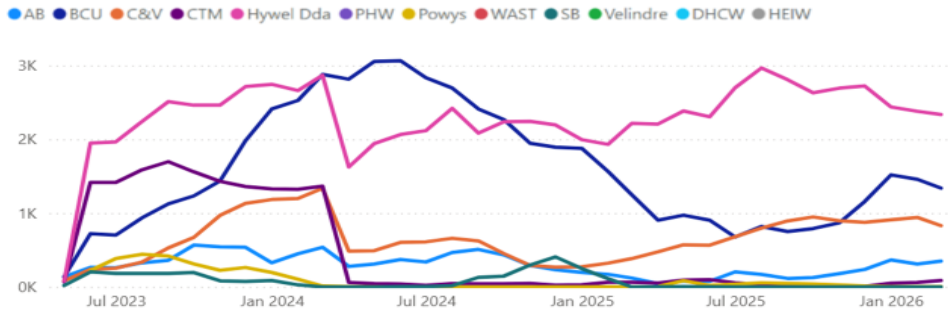
Therapy waits over 14 weeks (Ministerial priority)

Performance shows concerning variation (May 2026 = 2,969), with breaches rising by over 500 since April 2026.

Patients waiting >14 weeks for a specified therapy

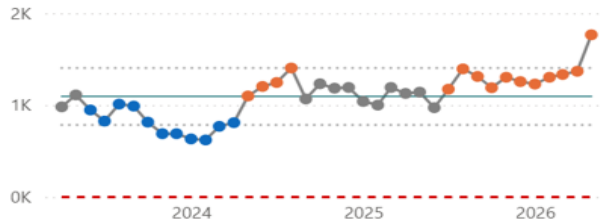


Patients waiting 14 weeks or more for a specified therapy: Welsh Health Boards (March 2026)

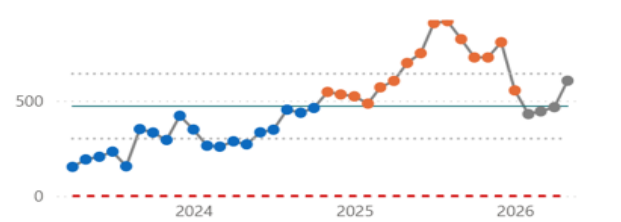


Therapies

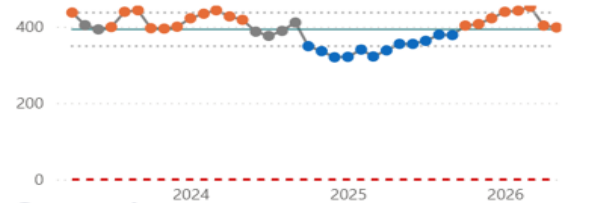
Number of patients waiting 14 weeks plus for Physiotherapy



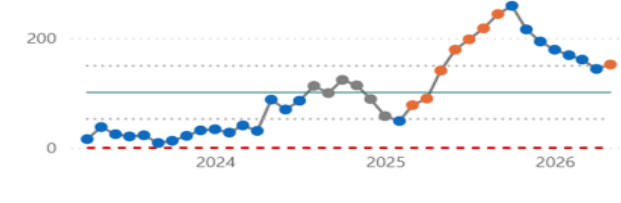
Number of patients waiting 14 weeks plus for Podiatry



Number of patients waiting 14 weeks plus for Occupational Therapy



Number of patients waiting 14 weeks plus for Dietetics (excluding Weight Management)



Overview:

- The Annual Plan forecasted a potential rise to 3,229 breaches by March 2027 without the necessary investment in additional capacity required
- The performance deterioration in May 2026 exceeds the expected rate of deterioration, driven primarily by additional short-term staffing challenges in Physiotherapy & Dietetics, alongside an expected reduction in podiatry senior capacity
- Each therapy service is pursuing a range of pathway transformation priority initiatives (described below) designed to part-mitigate the forecast rise in breaches

Patients waiting > 14 weeks for a specified therapy

Key challenges and Improvement Actions:

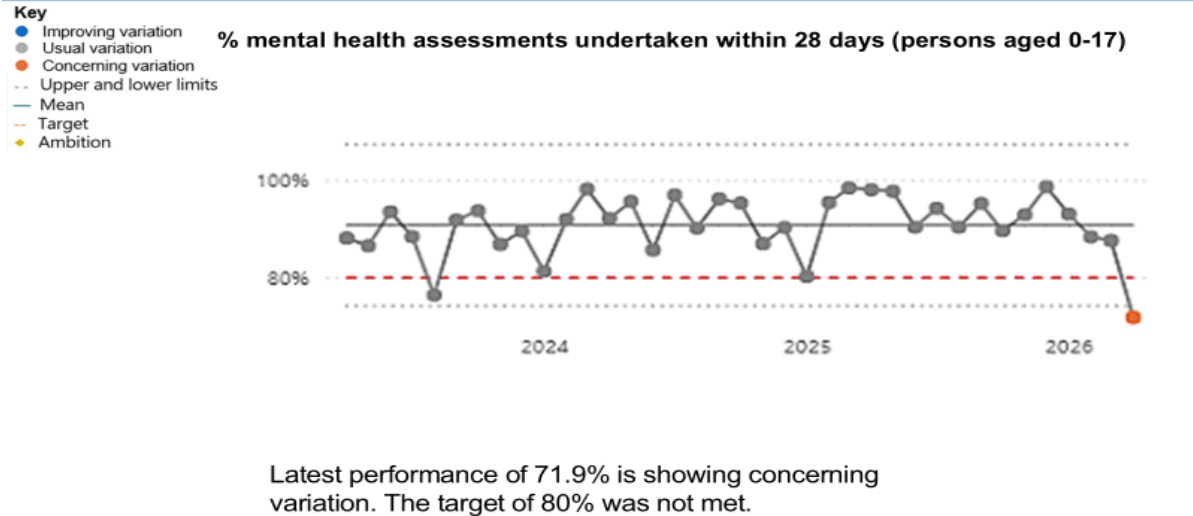
Therapy waits over 14 weeks (continued) (Ministerial priority)		
Key challenges / issues	Key actions / initiatives	Due date
Physiotherapy: in month increase in breach position is driven by reduced capacity and corresponding activity. This is caused by two staff on maternity leave, one vacancy, and unavailability of agency to backfill. This is compounded by increased urgency of demand (now 50%), notably in Musculoskeletal (MSK) Physiotherapy specialty (94% of breaches). Demand continues to grow and is greater than capacity, driven by changes to Community Health Pathways and other national pathways (E.g. South Wales Spinal Network Guidance) causing a shift of work from primary and secondary care towards community MSK Physiotherapy services. There is an increase in the proportion of urgent and complex work in community services as pathways have an increased focus on admission avoidance and early supported discharge. The remaining 6% breaches are within community and paediatric services. Occupational Therapy (Paediatrics) Performance within trajectory, 79.5% breeches within paediatrics, driven by increases (circa 30%) in new patient referrals over the past 3 years, placing significant pressure on service capacity. Compounded by a rise in urgency and complexity of demand, which continues to impact the service’s ability to meet demand. Podiatry Breaches had stabilised until March 2026 due to temporary management-led clinics; however, this is unsustainable and with the temporary clinics ceasing, performance has deteriorated. New patient referrals have risen by around 40% over six years without an increase in capacity, while patient complexity has increased. This has led to longer appointments and fewer patients being seen. Podiatry provides first-contact triage for Orthopaedics and Vascular services and has expanded roles (7 Independent Prescribers and 6 Sonographers) through internal reorganisation without additional funding. Dietetics Paediatrics (99% long wait demand): Short-term additional capacity had started to turn the curve of breaches, however further sickness in the team is now impacting negatively on performance. There is a further likelihood of deterioration from September 2026 when short-term additional capacity agreement ceases. Diabetes & Community: A very small proportion of breaches sit within these specialties; due to fragility in these areas (e.g. any short-term absence is adversely affecting capacity and increasing breach position).	The agreed trajectory in the Annual Plan for 2026/27 without the required investment in additional posts, forecasts 3,229 breaches by March 2027. Mitigating actions are described below. Physiotherapy: The actions below will reduce the rate of breach growth but will not off-set the capacity demand deficit. - A standard operating procedure (SOP) for a targeted telephone triage pilot, for patients who could be signposted towards supported self-management in place with further refinement of this process now planned using PDSA (plan-do-study-act) cycles to test the effectiveness of clinical risk stratification and patient activation tools to broaden the scope of the project. 3-month pilot starting on 20/04/26 to validate routine MSK waiting lists using new Microsoft Forms methodology. - A review of community prioritisation criteria aligned to clinical risk matrix is currently being undertaken Occupational Therapy (Paediatrics) - Increasing number of group appointments through the development of a sensory pathway - Increasing number of clinic appointments to increase service flow. - Working with estates to minimise any adverse impacts of planned accommodation changes through June and July. - Weekly performance meetings to review actions and progress on planned service improvements. Podiatry - Consultant podiatrist post in development. This will improve treatment flow, governance and waiting times. - Further action to continually embed successful telephone triage process Health Board wide, which reduces waiting times. Dietetics - Service delivery model review underway, access criteria and referral process updated and communicated (timeline dependant on access to Digital / IT support). - Demand and capacity mapping complete. This will inform the improvement plan which will be presented to the July Clinical Care Group (CCG) business and governance meeting.	31/08/26 17/07/26 30/09/26 30/09/26 30/09/26 30/07/26 30/09/26 15/08/26 31/07/26 31/08/26 31/07/26
Embedded improvement actions		
Physiotherapy: Financial Control Group approval given to actively recruit Band 5 bank staff, with 5 job offers made 3rd March 2026. Bank workforce are now in post. Action closed. Podiatry: New patient demand and capacity modelling found the service to be efficient, with full utilisation of a 10-session template, strong discharge and eligibility processes, and effective skill-mixing. A service review strengthened the management structure, with D&C modelling indicating a requirement for an additional 3.0 WTE to meet demand. Dietetics: First line resources developed and accessible to referrers via SharePoint ; this is aimed at reducing referral rate and first line advice provided and supports early risk management for those waiting.		

Mental Health Assessments within 28 days (0-17)

Key challenges and improvement actions:

Mental health assessments within 28 days

Mental Health



Overview:

Whilst performance in respect of the 18+ age group continues to be strong (above 98%), performance in respect of 0-17 age group has deteriorated in recent months and has now dropped below 80%. This is due to increased demand above forecast levels and reduced staffing (as described below)

Whilst staffing availability is expected to improve along with improved data oversight in the short term, longer-term pathway transformation changes are targeted for the end of 2026

Key challenges / issues	Key actions / initiatives	Due date
% mental health assessments undertaken within 28 days (persons aged 0-17): 71.9% of assessments (64 of 89) were within target in April. The decline in April followed a period of increased demand over the usually quieter winter period. Referrals between October 2025 and March 2026 were up 9.3% compared to the previous year. This coincided with reduced staffing in the largest team (Carmarthenshire). Efforts to improve on our performance for our 28 days treatment target also impacted on our assessment performance. This is expected to improve in the coming two months.	% mental health assessments undertaken within 28 days (persons aged 0-17): - Increased frequency of monitoring meetings, with more 'real time' data to inform these and the required actions to improve. - Piloting the 'One at a Time' approach to increase responsivity and reduce assessment burden, for which there is an 'Enabling Quality Improvement in Practice' (EQIIP) programme ongoing. Embedded improvement actions % mental health assessments undertaken within 28 days: Carmarthenshire remains fragile due to both long term and short-term sickness. All teams are utilising the Primary Care Liaison Service (PCLS) at point of referral supporting reducing pressure on local Primary Mental Health Support Services at this point of the patient journey.	30/06/26 31/12/26

%age Psychological Therapy waits < 28 weeks

Key challenges and improvement actions:

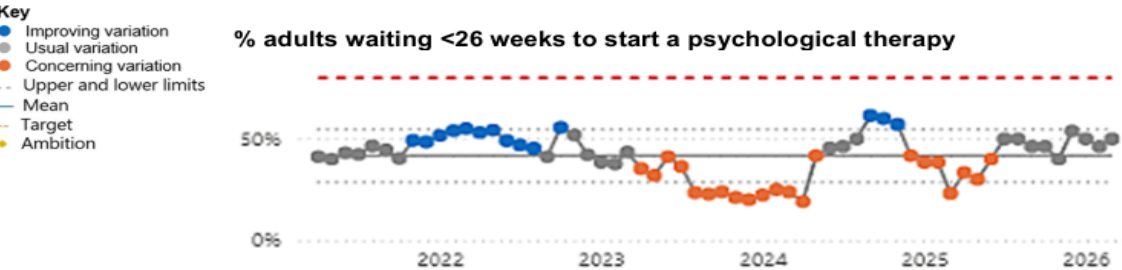


GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Psychological therapy waits (Enhanced monitoring condition and Ministerial priority)

Mental Health



Whilst performance improved in the month, performance over the past year has remained largely static, consistently below the target of 80%:

- 429 out of 825 (52%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 5 out of 11 (45.5%) were waiting <26 weeks to start an adult psychology assessment;
- 51 out of 90 (56.7%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.
- Alongside the embedded improvement actions described below, the CCG is pursuing additional pathway transformation priorities during the Summer period.

Key challenges / issues	Key actions / initiatives	Due date
Integrated Psychological Therapies Service (IPTS): IPTS has observed a marginal decrease in compliance of 1.2%; however, this is set against a significant overall reduction in the waiting list of 34% over the past 12 months. Referral and discharge rates remain broadly balanced, resulting in a steady-state flow that limits visible improvement in RTT performance despite meaningful backlog reduction. The transition to a stepped-care model has supported sustained improvements in service capacity, patient flow, throughput, and overall pathway management. However, the ability to expand group provision has been constrained by recruitment delays and increasing pressure on the balance between group delivery and 1:1 interventions. In addition, the ongoing digital system transition from Attend Anywhere to Medio has required focused management oversight, which has further impacted operational capacity—particularly in relation to group delivery.	IPTS: Several staff members have completed training in Dialectical Behaviour Therapy (DBT) for complex post-traumatic stress disorder (PTSD). This will strengthen the service's ability to address the trauma waiting list.	31/07/26
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.	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.	30/06/26
Embedded improvement actions		
Adult Psychology Mental Health (AMH): The waiting list for patients waiting under 26 weeks for treatment decreased in April. This follows the commencement of a Practitioner Psychologist, based in an area in Carmarthenshire where there was no community provision.	IPTS: - A number of high-intensity, evidence-based interventions have now been embedded within the service model and are demonstrating positive patient outcomes. The introduction of caps on therapy sessions is contributing to improved capacity management. - Staff are actively engaged in regular supervision to monitor 1:1 waiting lists, and all therapists have aligned job plans to support increased service capacity wherever feasible. 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 for providing consultations to other services, decreasing referrals to AMH. 'Gro' plans are in place.	



The Finance and Performance Committee is requested to:

- **NOTE** the key challenges and issues currently impacting the performance areas highlighted as Alerts in the Month 2 2026/27 IPAR
- **RECEIVE ASSURANCE** from the improvement focus being applied by each relevant Clinical Care Group as reflected in the improvement actions described (within the context of the delivery plans, resources and trajectories approved within the Annual Plan 2026/27)
- **NOTE** the further work underway to review the Radiology breach position and forecast



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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

2.3

10:10, 5 Mins

2.3 - NWSSP PERFORMANCE REPORT QUARTER 4 2025/26

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

| For assurance

Attachments

NWSSP Performance Quarter 4 2025.26 draft.pdf

Appendix 1-3 HDdUHB Summary Performance Report Q4 2025-26.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Shared Services Partnership Performance Report Quarter 4 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Rhian Davies, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Finance and Performance Committee (FPC) with summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 31 March 2026 (Quarter 4 2025/26).

The Finance and Performance Committee is requested to receive an assurance from the content of the NWSSP Performance Report for Quarter 4 2025/26.

Cefndir / Background

The NWSSP is hosted and governed by the Velindre NHS Trust Shared Services Regulations and the Shared Services Partnership Committee (SSPC). The SSPC is hosted by Velindre on behalf of the seven Health Boards, three Trusts and two Special Health Authorities within NHS Wales (the partners) and is responsible for monitoring governance and performance.

The required standards for effective governance are outlined within the SSPC's Standing Orders, Values and Standards of Behaviours framework, and associated policies. The partners participate in the SSPC and take collective responsibility for the delivery of the services through a hosting agreement between the partners.

The purpose of the SSPC is to:

- Set the policy and strategy for NWSSP;
- Monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- Seek to improve the approach to delivering Shared Services which are effective, efficient and provide value for money for partners;
- Ensure the efficient and effective leadership direction and control of NWSSP; and
- Ensure a strong focus on delivering savings that can be re-invested in direct patient care.

The Board has approved Standing Orders in relation to the establishment of joint committees. In line with these Standing Orders, Hywel Dda University Health Board (HDdUHB) has established a NWSSP Committee as a joint committee of the Board, the activities of which require reporting to the Board.

Asesiad / Assessment

As part of the approval of Year 1 of the SSPC Integrated Medium Term Plan (IMTP) for 2025-26, the SSPC reviewed its Key Performance Indicators. A number of Lead indicators were identified for each division. There are 21 Lead indicators in total.

Full details of the performance against all Wales agreed KPIs for services provided to HDdUHB are attached (**Appendix 1-3**) with comparison data for the rolling twelve-month period to 31 March 2026.

HDdUHB Specific Key Performance Indicators

In summary, of the 21 Lead indicators for Quarter 4 the performance is as follows:

	Green	Amber	Red	Not Applicable
Quarter 4 2025/26	19	1	1	
Quarter 3 2025/26	20	1		
Quarter 2 2025/26	20		1	
Quarter 1 2025/26	17		1	3

By exception, the areas where performance is not on target are highlighted below:

Audit and Assurance – Audits reported to agreed Audit Committee (Excluding External Factors)

Performance driven by both HDdUHB and NWSSP shows the organisation missing the following KPI:

- **Audits reported to agreed Audit Committee: Target 80%**

Performance: 76% (Amber)

What is happening?

Audits reported to agreed Audit Committee failed the 80% target reporting 76% as of March. Sixteen of the twenty-one reports were submitted on time. The delays were due to Internal resource pressures, client delays together with the audit field work taking longer than planned.

What is NWSSP doing about it?

Heads of Audit discuss any delays directly with the health organisations and are made aware of any revised timings of reports and submissions to Committees.

Accounts Payable – NHS Public Sector Prompt Payment (PSPP)¹

Performance driven by both HDdUHB and NWSSP shows the organisation missing the following KPI:

- **PSPP Compliance NHS: Target 95%**

Performance: 81.6% (Red)

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 4 reporting 82% with a **year-to-date position of 86.6%**.

What is NWSSP doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice hold data to help address the performance.

To improve compliance across the P2P process, the Core Accounting Team, local Procurement team and NWSSP Accounts Payable are working together to review issues and agree actions alongside NWSSP's national IOH initiatives. Despite raising this at the Finance and Digital Executive Improving Together Session in November and seeking Executive Team support to promote compliance as part of financial oversight, meeting the target remains challenging.

The Finance team has contacted another health board that has achieved the target to understand what processes could be applied in Hywel Dda. A key difference is that they require a Purchase Order for NHS suppliers, whereas NHS organisations are currently exempt under the all-Wales policy. They also provide dedicated resource to support the process.

The Health Board met the non NHS PSPP target at 31 March 2026 which is the required financial target.

All Wales Key Performance Indicators

Performance is reported on an all Wales basis for KPIs that cannot be attributed to a specific health organisation, with comparative data for the rolling twelve-month period to 31 March 2026.

Summary Assessment by NWSSP

The Quarter 4 performance for the organisation was good with 19 out of 21 KPIs showing as green. The time to hire target was achieved in March.

¹ Definition of the CBI Prompt Payment Code financial target for NHS bodies:

Payment of at least 95% of non-NHS invoices within 30 calendar days from the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. NHS bodies must disclose in their financial statements performance against the measure set out above and also performance on the same basis for NHS invoices (although the latter is not a financial target).

Further action will continue to be taken forward to address the performance in areas of underperformance.

Both KPIs that did not achieve the target are a combination of NWSSP and Health Board responsibility. NWSSP continues to support the organisation in relation to audit and accounts payable performance.

Appendix 4 shows the Outcome measures that NWSSP has been working on at the end of March 2026 to highlight and report the impact and importance of what it does.

Extra tables and charts have been included by NWSSP to provide additional detailed insights gathered from feedback from health organisations performance meetings. These tables have been headed as 'For Information' within the various appendices. Accounts Payable (page 11) and Payroll Overpayments (page 24) are routinely monitored via the Financial Assurance paper presented to Audit and Risk Assurance Committee (ARAC).

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

- **RECEIVE ASSURANCE** from the content of the NWSSP Performance Report for Quarter 4 2025/26 that services provided are being delivered to expected standards; and
- **NOTE** the work being developed regarding outcome measures reporting.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.11 Commission regular reviews of key contracts, suppliers and partners to ensure they continue to deliver value for money.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 31 March 2026.
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad: Parties / Committees consulted prior to Finance and Performance Committee:	Shared Services Partnership Committee (SSPC)

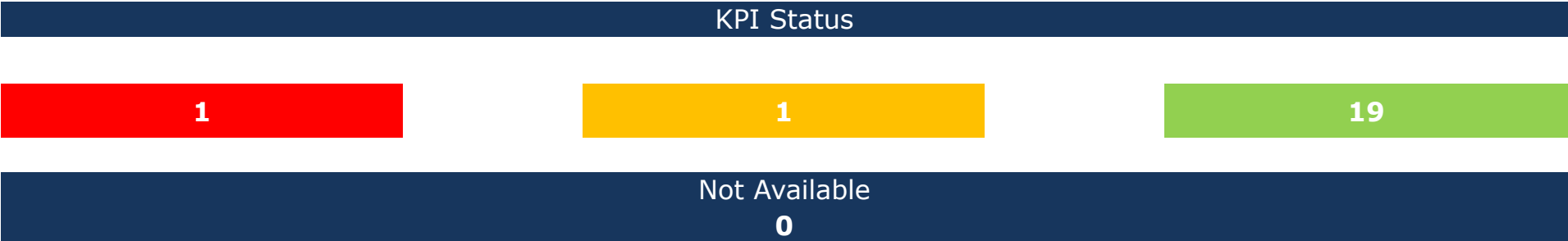
Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	NWSSP was established to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners.
Ansawdd / Gofal Claf: Quality / Patient Care:	NWSSP has a remit to focus on delivering savings that can be re-invested in direct patient care.
Gweithlu: Workforce:	NWSSP is hosted by Velindre NHS Trust and any workforce implications are dealt with by the Trust.
Risg: Risk:	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.
Cyfreithiol: Legal:	In line with its Standing Orders, the Health Board has established a NWSSP Joint Committee, the activities of which require reporting to the Board.

Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

NWSSP SUMMARY PERFORMANCE REPORT

HYWEL DDA UNIVERSITY HEALTH BOARD

**Period 1st January 2026 – 31st March
2026**



Points of Contact

Rebecca Nelson – Director of Planning, Performance & Informatics (Rebecca.Nelson2@wales.nhs.uk)
Richard Phillips – Assistant Director of Planning & Performance (Richard.phillips@wales.nhs.uk)

The purpose of this report is to provide summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ended 31st March 2026.

As part of the approval of our Year 1 of our IMTP for 2025-26, the Shared Services Partnership Committee (the Committee) reviewed our Key Performance Indicators. We then identified a number of Lead indicators for each division. There are 21 Lead indicators in total.

The Quarter 4 performance for the organisation was good with 19 out of 21 KPIs showing as green.

The time to hire target was achieved in March .

Further action will continue to be taken forward to address the performance in areas of underperformance.

Of the 2 KPIs that did not achieve the targets:

- 2 are a combination of NWSSP and Health Board responsibility.

NWSSP continue to support the organisation in relation to audit and accounts payable performance.

The main financial benefits accruing from NWSSP relate to professional influence benefits derived from NWSSP working in partnership with Health Boards and Trusts. These benefits relate to savings and cost avoidance.

- Legal Services – Settled Claims savings, damages and cost savings.
- Procurement Services – Cost reduction, catalogue management etc. (Heads of Procurement discuss with Director of Finance of Health Orgs)
- Specialist Estates Services – Property management/lease/rates negotiated reductions and Build for Wales framework savings.
- Counter Fraud Services – Financial Recoveries and prevention.
- Accounts Payable - statement reconciliation, priority supplier programme (PSP) and the prevention of duplicate payments.

The indicative financial benefits arising in the period April – March 2026 for the organisation is £15.2M with the breakdown in the following table.

Service	YTD Benefit £m
Specialist Estates Services	0.17
Procurement Services	6.35
Legal & Risk Services	7.83
Accounts Payable	0.57
Oxygen Finance – PSP	0.03
Counter Fraud Services*	0.24
Total	15.2

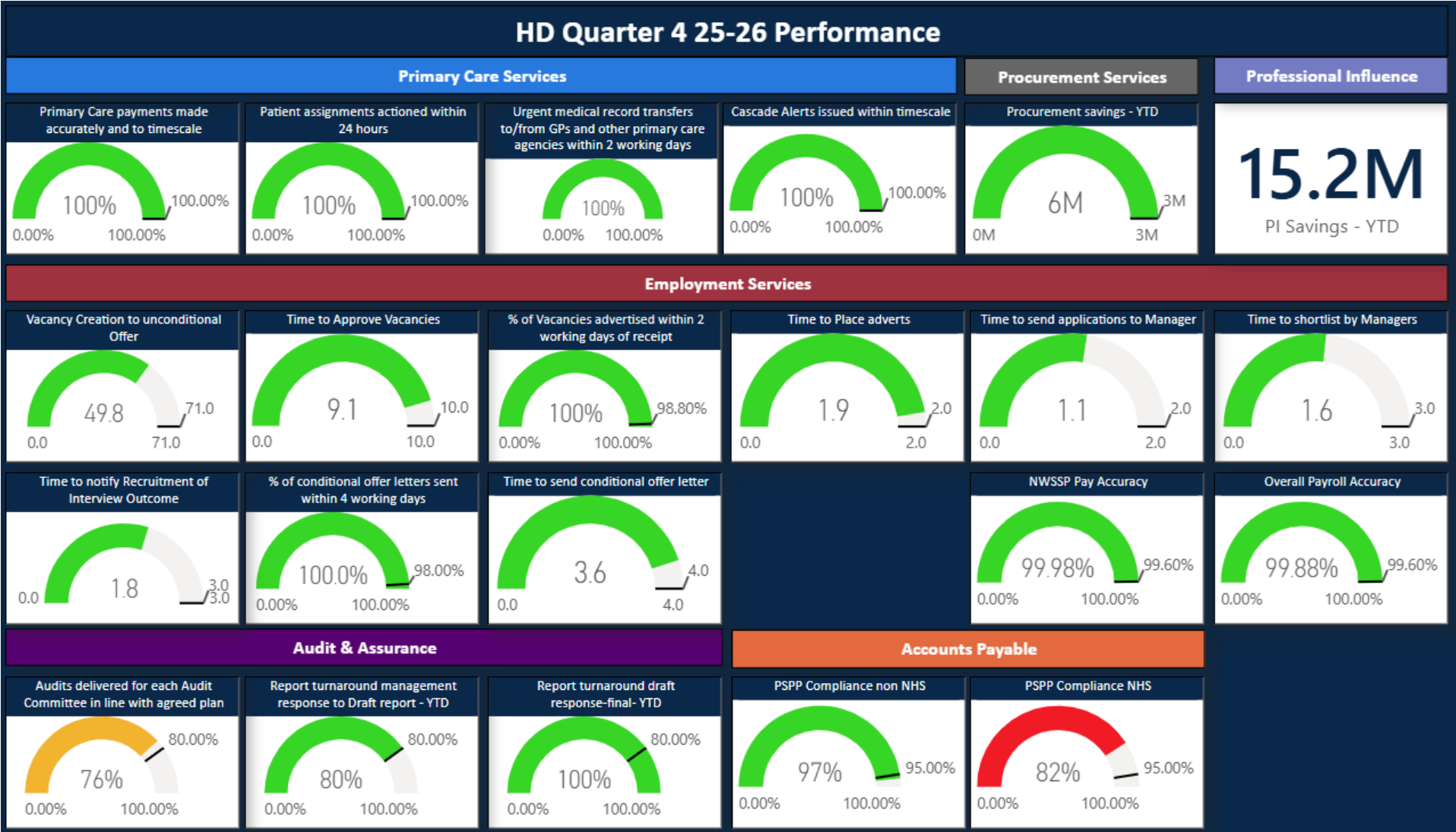
* Q1- Q3 only

Appendix 1 provides the March performance for your health organisation against the Lead indicators with comparison data for the rolling twelve-month period to 31st March 2026.

Appendix 2 provides March performance against All Wales KPIs which cannot be attributed to a specific health organisation, these report an All-Wales position with comparison data for the rolling twelve-month period to 31st March 2026.

Appendix 3 highlights the position for all health organisations at the end of March 2026.

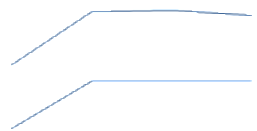
Appendix 4 highlights the Outcome measures reporting at the end of March 2026 along with some supporting information.



Action Plan for Lead Indicators

There was one KPI showing as red for the in-month March position.

There was one KPI showing as amber for the in-month March position.

HD High Level - KPIs Mar 26	Target	30/06/2025	30/09/2025	31/12/2025	31/03/2026	Trend
Audit & Assurance						
Audits reported to agreed Audit Committee (Excluding External Factors)	80%	Not Applicable	88%	67%	76%	
% of audit outputs in progress		16%	27%	14%	21%	
Report turnaround management response to Draft report - YTD	80%	Not Applicable	86%	90%	80%	
Report turnaround draft response-final- YTD	80%	Not Applicable	100%	100%	100%	

What is happening?

Audits reported to agreed Audit Committee failed the 80% target reporting 76% as of March. Sixteen of the twenty-one reports were submitted on time. – The delays were due to Internal resource pressures, client delays together with the audit field work taking longer than planned.

What are we doing about it?

Heads of Audit discuss any delays directly with the health organisations and are made aware of any revised timings of reports and submissions to committees.

Supplementary Information - All Wales Audit & Assurance performance at the end of March 2026.

Client	Total Reviews Planned	Audits Reported (Draft / Final)	Audits in Progress	On Track/ Achieved Proposed Audit Committee	Report turnaround fieldwork to draft reporting [10 days]	Report turnaround management response to draft report [15 days]	Report turnaround draft response to final reporting [10 days]
Aneurin Bevan	25	64.0%	28.0%	86.96%	100.0%	38.5%	100.0%
Betsi Cadwaladr	35	74.3%	25.7%	85.00%	100.0%	61.9%	100.0%
Cardiff & Vale	33	72.7%	27.3%	64.71%	100.0%	76.5%	100.0%
Cwm Taf Morgannwg	29	62.1%	34.5%	60.87%	100.0%	27.3%	100.0%
DHCW	12	91.7%	8.3%	91.67%	100.0%	70.0%	100.0%
HEIW	11	100.0%	0%	81.82%	100.0%	80.0%	100.0%
Hywel Dda	29	69.0%	20.7%	76.19%	100.0%	66.7%	100.0%
Joint Commissioning Committee	3	33.3%	33.3%	66.67%	100.0%	100.0%	100.0%
NHS Wales Performance & Improvement	4	75.0%	25.0%	100.00%	100.0%	66.7%	100.0%
NWSSP	18	55.6%	16.7%	66.67%	100.0%	55.6%	100.0%
PHW	12	66.7%	33.3%	91.67%	100.0%	87.5%	100.0%
Powys THB	21	71.4%	19.0%	78.57%	100.0%	84.6%	100.0%
Swansea Bay	26	61.5%	38.5%	88.46%	100.0%	61.5%	100.0%
Velindre	17	70.6%	29.4%	68.75%	100.0%	50.0%	100.0%
WAST	20	75.0%	25.0%	75.00%	100.0%	90.0%	100.0%
Total	295	69.8%	25.4%	78.35%	100.0%	65.3%	100.0%

HD High Level - KPIs Mar 26	Target	30/06/2025	30/09/2025	31/12/2025	31/03/2026	Trend
Accounts Payable						
PSPP Compliance non NHS	95%	96.8%	96.2%	96.8%	96.6%	
PSPP Compliance NHS	95%	80.2%	85.8%	98.9%	81.6%	

What is happening?

PSPP Compliance NHS missed the 95% target during Quarter 4 reporting 82% with a **year-to-date position of 86.6%**.

What are we doing about it?

Accounts Payable continues to support NHS and non-NHS PSPP reporting by providing regular updates and invoice on hold data to help address the performance.

For Information - The following table highlights the All Wales performance in relation to P2P as at the end of March 2026.

All Wales Accounts Payable data - July 2025 to March 2026																										
July 2025 to March 2026	AB		BCU		C&V		CTM		DHCW		HEIW		HD		POWYS		PHW		SBU		VEL		WAST		TOTAL	
	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March	End of July	End of March
Number of Invoices on Hold	6,077	6,347	8,176	7,299	7,169	6,546	6,412	6,665	167	121	442	334	3,085	3,121	841	816	1,440	910	5,686	4,360	2,422	1,818	541	506	42,458	38,843
Value of Invoices on Hold £m	10.145	17.904	18.128	20.849	24.440	22.489	14.918	24.920	2.184	1.768	6.618	2.192	7.690	15.615	8.937	19.175	17.162	4.251	13.789	17.905	7.635	10.933	7.011	2.665	138.656	160.666
No of Invoices on hold > 30 days	4,606	4,347	5,748	4,910	5,211	4,354	4,295	4,372	76	60	115	89	1,777	1,778	506	422	1,019	497	3,749	2,575	1,735	1,086	329	192	29,166	24,682
No of invoices on No PO No Pay Hold	985	927	727	814	288	462	1,158	862	7	11	6	10	95	106	100	127	121	97	1,141	699	127	233	62	87	4,817	4,435
No of NPNP invoices - Top 15 suppliers	509	237	297	191	74	100	748	240	2	4	2	1	16	5	19	36	26	2	642	296	31	62	12	12	2,378	1,186
No of invoice lines - Receipting hold	4,739	4,934	5,202	4,948	3,687	3,484	4,368	5,139	58	50	74	30	2,477	3,400	854	493	389	362	4,245	3,489	1,645	946	320	208	28,058	27,483
Priority Supplier - Rebate income	£14,767	£37,216	£39,112	£117,600	£17,522	£63,189	£43,509	£105,499	£1,706	£5,376	£413	£1,530	£11,806	£28,834	£1,896	£5,325	£1,447	£4,967	£36,078	£105,293	£21,512	£61,279	£18,538	£70,894	£208,306	£607,002

Key

- Deterioration on end of July position
- Same as end of July position
- Improvement end of July position

Appendix 1 – Performance for the period to 31st March 2026

HD High Level - KPIs Mar 26	Target	30/06/2025	30/09/2025	31/12/2025	31/03/2026	Trend
Financial Information						
Professional Influence Savings - YTD		£2.217 m	£4.398 m	£7.271 m	£15.181 m	
Employment Services						
Payroll Services						
NWSSP Pay Accuracy	99.6%	99.98%	99.98%	99.99%	99.98%	
Overall Pay Accuracy	99.6%	99.93%	99.91%	99.89%	99.88%	
Organisation KPIs Recruitment						
% of vacancy creation to unconditional offer within 71 days		92.4%	86.6%	86.8%	87.5%	
Vacancy creation to unconditional offer	71	49.6	52.2	51.4	49.8	
% of vacancies approved within 10 working		81.5%	91.5%	84.8%	82.8%	
Time to Approve Vacancies	10	9.0	5.9	7.8	9.1	
% of vacancies shortlisted within 3 working		95.1%	90.4%	90.8%	91.5%	
Time to Shortlist by Managers	3	1.1	1.7	1.4	1.6	
% of interview outcomes notified within 3 working		80.9%	88.5%	79.7%	85.7%	
Time to notify Recruitment of Interview Outcome	3	2.3	1.6	2.0	1.8	
NWSSP KPIs Recruitment						
% of Vacancies advertised within 2 working of receipt	95.00%	100.0%	100.0%	100.0%	100.0%	
Time to Place Adverts	2	1.6	1.8	1.8	1.9	
% of applications moved to shortlisting within 2 working of vacancy closing		100.0%	100.0%	100.0%	100.0%	
Time to Send Applications to Manager	2	1.2	1.1	1.1	1.1	
% of conditional offer letters sent within 4 working	95.00%	100.0%	100.0%	99.3%	100.0%	
Time to send Conditional Offer Letter	4	3.2	3.6	3.7	3.6	
Procurement Services						
Procurement savings - YTD		Target £0.983m Actual £1.983m	Target £2.046m Actual £3.973m	Target £2.284m Actual £5.300m	Target £2.864m Actual £6.346m	
Accounts Payable						
PSPP Compliance non NHS	95%	96.8%	96.2%	96.8%	96.6%	
PSPP Compliance NHS	95%	80.2%	85.8%	98.9%	81.6%	
Primary Care Services						
Primary Care payments made accurately and to timescale	100%	100%	100%	100%	100%	
Patient assignments actioned within 24 hours	100%	100%	100%	100%	100%	
Urgent medical record transfers to/from GPs and other Primary Care agencies within 2 working days	100%	100%	100%	100%	100%	
Cascade Alerts issued within timescale	100%	100%	100%	100%	100%	
Audit & Assurance						
Audits reported to agreed Audit Committee (Excluding External Factors)	80%	Not Applicable	88%	67%	76%	
% of audit outputs in progress		16%	27%	14%	21%	
Report turnaround management response to Draft report - YTD	80%	Not Applicable	86%	90%	80%	
Report turnaround draft response-final- YTD	80%	Not Applicable	100%	100%	100%	

Appendix 2 – All Wales Performance for the period to 31st March 2026

ALL WALES KPIs		30/06/2025	30/09/2025	31/12/2025	31/03/2026	Trend
Primary Care Services						
Prescription - Payment Month keying Accuracy rates	99%	99.69%	99.81%	99.23%	99.70%	
Prescriptions processed (Apr - Jan)		7.03m	42m	50m	72m	
Welsh Risk Pool						
Time from submission to consideration by the Learning Advisory Panel	95%	100%	100%	100%	100%	
Time from consideration by the Learning Advisory Panel to presentation to the Welsh Risk Pool Committee	100%	100%	100%	100%	100%	
Holding sufficient Learning Advisory Panel meetings	90%	100%	100%	100%	100%	
Legal and risk						
Advice acknowledgement- 24hrs	90%	100%	100%	100%	100%	
Advice response – within 3 days	90%	100%	100%	100%	100%	
Student Awards						
% of NHS Bursary Applications processed within 20 days	100%	100%	100%	100%	100%	
Student Awards % Calls Handled	95%	98.9%	98.4%	99.3%	99.3%	
CTeS						
P1 incidents raised with the Central Team are responded to within 20 minutes	80%	100%	Not Applicable	Not Applicable	Not Applicable	
BACS Service Point tickets received before 14.00 will be processed the same working day	92%	100%	99%	100%	0%	
Digital Workforce						
DWS % Calls Handled	85%	96%	98%	96%	91%	
SMTL						
% of Monitoring reports completed within 14 days from receipt into the laboratory	91%	100%	100%	100%	100%	
% of Monitoring reports completed within 40 days from receipt into the laboratory	91%	100%	100%	100%	100%	
% delivery of Audited reports on time (NHS)	92%	100%	100%	100%	100%	
Pharmacy Services						
Complaints	0	0	0	0	0	
Medical Examiner						
Deaths Scrutinised		100%	100%	100%	0%	
All Wales Laundry						
Orders dispatched meeting customer standing orders	90%	94%	97%	98%	94%	
Microbiological contact failure points	85%	97%	95%	95%	97%	
Number of pieces of returned linen by customer not meeting quality standards	<100	0	0	0	0	

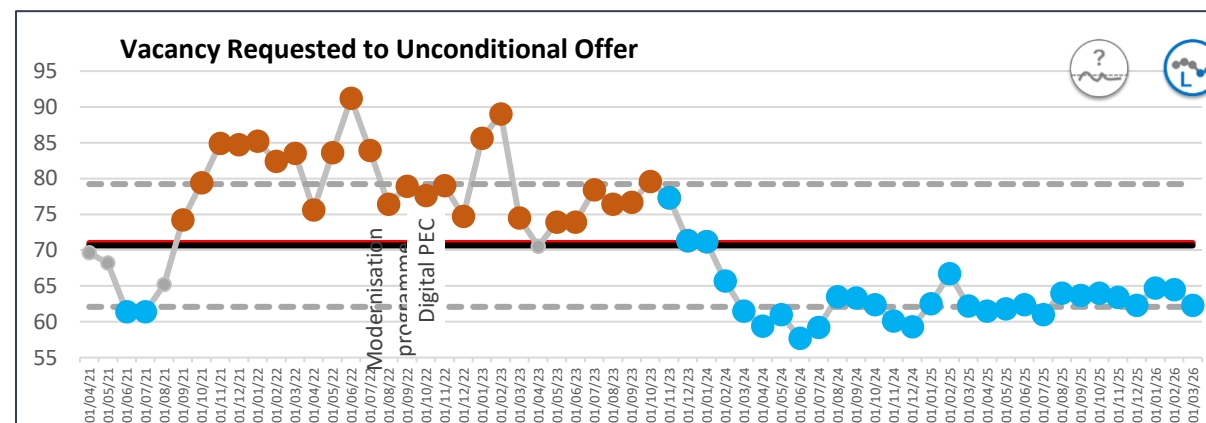
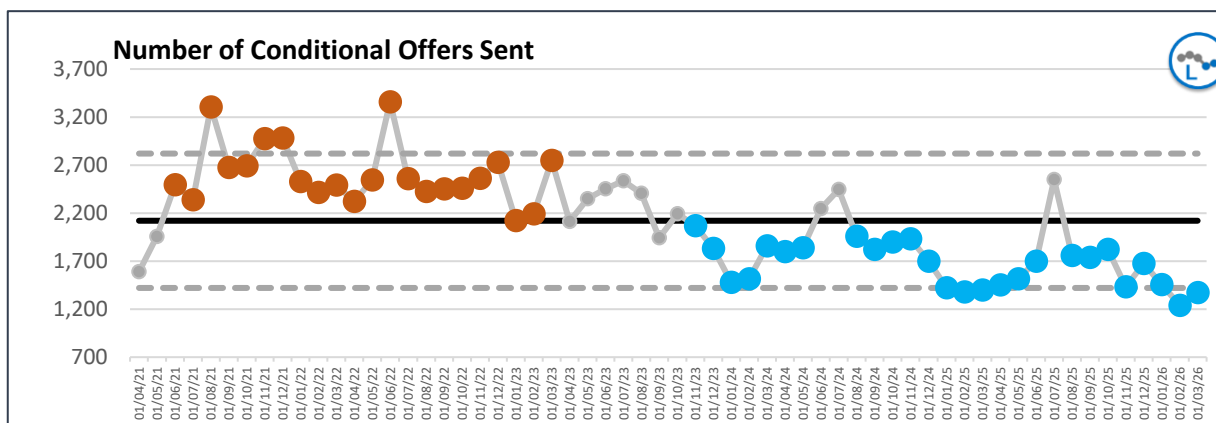
Appendix 3 – Health Org Performance comparison 31st March 2026

KPIs Mar 26	KFA	Target	SB	AB	BCU	C&V HEALTH ORG KPIs Financial Information	CTM	HD	PHW	PTHB	VEL	WAST	HEIW	DHCW
Professional Influence Savings- YTD	Our Value		£81.189 m	£42.854 m	£66.196 m	£47.898 m	£40.905 m	£15.181 m	£1.902 m	£0.982 m	£2.030 m	£3.098 m	£0.081 m	£0.327 m
Employment Services														
Payroll Services														
NWSSP Pay Accuracy	Our Services	99.6%	99.86%	99.98%	99.96%	99.93%	99.96%	99.98%	100.00%	99.93%	99.81%	100.00%	99.87%	100.00%
Overall Pay Accuracy	Our Services	99.6%	99.77%	99.90%	99.83%	99.82%	99.73%	99.88%	99.80%	99.81%	99.72%	99.69%	99.87%	99.96%
Calls Handling % Quarterly Average	Our Services	95%						99.0%						
Organisation KPIs Recruitment														
Vacancy creation to unconditional offer	Our Services	71 days	86.4	56.8	67.7	84.3	79.9	49.8	47.0	64.8	63.4	70.4	47.8	60.5
Time to Approve Vacancies	Our Services	10 days	40.0	7.4	3.9	30.2	24.4	9.1	5.2	2.3	0.8	0.7	7.5	0.4
Time to Shortlist by Managers	Our Services	3 days	20.4	5.6	5.9	6.2	8.6	1.6	8.2	6.2	14.1	3.0	19.5	9.5
Time to notify Recruitment of Interview Outcome	Our Services	3 days	4.0	3.3	1.9	1.5	2.8	1.8	4.2	2.3	7.5	3.0	21.0	3.5
NWSSP KPIs Recruitment														
Time to Place Adverts	Our Services	2 days	1.3	1.8	1.5	1.8	1.7	1.9	1.6	1.8	1.6	1.6	1.6	2.0
Time to Send Applications to Manager	Our Services	2 days	1.0	1.0	1.0	1.0	1.0	1.1	1.0	1.0	1.0	1.0	1.0	1.0
Time to send Conditional Offer Letter	Our Services	4 days	3.4	3.6	3.8	3.6	3.6	3.6	3.3	3.5	1.4	3.8	3.2	2.4
Calls Handling % Quarterly Average	Our Services	95%						99.1%						
Procurement Services														
Procurement Savings- YTD	Our Value		Target £3.707m Actual £6.263m	Target £6.076m Actual £11.874m	Target £4.280m Actual £8.788m	Target £5.387m Actual £8.008m	Target £3.518m Actual £6.287m	Target £2.864m Actual £6.346m	Target £0.237m Actual £0.063m	Target £0.333m Actual £0.790m	Target £0.284m Actual £1.431m	Target £0.045m Actual £0.428m	Target £0.004m Actual £0.047m	Target £0.000m Actual £0.000m
Accounts Payable														
Call Handling% - Quarterly Average	Our Services	95%						98.6%						
PSPP Compliance non NHS	Our Services	95%	96.7%	96.8%	96.7%	94.4%	94.8%	96.6%	97.1%	91.5%	96.8%	98.5%	97.5%	99.5%
PSPP Compliance NHS	Our Services	95%	87.1%	95.5%	88.6%	85.6%	71.0%	81.6%	96.0%	82.0%	81.7%	98.3%	98.9%	98.6%
Audit & Assurance														
Audits reported to Agreed Audit Committee (Excluding External Factors)	Our Services	80%	88%	87%	85%	64%	61%	76%	92%	78%	69%	75%	82%	92%
% of Audit outputs in progress	Our Services		39%	28%	26%	27%	35%	21%	33%	19%	29%	0%	0%	8%
Report turnaround (15 days) management response to Draft report - YTD	Our Services	80%	62%	39%	62%	77%	27%	80%	88%	85%	50%	25%	80%	70%
Report turnaround (10 days) draft response-final- YTD	Our Services	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%
Primary Care Services														
Primary Care payments made accurately and to timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Patient assignments actioned within 24 hours	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Urgent medical record transfers to/from GPs and other Primary Care Agencies within 2 working days	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A
Cascade Alerts Issued within timescale	Our Services	100%	100%	100%	100%	100%	100%	100%	N/A	100%	N/A	N/A	N/A	N/A

Employment Services – Recruitment

For information - All Wales performance in relation to recruitment time to hire for the last 12 months ending March 26.

Recruitment		Vacancy Creation to Unconditional Offer														
Org	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Trend	
AB	71	64	58	59	61	58	62	60	68	63	57	64	63	57		
BCU	71	56	60	58	63	68	64	65	62	62	66	68	70	68		
CV	71	95	88	86	94	102	104	98	107	116	90	95	94	84		
CTM	71	74	70	68	70	71	70	69	71	74	77	76	85	80		
HD	71	51	48	49	50	49	55	52	48	50	51	55	59	50		
HEIW	71	47	60	48	58	63	55	49	49	55	61	58	60	48		
DHCW	71	32	34	58	46	48	59	57	47	47	46	55	56	61		
NWSSP	71	61	58	54	58	42	52	57	54	48	51	55	54	56		
PTHB	71	81	65	68	71	58	68	64	72	78	69	71	62	65		
PHW	71	63	55	59	58	59	55	53	61	61	50	62	50	47		
SBU	71	72	76	73	70	70	80	73	85	79	81	85	92	86		
VEL	71	54	55	50	54	50	57	63	54	44	53	53	55	58		
WAST	71	76	84	96	76	78	63	72	74	88	77	71	75	70		
All Wales	71	62	62	62	62	61	64	64	64	63	62	65	65	62		



Employment Services – Recruitment



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Shared Services
Partnership

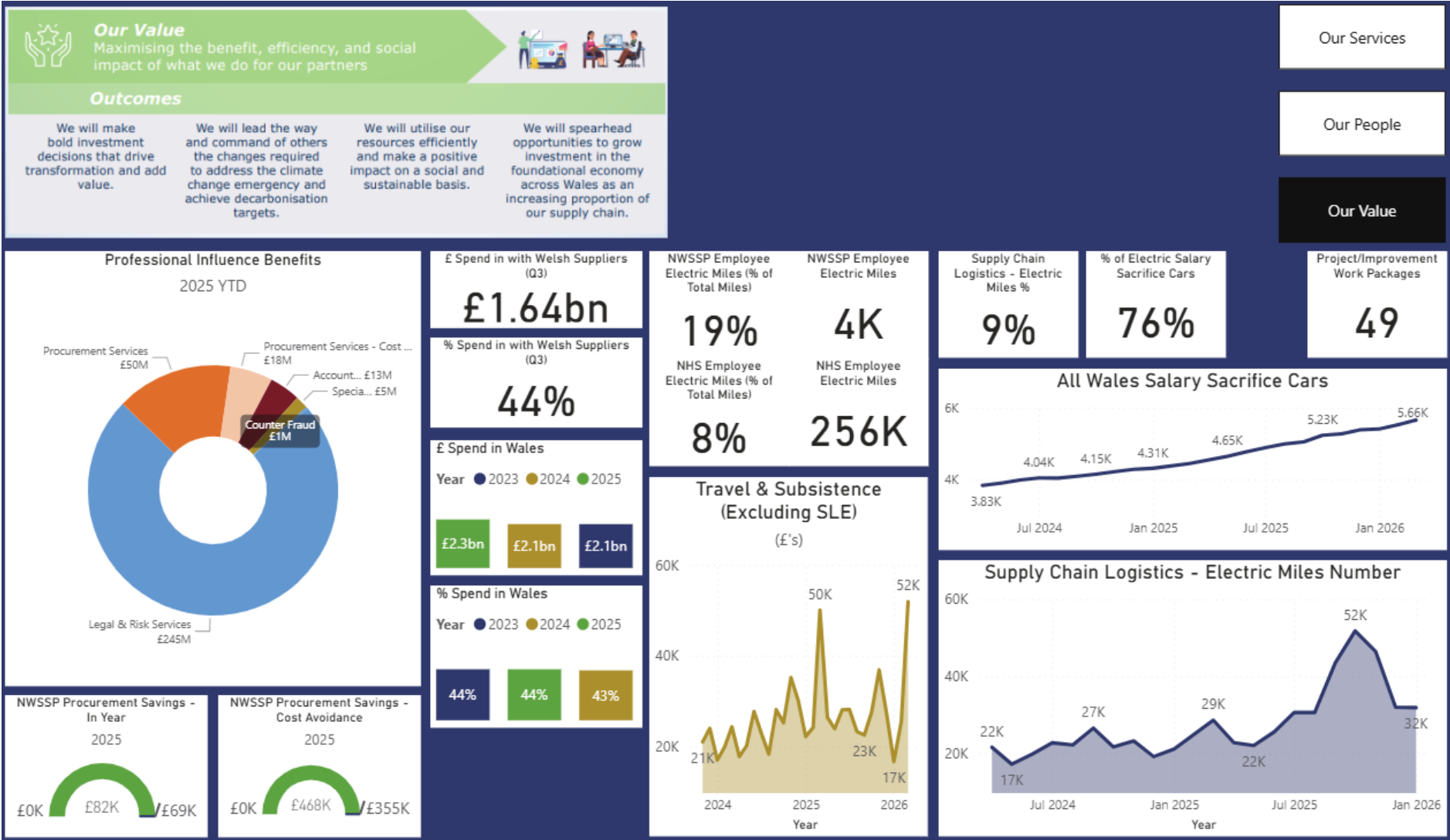
The charts below show the Vacancy creation to unconditional offer performance for the individual organisations October – March 26.



Appendix 4 – Outcome Reporting



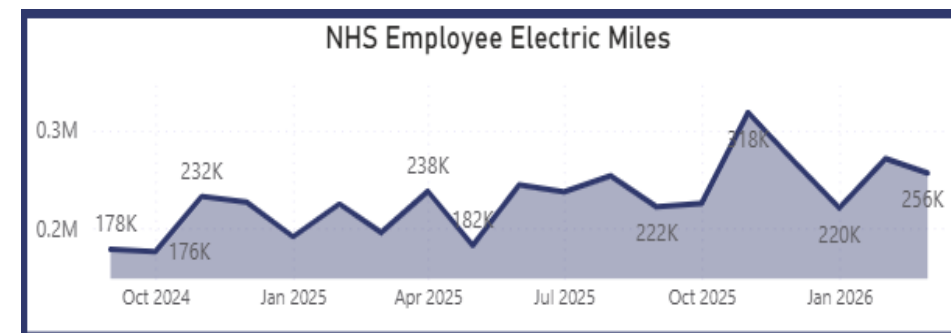




Mileage Claims

For information - The table below provides an overview of the total mileage claims by organisation, along with the proportion that are electric miles in March 26.

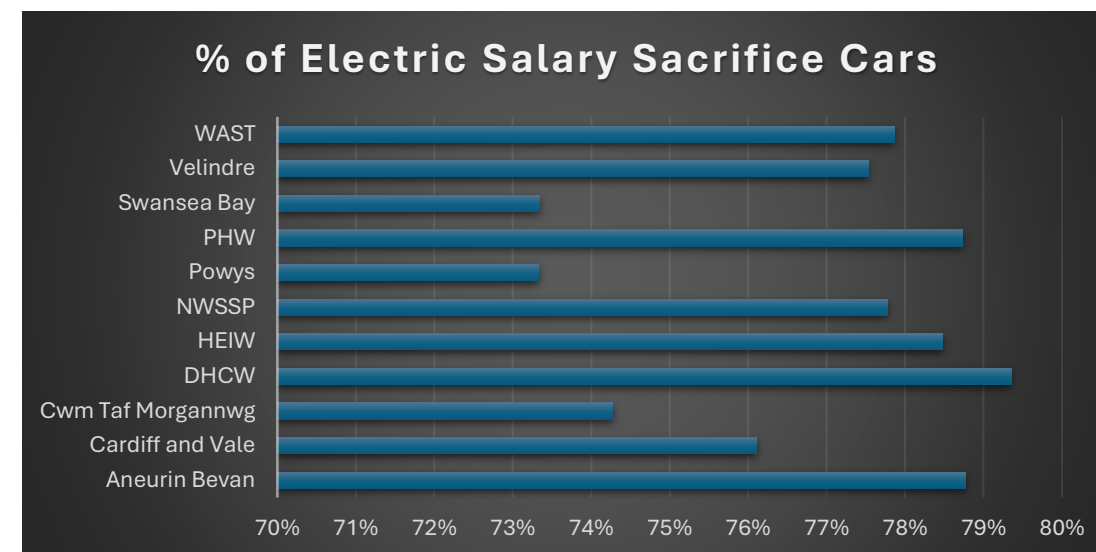
Organisation	Total Miles Claimed	Electric Miles Claimed	Electric Miles %
Cardiff & Vale	165,235	9,871	6%
WAST	162,930	21,298	13%
DHCW	11,553	2,717	24%
CVB	6,940	-	0%
Public Health	70,611	6,475	9%
AB	411,946	36,677	9%
NWSSP SLE	327,214	22,716	7%
NWSSP exc SLE	18,917	3,587	19%
BCU	587,515	58,607	10%
Powys	161,579	11,474	7%
HEIW	10,605	1,823	17%
Hywel Dda	427,642	28,044	7%
Cwm Taf	365,372	28,253	8%
Velindre	17,024	887	5%
Swansea Bay	304,619	23,877	8%
Total	3,049,702	256,305	8%



Salary Sacrifice Cars

For Information - The table and chart below provide an overview of the total number of vehicles managed under the NWSSP scheme, along with the proportion that are electric as of March 26.

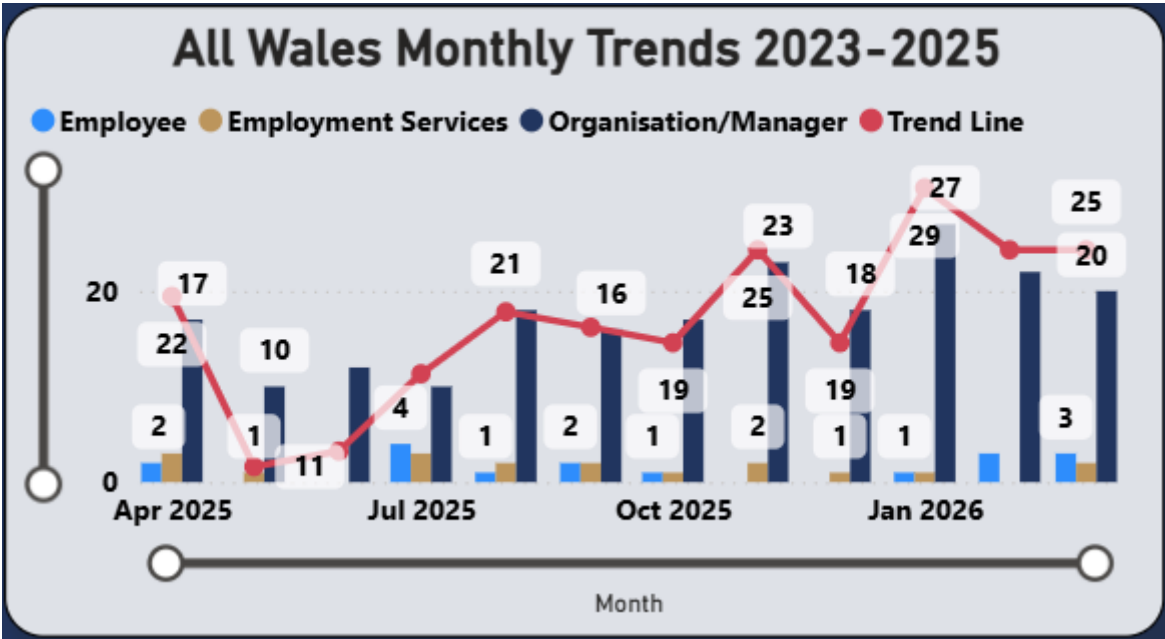
Organisation	Total Cars	Live Electric	Live Hybrid	Live Petrol	% Electric
Aneurin Bevan	1060	835	200	25	79%
Cardiff and Vale	1080	822	218	40	76%
Cwm Taf Morgannwg	964	716	206	42	74%
DHCW	155	123	28	4	79%
HEIW	79	62	15	2	78%
NWSSP	360	280	79	1	78%
Powys	120	88	25	7	73%
PHW	174	137	33	4	79%
Swansea Bay	1024	751	225	48	73%
Velindre	138	107	28	3	78%
WAST	506	394	100	12	78%
TOTAL	5660	4315	957	188	76%



Supporting information for the Procurement savings - The table below provides an overview of the identified cash releasing procurement savings by procurement team for April – March 2026.

HB	HDT	
TEAM DELIVERING SAVINGS	Target	Actual
HYWEL DDA PROCUREMENT TEAM	£659,320	£1,974,936
NATIONAL - CLINICAL	£311,162	£329,243
NATIONAL - COMMISSIONING	£12,443	£12,443
NATIONAL - ENERGY	£1,179	£8,432
NATIONAL - HOTEL SERVICES AND TEXTILES	£42,139	£52,812
NATIONAL - ICT & OFFICE EQUIPMENT	£61,383	£104,459
NATIONAL - MAINTENANCE	£8,611	£52,122
NATIONAL - MEDICAL	£257,613	£333,770
NATIONAL - PHARMACY	£1,450,290	£3,462,963
NATIONAL - PROVISIONS	£59,885	£15,377
	£2,864,023	£6,346,557

For information - The chart below provides a summary of the payroll overpayment volumes for the organisation, based on data from the overpayments dashboard covering the period from April to March 2026.



Note: The data was recorded as at the end of March .



*Delivering
Value, Innovation and
Excellence through
Partnership*

2.4

10:15, 15 Mins

2.4 - UEC BUSINESS CASE:
IMPLEMENTATION AND EVALUATION- TO
FOLLOW

*Keith Jones (Hywel
Dda UHB - Director
of Operational
Planning &
Performance)*

| For assurance

3 - ESCALATION OVERVIEW

3.1

10:30, 15 Mins

3.1 - ESCALATION OVERSIGHT AND HIGHLIGHT REPORT

**Shaun Ayres (Hywel
Dda UHB - Director
of Delivery)**

| For assurance

Attachments

[Escalation Oversight and Highlight Report FPC 30 June 2026.pdf](#)



ESCALATION UPDATE AGAINST TARGETED INTERVENTION CRITERIA

30 June 2026

Mr Lee Davies, Director of Strategy and Planning
Mr Shaun Ayres, Director of Delivery

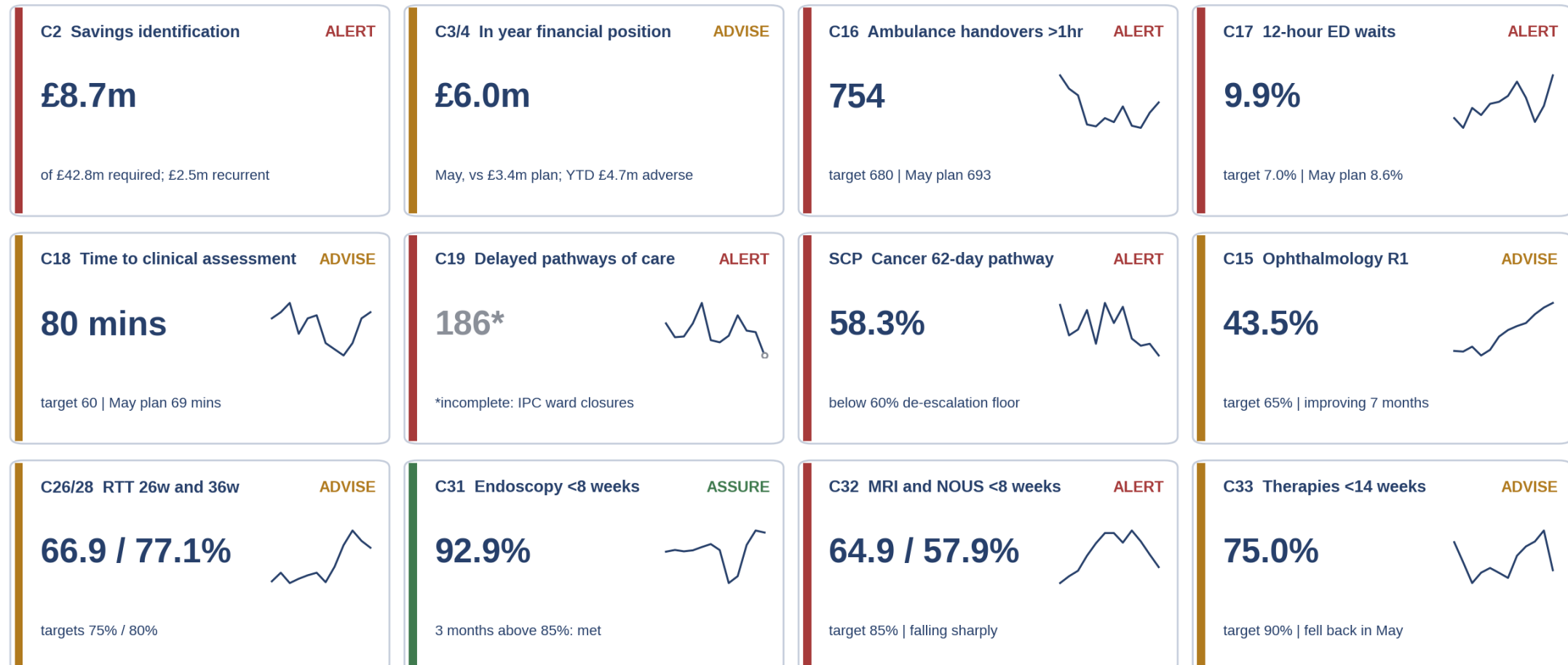
Escalation Dashboard: Position at a Glance



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Six alert, five advise, one assure. Urgent and emergency care moved against the Health Board in April and May; the savings gap is the dominant financial risk; the May delayed pathways figure is incomplete, with no improvement claimed.





Year to date £4.7m adverse to plan

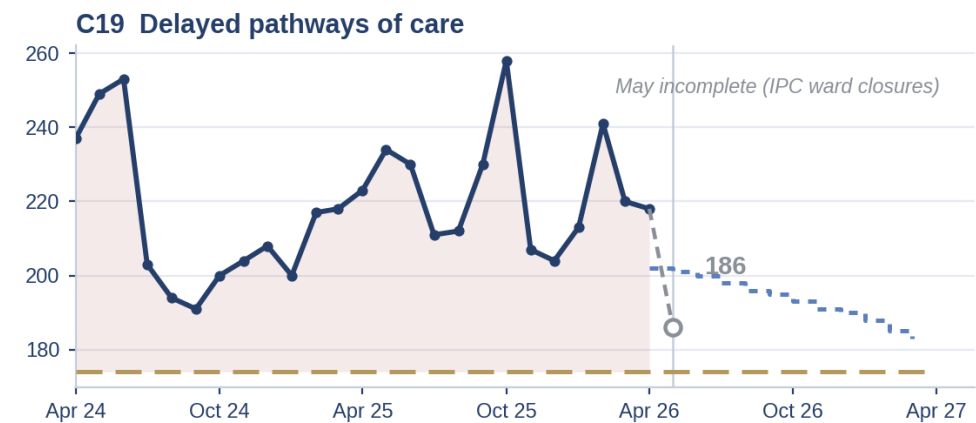
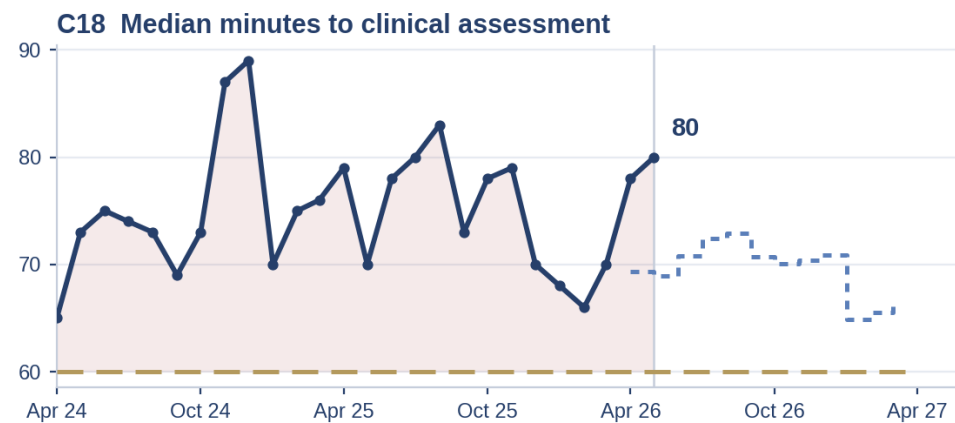
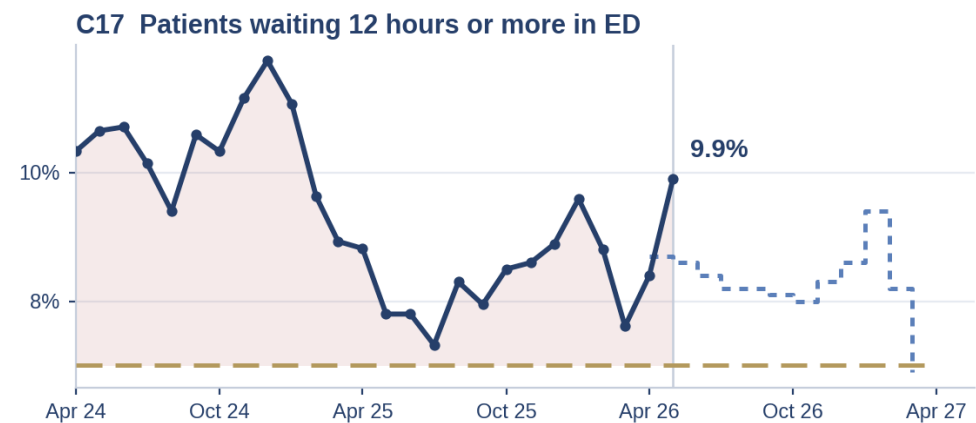


Identified schemes forecast to deliver in full; the gap is identification, not slippage

- **Position.** Two months in, we are £4.7m adverse to plan: May run rate £6.0m against a £3.4m monthly plan. We delivered the 2025/26 control total; the 2026/27 run rate is above plan from month one.
- **Forecast.** Year end is reported on plan at £41.0m only by assuming £20.9m of future mitigating actions not yet converted into schemes. The gross forecast is £61.9m.
- **Savings.** £8.7m identified against the £42.8m requirement; only £2.5m is recurrent against a wholly recurrent target. Welsh Government requires updated plans with full delivery confidence by 12 June.
- **Considerations.** Expenditure above plan (medical premium cover £8.3m, continuing healthcare £4.3m) compound delivery; the radiology outsourcing saving now presents as a risk (see diagnostics).

Urgent and Emergency Care: the gap to close

Three of the four criteria moved away from target in April and May; C18 (advise) has risen three months running to 80 minutes against the 60-minute standard. May sat above the signed off plan profile on all four measures.



C16 Ambulance Handovers: the run has reset

ALERT

WORSENING: run below target broken in May



- **Position.** 754 handovers over one hour in May, against the 680 de-escalation threshold and a May plan profile of 693.
- **Signal.** February to April sat below the threshold; May broke that run and is the worst month since August 2025.
- **Plan.** The signed off profile tightens to 530 in September; the year must total 7,542.
- **Action.** Community streaming hub goes live in June; same day emergency care at Withybush is scheduled for October. These actions and impacts will need to be monitored; however, they are unlikely to deliver improvements beyond the annual plan trajectory.

C17 Twelve Hour Waits: a 16-month high

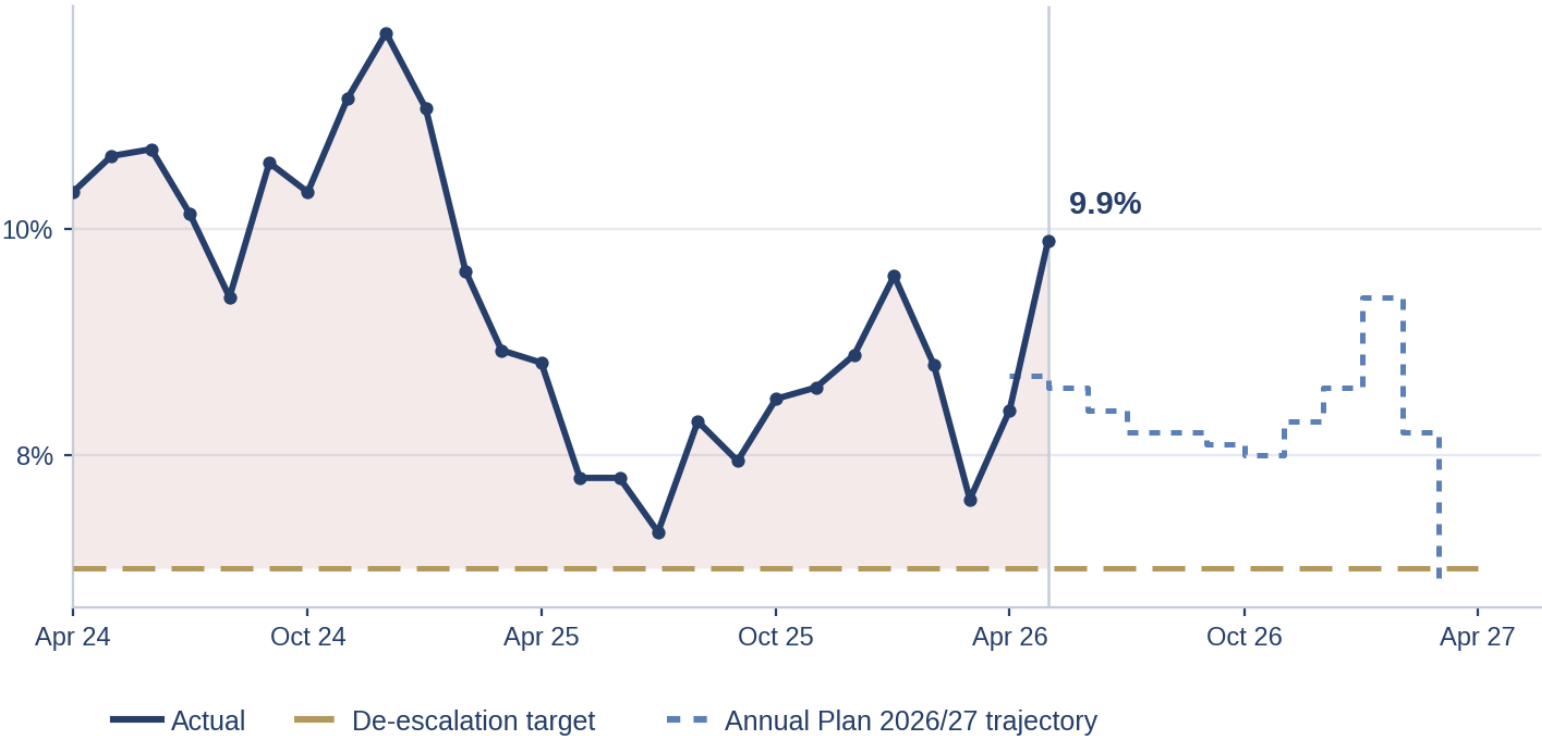


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ALERT

WORSENING: highest since January 2025



- **Position.** 9.9% of patients waited 12 hours or more in our emergency departments in May, against the 7% criterion and an 8.6% May plan.
- **Signal.** A statistically significant deterioration, not noise. Glangwili (15.1%) and Withybush (15.2%) drive the position; Prince Philip held zero.
- **Plan.** The profile averages 8.3% across the year and lands at 6.9% in March; the criterion is continuous improvement towards 7%.
- **Action.** Flow actions concentrate on the two outlier sites; the plan relies on same day emergency care from October for a 2.6 percentage point reduction (impact).

C19 Delayed Pathways: May is incomplete

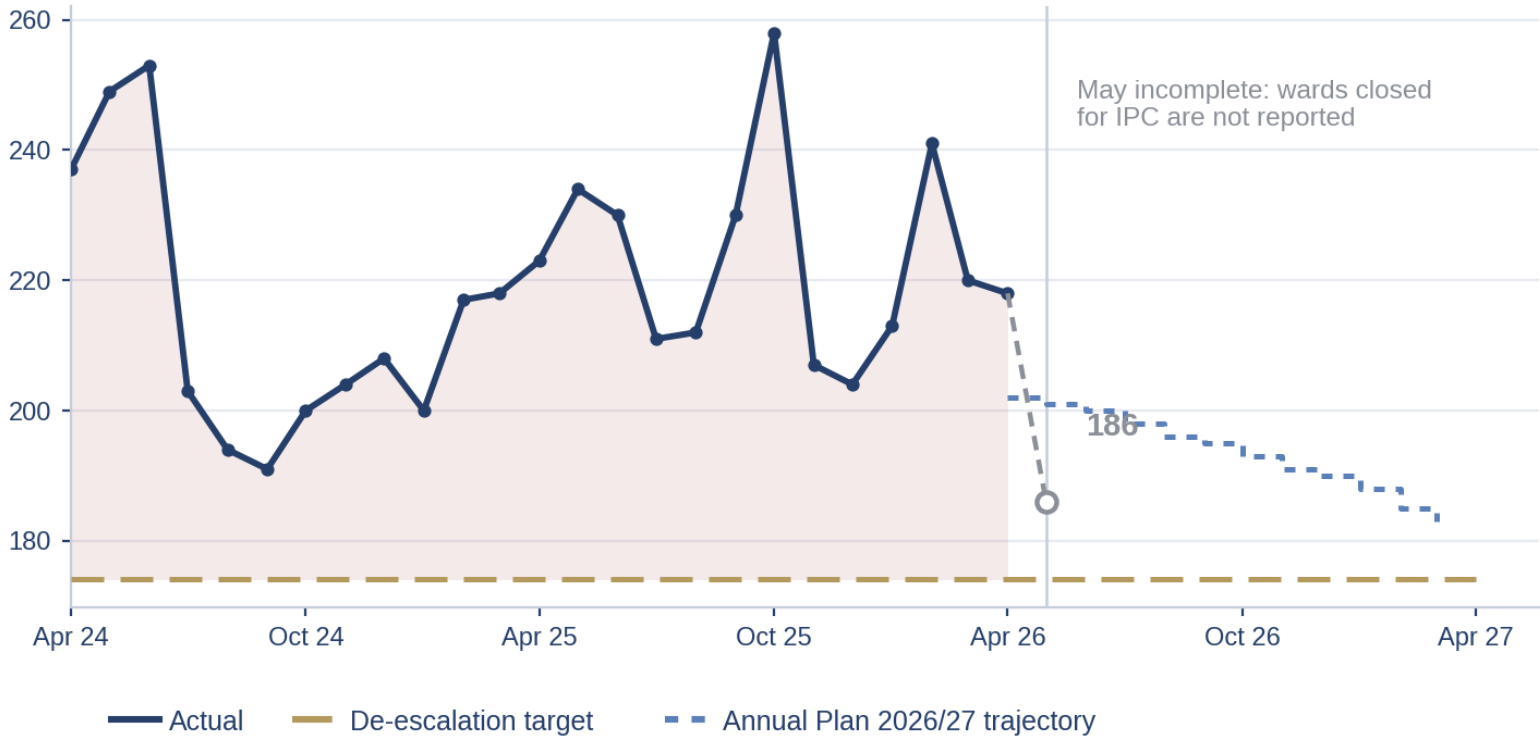


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ALERT

DATA INCOMPLETE: no improvement claimed



- **Position.** April, the last complete month, recorded 218 delayed pathways of care against the 174 criterion and a 202 April plan.
- **Data.** May reports 186, but wards closed for infection prevention and control do not report delays. We treat May as incomplete and claim no improvement.
- **Plan.** The trajectory steps down to 183 by March 2027. The criterion remains a 5% reduction sustained for three consecutive months.
- **Action.** Reporting coverage returns as wards reopen; we will restate May alongside the June data. However, DPOCs remain a key driver of performance and a significant concern.

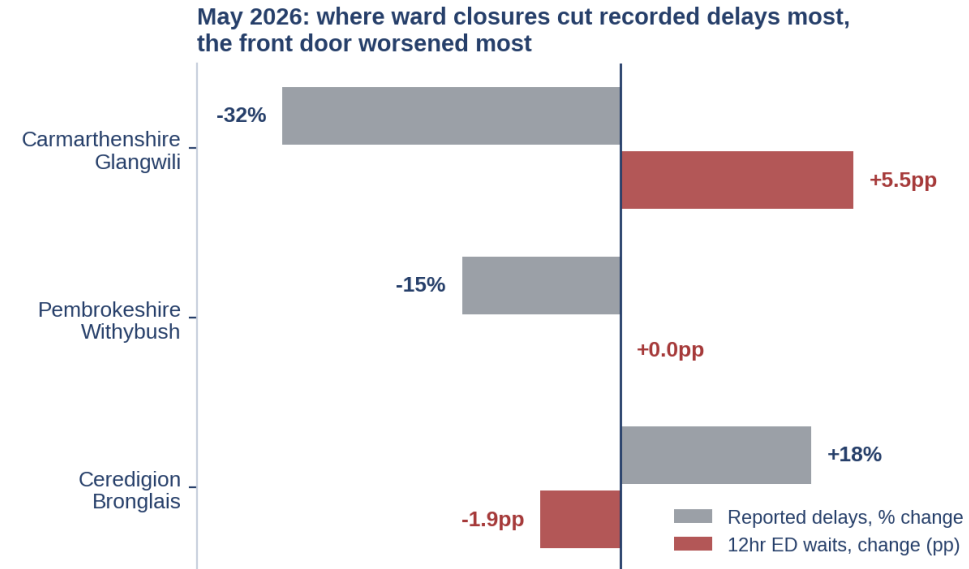
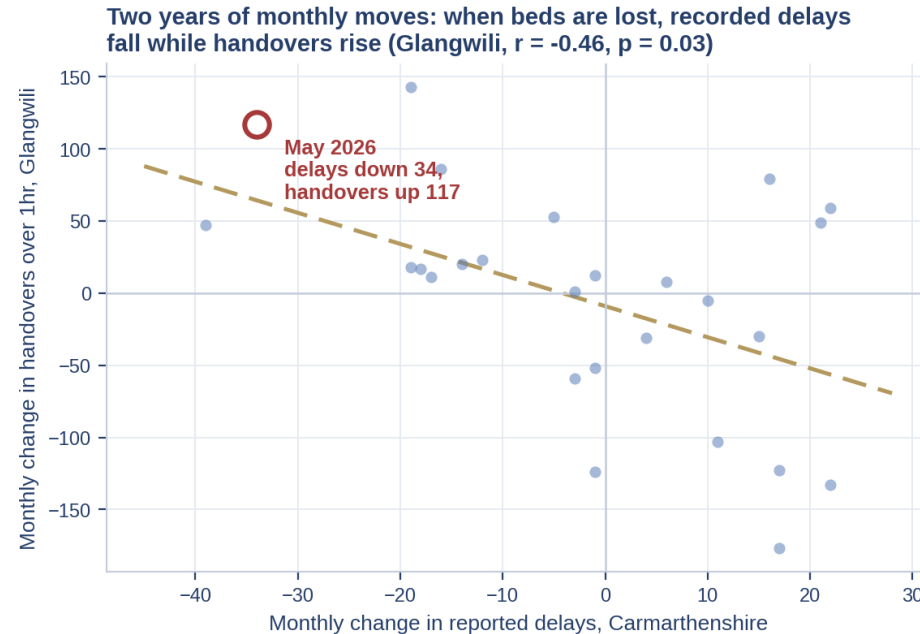
C19: Fewer beds, fewer counted delays



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County delay counts set against their acute sites: Carmarthenshire with Glangwili and Prince Philip, Pembrokeshire with Withybush, Ceredigion with Bronglais.

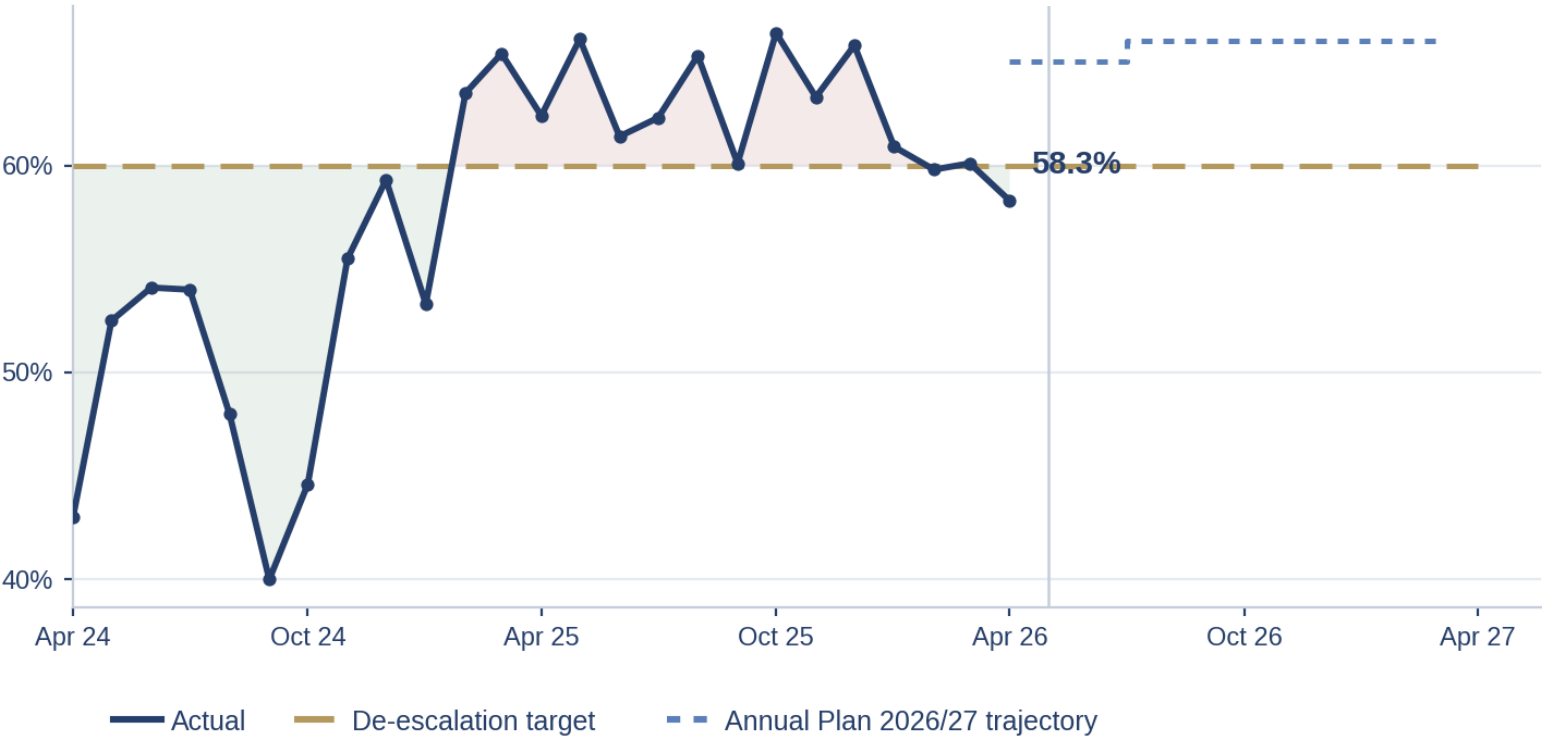


- Why this looks back to front: more delays should mean a more congested hospital. But a delay can only be recorded against an open, staffed bed. When wards close, recorded delays fall at exactly the moment beds are lost: the count improves on paper while the front door worsens in reality.
- May is the clearest example yet. Wards closed for infection prevention and control cut both the recorded delays in Carmarthenshire (down 32%) and the beds available to admit into, and Glangwili deteriorated most in the health board. Ceredigion, where recorded delays rose, improved on every front door measure.
- For the committee: a falling delay count is not always good news; this month it is a symptom of lost capacity, not improved flow. The restated June position will show the true delay level once the wards reopen.

Cancer: Below the de-escalation floor

ALERT

BELOW DE-ESCALATION FLOOR in April



- Position.** 58.3% of patients started first definitive treatment within 62 days in April, against the 60% floor that secured de-escalation and a 65% quarter one plan.
- Signal.** Two of the last three months below the floor (February 59.8%, March 60.1%, April 58.3%); the worst month since January 2025.
- Implication.** De-escalation in February 2026 rested on 60% sustained. Re-escalation of this criterion is now a live risk.
- Action.** Tumour site recovery actions under P&S CCG. There is a clear correlation in the reduction in outsourcing of 8 weeks and the impact on the SCP performance.

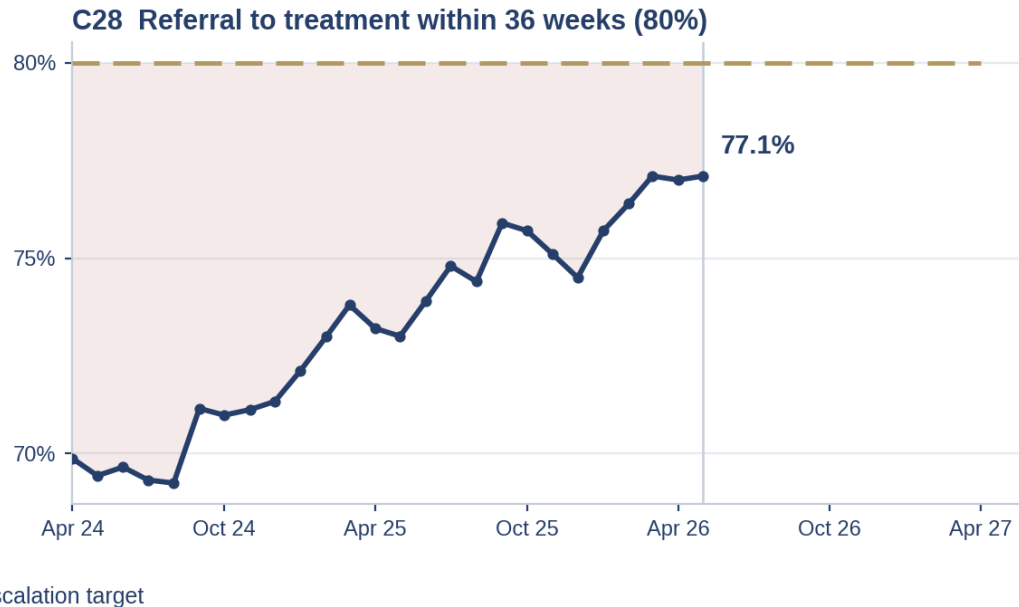
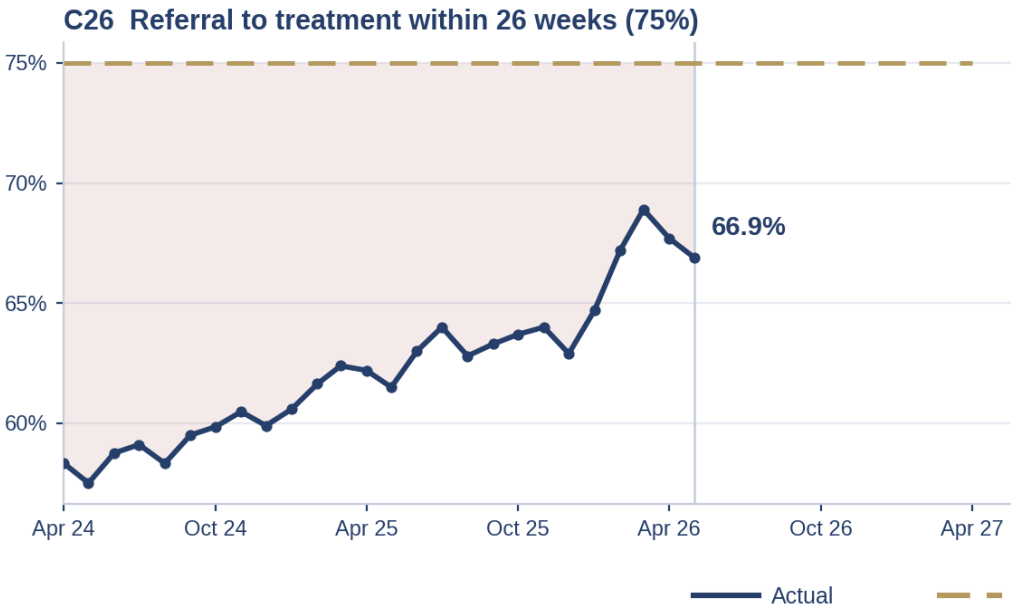
Planned Care: the recovery has stalled



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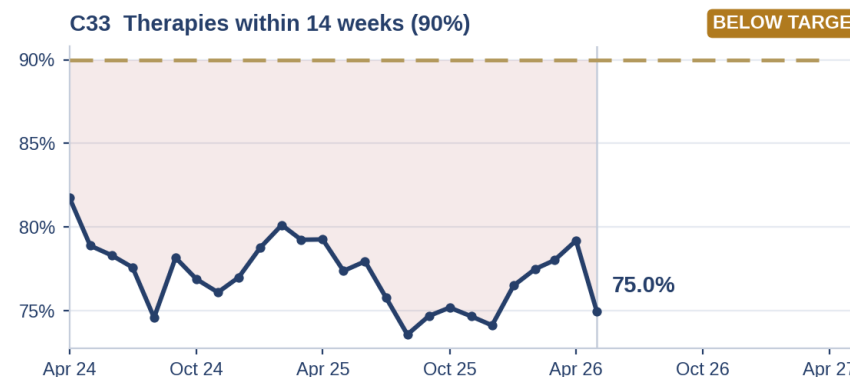
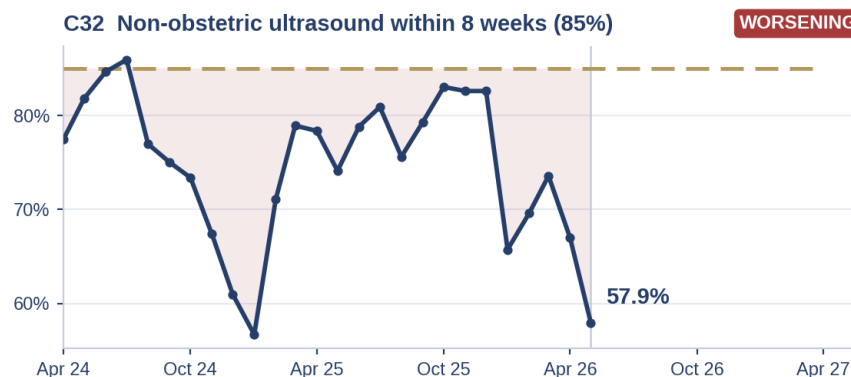
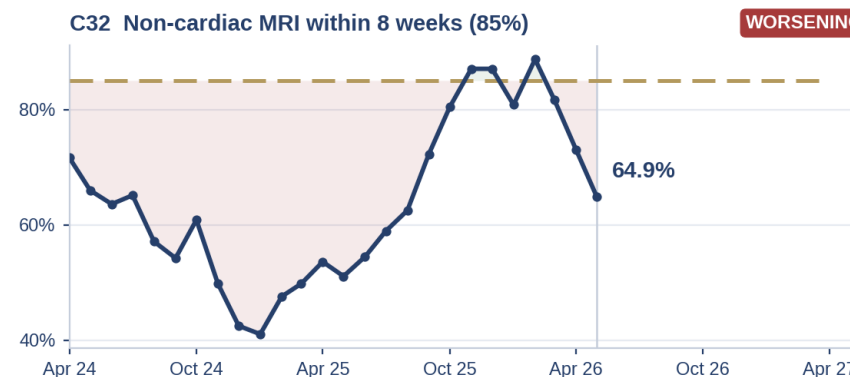
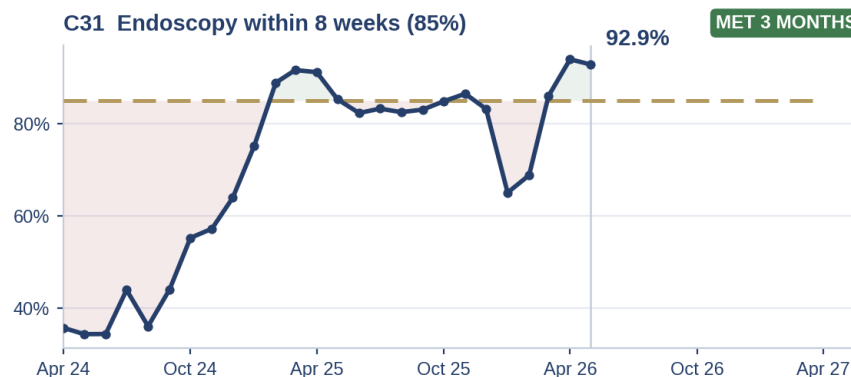
- **26 weeks.** 66.9% in May. The recovery from 62.9% in December peaked at 68.9% in March and has slipped for two months since.
- **36 weeks.** 77.1%, flat against the 80% criterion for four months. Stability is not the same as progress towards the target. Although, it doesn't need to be considered against the backdrop of the annual plan and wider reduction in recovery monies.
- **Follow ups.** 14,842 patients waiting beyond target against the 11,368 threshold; improving steadily from 15,753 in January.

Diagnostics: one met, two moving away



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— Actual — De-escalation target

- **Endoscopy has met its de-escalation test** with three consecutive months above 85%.
- **MRI (64.9%) and ultrasound (57.9%) are deteriorating sharply.** This connects to the radiology workforce risk on the finance slide: the outsourcing of 8 weeks and the imaging position are one issue, not two.

Internal Escalation: the balance has turned



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Internal escalation levels by domain, May 2026

	Quality	Governance	Workforce	Finance*	Planning	Pop. health	Performance
Community and integrated medicine	3	3	2	3	3	2	3
Planned and specialist care	3	2	3	3	3	3	3
Mental health and learning disabilities	3	1	2	3	3	3	3
Operational allied health	2	1	2	3	3	1	3
Primary care	2	1	2	1	2	3	3
Chief operating officer management	1	1	2	2	1	1	n/a
Executive functions (highest)	2	2	2	3	1	3	3

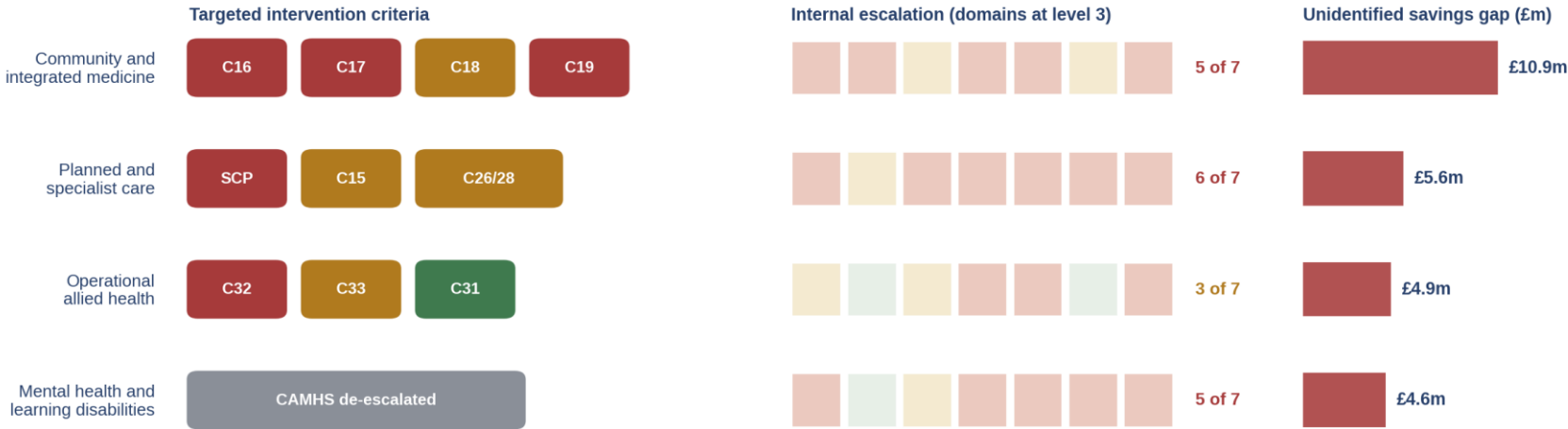
* Finance domain: two care group levels under review for level 4; executive director of finance to confirm.

Levels: 1 routine (green) | 2 enhanced (gold) | 3 intensified (salmon) | 4 highest (red). May 2026 scoring.

- **Movers.** Quality escalated two functions up and workforce three; performance moved the cancer pathway up and added cardiology at level 3; population health de-escalated four.
- **Finance.** Two care group finance levels are under review for level 4, with the executive director of finance to confirm. Long term agreements sit at level 3 on Swansea Bay activity trends.
- **Direction.** In April the net movement was downward; this cycle it is upward. The internal system has turned with the same data the criteria show.
- **Integrity.** The community and integrated medicine performance score cites 186 delayed pathways, the figure we treat as incomplete, so its level is if anything understated.

Alignment: one risk, three lenses

The same groups carry the alert criteria, the internal escalation and the savings gap



Chips: red alert, gold advise, green assure. CAMHS criteria were de-escalated in February 2026 and quality oversight continues at the quality committee. Primary care, chief operating officer management and executive functions carry no alert criteria and £8.1m of the gap between them.

- The three groups holding every alert criterion also hold £21.4m of the £34.1m unidentified savings (63%) and 14 of the 26 internal level 3 positions; adding mental health, the four most escalated groups carry £26.0m (76%).
- The implication is prioritisation, not addition: the front door actions, theatre and cancer recovery, the radiology decisions and savings conversion all route through the same management teams. Protecting their delivery capacity is the committee's main lever.



THE FINANCE AND PERFORMANCE COMMITTEE IS ASKED TO:

- **NOTE** and scrutinise the urgent and emergency care de-escalation position (criteria 16 to 18), and the June actions (community streaming hub, front door changes) on which recovery now depends.
- **ACKNOWLEDGE** the May delayed pathways figure as incomplete because of the infection prevention and control ward closures and endorse restating May alongside the June data.
- **SCRUTINISE** the cancer position below the 60% de-escalation floor within the IPAR.
- **CONSIDER** and **CHALLENGE** the 2026/27 financial position at month 2: £4.7m adverse to plan, a £34.1m savings identification gap against the £42.8m requirement, and a year end forecast held at £41.0m only by £20.9m of unconverted mitigating actions.
- **REVIEW** the internal escalation position movements

4 - ESCALATION RESPONSE – RECOVERY ACTION PLANS AND IMPROVEMENT TRAJECTORIES

4.1

10:45, 15 Mins

4.1 - DE-RISKING THE ANNUAL PLAN -
SUMMARY OUTPUT FROM IN-COMMITTEE
BOARD- TO FOLLOW

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

| For assurance

5 - FINANCE

5.1

11:00, 15 Mins

5.1 - 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

FPC SBAR - P02-27 Financial Performance Assurance Report final.pdf

Appendix 1 - P02-27 Finance Performance Report.pdf



PWYLLGOR CYLLID A PHERFFORMIAD FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial Performance Assurance Report – Month 2 2026/27
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Andrew Spratt, Deputy Director of Finance Jennifer Thomas, Head of Corporate Reporting

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to outline the Health Board's financial position to date against the Annual Financial Plan and assesses the key financial projections, risks and opportunities for the financial year, including the implications of in-year recurrent delivery for the forthcoming financial year.

Cefndir / Background

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.

Asesiad / Assessment

Month 2 Summary

- In-month deficit: In-month £6.0m (worse than plan by £2.6m)
- Savings gap: £34.1m (£8.7m delivered against a target of £42.8m)
- Forecast deficit: £41.0m dependent on £20.9m mitigations
- Overall: **High risk to delivery**

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	6.8	41.0
Unidentified / (Identified) savings gap / (improvement)	2.4	5.0	34.1
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core operational variation	0.2	(0.3)	(13.2)
Gross Forecast	6.0	11.5	61.9
Future Mitigating Actions	0.0	0.0	(20.9)
Reported Position	6.0	11.5	41.0

Welsh Government response to Annual Plan submission

Welsh Government has deemed the 2026/27 annual plan – forecasting a £41.0m deficit – unacceptable due to worsening financial and performance trajectories, and now requires a credible, fully deliverable savings plan and clear route to breakeven by the end of June 2026, supported by urgent actions to strengthen and de-risk existing savings schemes.

Appendix 1 sets out a detailed assessment of the current financial position, including the assumptions made around future mitigating actions that are not yet identified but required to achieve 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. Savings Plan Credibility

- Material under-identification (£34.1m) remains
- Heavy reliance on non-recurrent and unconfirmed mitigations
- Limited confidence in delivery trajectories
- No material action taken pertaining to conversion of underspends to savings

Implication:

There is a high risk to financial delivery and external credibility.

2. Underlying Deficit Deterioration

Underlying deficit remains significantly above last year's outturn, at £71.5m, with a savings gap persisting with no material action taken pertaining to the conversion of underspends to recurrent savings.

Implication:

This represents a significant structural imbalance, worsening future financial sustainability.

3. Cost Pressures and Uncontrolled Decisions

Key drivers include:

- Continued premium workforce spend (agency, locum and additional duties)
- Decisions taken outside planning assumptions, driven by service fragility risk
- Increasing demand-led pressures (e.g. CHC, out-of-area placements)

Implication:

These factors are compounding the delivery gap and reducing controllability.

4. Inadequate Cashflow

Cash is forecast to run out at the start of March 2026 with WG only likely to support the target control total. Ongoing dialogue pertaining to the acceptability of the annual plan continues with WG, and depending on the outcome, the cash management strategy could be required to be implemented.

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.

1. Accountability and Grip

a) Transition in Governance and Ways of Working

- New accountability framework introduced, replacing previous governance arrangements
- Shift from central control to devolved ownership, with Executive Directors accountable for delivery
- Monthly reporting through Executive Team to support oversight by the Accountable Officer (included within Appendix 1)

Implication:

This represents a significant cultural and operating model shift, however the effectiveness of the new approach is not yet evidenced and introduces transitional delivery risk.

b) Escalation and Accountability Risk

- Key operational areas (Community & Integrated Medicine; Planned & Specialist Care) are at risk of escalation to Level 4 due to savings delivery gaps
- Continued reliance on escalation indicates inconsistent ownership and grip across the organisation

Implication:

There is a material risk that accountability arrangements are not yet sufficiently embedded to drive delivery at pace.

2. Ministerial Priorities and Enabling Actions

Requirements include:

- 30% reduction in agency spend and variable pay from 2025/26 outturn
- Elimination of off-contract agency (achieved)
- Reduction in out-of-area placements
- Delivery of productivity improvements
- Strengthened workforce planning and sickness management

Current position:

- Success in reducing off-contract agency spend to nil
- Increase in on-contract agency spend due to service fragility and workforce pressures
- Ongoing non-compliance in MH&LD agency usage for Health Care Support Workers
- Out-of-area placements reduction plan not yet fully developed

Implication:

Delivery against ministerial priorities is mixed, with some progress but continued areas of non-compliance and emerging risks to credibility.

3. Budget delegation accountability letters from 2026/27 financial plan

Appendix 1 includes an update on the accountability letter responses, with a status as of 23 June 2026.

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

There is currently no risk foreseen of over or underspending of the Capital Resource Limit (CRL) at this stage. Capital plans will be reviewed in continuously and updates provided appropriately.

2. In-Year Investment Decisions

Investments, whether budgets are made available and delegated to services, made outside of annual plan process need to be approved by Public Board, and scrutinised through the Finance and Performance Committee. If there are financial consequences, and unless full or part funding can be identified to mitigate, this will give rise to an in-year negative central budget reserve with the recurrent funding requirement being included in next year's annual plan.

The Finance and Performance Committee will monitor the financial impact, and a summary of the current in-year negative central budget reserves are as follows:

Item Description	£'k	Approval status
Band 2/3 Funding shortfall	812	Presented to June 2026 Finance and Performance Committee
Resident Doctors contract	313 - 446	Approved via Chair's Action on 4 June 2026, financial costings to be finalised
Nurse Staffing Levels	TBC	Expected to be presented to July Public Board
Grand Total	1,125 - 1,258	

Argymhelliad / Recommendation

The Committee is asked to:

- **SCRUTINISE** and **CHALLENGE** the current financial forecast, including the reliance on £20.9m of unconfirmed mitigations
- **CHALLENGE** whether the current trajectory is sufficient to close the £34.1m savings gap and improve the underlying deficit position
- **ENDORSE** strengthened escalation and accountability arrangements in areas where delivery is at risk, including those at risk of Level 4 escalation
- **SUPPORT** immediate actions, where appropriate, to strengthen grip and control over key cost drivers, particularly workforce and demand-led pressures
- **SEEK ASSURANCE** that:
 - a credible, time-bound recovery plan is in place to close the savings gap
 - targeted recovery actions are being implemented in all portfolios with Alert or Advise status
 - the new Ways of Working and accountability framework are driving demonstrable improvements in financial control and delivery
- **RECOMMEND to Board for approval, having regard to their impact on the financial position and affordability**
- **NOTE** the material risks to financial sustainability, including:
 - the current forecast deficit position
 - the trajectory of the underlying deficit
 - cashflow will run out before the end of March 2027 without additional support from Welsh Government, that has not been confirmed to date

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.1.5.1 The reporting of monthly, year to date and forecast financial position alongside operational drivers; 3.1.5.2 Performance against the savings requirement; 3.1.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2326 (score 20) Risk to achieving 2026/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non-recurrent funding.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply Choose an item. Choose an item. Choose an item.

Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply Choose an item. Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply Choose an item. Choose an item. Choose an item.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termiau: Glossary of Terms:	BGH – Bronglais General Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili General Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush General Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy:	Finance Team Management Team Executive Team

Parties / Committees consulted prior to Sustainable Resources Committee:	
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.
Gweithlu: Workforce:	The report considers the financial implications of our workforce.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Gyfrinachedd: Privacy:	Not applicable.
Cydraddoldeb: Equality:	Not applicable.



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2026/27 Financial Performance Report

Finance and Performance Committee

Month 02 Reporting - May 2026/27

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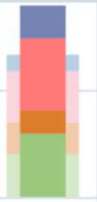
Key

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

Financial Accountability Status



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Background and Context

The Ways of Working consciously sets out to evolve the culture of the organisation away from imposed cost 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

Community & Integrated Medicine and Planned & Specialist Care are likely to be escalated to Level 4 in June 2026 should there not be a significant improvement in their assured savings gap and breakeven mitigation plans through the 18 June rapid savings reviews and submissions.

Executive Director Portfolio	Status	Explanation (Number of portfolios and their escalation levels)
Chief Executive	Assure	Delivering breakeven and savings
Chief Operating Officer	Alert	3 x Level 3 (2 of which are likely to be escalated to Level 4 in June 2026 due to Savings and Breakeven gap), 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)

Delegated Budget Accountability Letter Update



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The following table summarises the current status, as at 23 June 2026, for the signed acceptance and return of the Delegated Budget Accountability Letters, issued by the Accountable Officer (CEO) on 2 March 2026 to Executive Directors and Nominated Function Leads.

A similar summary will be provided to the Finance & Performance Committee on 30 June 2026, with any outstanding responses to be reviewed in a 1-2-1 meeting between the delegated officer and the CEO ahead of the committee meeting.

Executive Director Portfolio	Executive Director	Nominated Lead	Comments
Chief Executive	N/A	Complete	
Chief Operating Officer	Complete	Complete	
Executive Medical Director	Complete	Complete	
Executive Director of Nursing, Quality and Patient Experience	Complete	Complete	
Executive Director of Workforce and Organisational Development	Complete	Complete	
Executive Director of Finance	Complete	Complete	
Executive Director of Strategy and Planning	Outstanding	Outstanding	Strategy & Planning outstanding, LTA received
Executive Director of Public Health	Complete	Awaiting	Re-issued from Deputy to Assistant Director
Executive Director of Allied Health Professions and Health Sciences	Partial	N/A	Awaiting signed letter, received covering email

Actionable Insights – Top Priority Alerts



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Action / Decision	£m	Description	Owner	Status	Due Date
Medical pay and rostering Additional cover at premium costs	8.3	Continuing use of additional medical cover, including premium locum and agency in BGH, WGH, Planned Care and Mental Health. The Medical Rate card has been adopted and an impact assessment is required of its compliance across the Health Board. The comprehensive use of Allocate also needs to be embedded.	Mark Henwood	Paper to Finance and Performance Committee	30 June
Identification and delivery of robust savings plans	34.1	There is a significant identification gap for savings schemes across Clinical Care Groups, Estates & Facilities and Pharmacy & Medicines Management. Escalation for the Finance domain is partly due to risk associated with delivering the annual plan equitably across services. This has been highlighted by Welsh Government and NHS P&I at the escalation meetings of w/c 1 June with the clear requirement of a savings plan with 100% delivery confidence.	All Executive Directors, excluding Workforce, Finance and Chief Executive	Outstanding, urgent action required as part of de-risking the annual plan with deadline of 12 June (In-Committee Board 18 June) prior to paper to Finance and Performance Committee	30 June
Robustness of Continuing Healthcare approach	4.3	A revised forecast approach has been introduced in Month 2. Urgent action required - for full review of CHC spend levels and mitigating actions to reduce activity demand.	Richard Jenkins along with CHC Service Leads	Paper to Finance and Performance Committee	30 June
Conscious decisions compounding delivery of Annual Plan		Known decisions have been made outside of the annual planning process: - Newly qualified streamlining nursing over establishment - Anaesthetist rate card extended, increasing Medical costs - Breast consultant over-established – retiree budget should have offset - Out of area MH&LD outsourcing beds – Ministerial Priorities conflict - Patient Flow Unit established without business case approval - First Contact Point Physiotherapy service continuation despite cessation of Cluster funding, exit strategy required where funding will cease. - Resident Doctors – additional 5wte for Medical rotas in WGH	Sharon Daniel Mark Henwood Andrew Carruthers Andrew Carruthers Andrew Carruthers Andrew Carruthers Mark Henwood	Update paper required No further extension Confirmation required Review/plan required OCP2 finalisation Defined exit strategies for non recurrent funding Chair's action approved	Overdue

Cash Releasing Savings



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- Savings figures are shared, based on the finalised Month 2 Savings tracker as at 5 June 2026.
- Several areas have underspent against budget in Month 2, further opportunities exist to convert these to recurrent savings, as highlighted through the 'rebuttable' process in the annual plan.
- The table below include Cash-Releasing savings – those which are reportable to Welsh Government.

Portfolio (£'m)	Target	Delivery (G&A)	Gap	Green	Amber	Red	Blue	Total
Chief Operating Officer Management	0.8	0.0	0.8	0.0	0.0	0.0	0.0	0.0
Community and Integrated Medicine	12.5	1.6	10.9	0.4	1.2	3.6	0.4	5.6
Mental Health and Learning Disabilities	6.4	1.8	4.6	1.8	0.0	0.1	1.0	2.9
Operational Allied Health and Health Sciences	4.9	0.0	4.9	0.0	0.0	0.7	0.1	0.8
Planned and Specialist Care	5.9	0.3	5.6	0.3	0.0	3.5	0.0	3.8
Primary Care	0.2	0.2	0.0	0.0	0.2	0.0	0.0	0.2
Executive Functions	12.1	4.8	7.3	3.2	1.6	0.5	2.4	7.7
Grand Total	42.8	8.7	34.1	5.7	3.0	8.4	3.9	21.0

Run Rate Reduction Savings



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- Savings figures are shared, based on the finalised Month 2 Savings tracker as at 5 June 2026.
- The table below includes Run Rate Reduction savings – these are not formally recognised as Savings and neither are they reportable to Welsh Government.
- Green and Amber schemes are included within the Forecast, with Red and Blue required further action to convert to delivery.

Portfolio (£'m)	Green	Amber	Red	Blue	Total
Chief Operating Officer Management	0.0	0.0	0.0	0.0	0.0
Community and Integrated Medicine	0.0	0.0	0.0	0.0	0.0
Mental Health and Learning Disabilities	0.0	0.0	0.0	0.0	0.0
Operational Allied Health and Health Sciences	0.0	0.0	0.0	4.2	4.2
Planned and Specialist Care	0.0	0.0	1.7	0.0	1.7
Primary Care	0.0	0.0	0.0	0.0	0.0
Executive Functions	0.1	0.0	0.9	0.0	1.0
Grand Total	0.1	0.0	2.6	4.2	6.9

Position Overview – Executive Summary



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The Health Board's Annual Planned Deficit is £41.0m with an Annual Savings Target of £42.8m. Gross forecast position is £61.9m, with unplanned mitigating actions of £20.9m to be finalised, to achieve the reported end of year forecast position of £41.0m. Total savings delivery are £8.7m, leaving a savings delivery gap of £34.1m against the savings target.

The in-month financial position is a deficit of £6.0m, which is an adverse variance against the £3.4m in-month deficit plan due to the savings target of £3.6m has been under identified by £2.4m, and the £1.2m savings identified being fully delivered in-month, and a core operational overspend of £0.2m.

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	6.8	41.0	41.0
Unidentified / (Identified) savings gap / (improvement)	2.7	2.4	5.0	35.6	34.1
Under / (Over) delivery of savings schemes	0.0	0.0	0.0	0.0	0.0
Core operational variation	(0.6)	0.2	(0.3)	(13.0)	(13.2)
Gross Forecast	5.5	6.0	11.5	63.6	61.9
Future Mitigating Actions	0.0	0.0	0.0	(22.6)	(20.9)
Reported Position	5.5	6.0	11.5	41.0	41.0

Key Measures BRAG based on Plan £30.0m (Risk rating = Impact x Likelihood)	Core Operational Variation	Risk #2326 5 x 4 = 20	The in-month core overspend of £0.2m is largely driven by Medical locum agency usage £0.8m, Continuing Healthcare packages within Community and Integrated Medicine and Mental Health £0.5m Digital Strategic Partnership Contract phasing £0.2m, Planned & Specialist Care theatre consumables and insourcing £0.2m and Losses claims increases £0.2m. There are offset by pay vacancies across all service areas £(0.8)m and Dental contract hand back and delay in Cluster projects £(0.9)m.
	Cash		The Health Board will require strategic cash assistance in-year in line with the forecast deficit and working capital balances.
	Savings		Of the annual savings target of £42.8m, £8.7m has been identified and forecast to fully deliver on an in-year basis resulting in a £34.1m under-identification gap. Of the schemes identified £2.5m are recurrent savings and £6.2m are non-recurrent savings.
	Capital	N/A	Delivery against the capital programme is currently assessed as low risk. Capital projects are currently expected to deliver the Capital Resource Limit; this assessment will be kept under review as the year progresses.
	Underlying Deficit	Risk #1199 5 x 5 = 25	The planned underlying deficit is £40.8m which assumes £42.8m of recurrent savings delivery. As at Month 2 only £2.6m of recurrent schemes have been identified leaving a recurrent savings identification gap of £40.2m. Recurrent planned mitigating actions of £(10.3)m have been recognised in line with red and pipeline savings, offset by £0.8m recurrent cost pressure for the Healthcare Support Workers rebanding dispute, resulting in an underlying deficit of £71.5m. The organisation recognises the need to improve the financial trajectory year on year to achieve financial breakeven by 2027/28, as part of the criteria associated with £26.0m of conditionally recurrent funding.

Position Overview – Change from Prior Month



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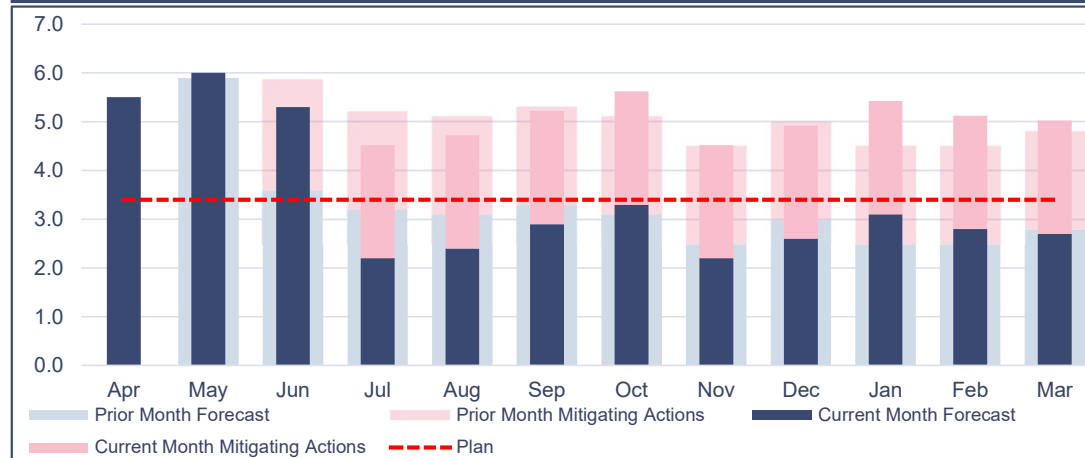
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Key Driver (£'m)	Prior Month Reported Position	Current Month Reported Position	Movement
Planned Deficit	3.4	3.4	0.0
Savings gap / (improvement)	2.7	2.4	(0.3)
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	(0.6)	0.2	0.8
Gross Forecast	5.5	6.0	0.5
Future Mitigating Actions	0.0	0.0	0.0
Reported Net Position	5.5	6.0	0.5

In-Month Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
Agency pay expenditure reduction	(0.2)
Workforce contract saving	(0.1)
Movement in Unidentified Savings Gap	(0.3)

Under / (Over) Delivery of Savings Schemes (£'m)	Change
No change to report	0.0
Movement in Savings Delivery	0.0

Core Operational Variation (£'m)	Change
Voluntary Early Retirement Scheme payments	0.4
Planned & Specialist Care theatre consumables and theatres insourcing	0.2
Digital Strategic Partnership Contract phasing	0.2
Losses claims increase of 13 additional cases compared to average of 7	0.2
Primary Care due to one-off recovery payments recognised in prior month	(0.2)
Movement in Core Operational Variation	0.8

Position Overview – Change from Prior Forecast



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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)	35.6	34.1	(1.5)
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	(13.0)	(13.2)	(0.2)
Gross Forecast	63.6	61.9	(1.7)
Future Mitigating Actions	(22.6)	(20.9)	1.7
Reported Net Position	41.0	41.0	0.0

End of Year Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
Workforce contract saving	(0.8)
Secondary high-cost drugs review	(0.3)
Agency pay expenditure reduction	(0.2)
VAT Recovery programme	(0.1)
Additional pay vacancies	(0.1)
Movement in Unidentified Savings Gap	(1.5)

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
VAT Recovery further reviews	(1.3)
Continuing Healthcare change of anticipated packages forecast approach	(0.6)
Community and Integrated Medicine Medical agency premium usage	0.9
Planned & Specialist Care operating theatres consumables and insourcing	0.8
Movement in Core Operational Variation	(0.2)

Financial Summary

In-Month Actual

£116.6m

Variance to Plan £2.6m

YTD Actual

£232.2m

Variance to Plan £4.7m

EOY Forecast

£1,384.9m

Variance to Plan £0.0m

3-Year Growth

5.5%

2023-24 Outturn £1,313m*

In-Year Growth

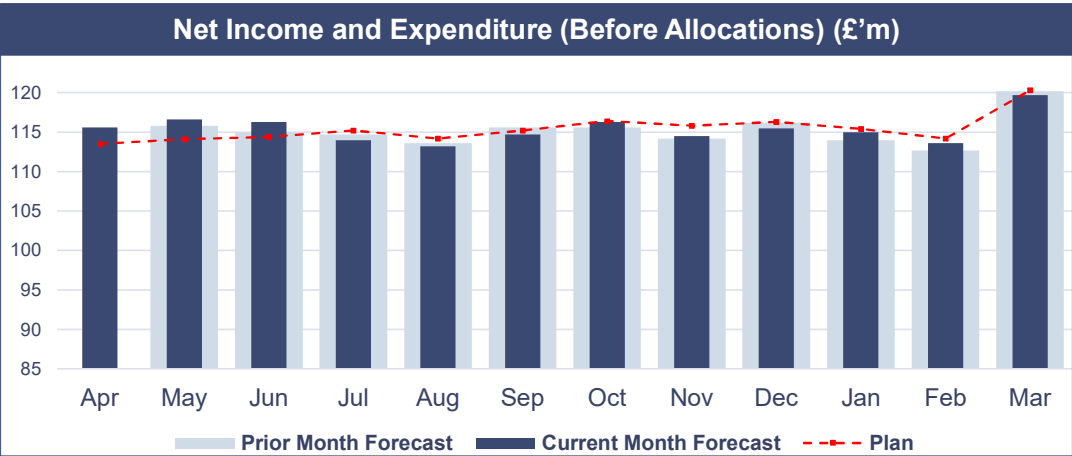
(2.6)%

2025-26 Outturn £1,422m*

YTD Extrapolation

£1,393.3m

Risk / (Opp) £8.4m



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay	103.6	59.3	59.6	118.9	713.1	706.1		7.0
Administration and Estates	21.2	12.2	12.3	24.6	147.3	146.3		1.0
Allied Health, Scientists and Other	13.1	7.4	7.3	14.7	88.4	88.2		0.2
Medical and Dental	22.5	13.4	13.5	26.9	161.3	157.9		3.4
Nursing, Midwifery and Clinical Support	46.8	26.3	26.4	52.7	316.1	313.7		2.5
Non Pay	83.8	63.1	64.0	127.1	762.4	760.2		2.2
Clinical Services and Supplies	4.5	3.8	4.4	8.2	49.1	50.0		(0.8)
Commissioned Healthcare Services	40.1	37.2	37.6	74.8	449.1	446.1		2.9
Drugs and Prescribing	13.5	13.1	12.4	25.5	153.1	161.1		(8.0)
Other Non-Pay	25.6	8.9	9.6	18.5	111.1	103.0		8.1
Income	(10.4)	(6.7)	(7.0)	(13.7)	(82.2)	(81.3)		(0.9)
Net Income and Expenditure	177.0	115.6	116.6	232.2	1,393.3	1,384.9		8.4
Allocations	173.1	110.1	110.6	220.8	1,324.5	1,343.9		19.4
Reported Position	4.0	5.5	6.0	11.5	68.8	41.0		27.8

Key Information

Month 1, April, reduction in pay expenditure from prior month due to 9.4% National Pension Resource £42.8m expenditure being recognised in Month 12, and reduction in non-pay expenditure from prior month due to Depreciation and Amortisation Impairment increases of £13.8m recognised in Month 12.

Month 4, July, onwards includes a reduction in expenditure due to unplanned mitigating actions of £20.9m anticipated within Non Pay £9.6m and Pay £11.3m in line with latest anticipated future savings forecast, resulting in a corresponding risk for Non Pay and Pay due to the future months forecast being lower than year to date expenditure levels seen.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £5.0m, with a corresponding increase in Revenue Resource Limit.

Note an opportunity within Drugs and Prescribing due to end of year forecast expenditure being higher than the year to date average due to increase in price from £8.05 to £8.14 per item.

*Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m

Financial Summary – Key Drivers vs Plan



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In-Month

Reported Position

£6.0m



Planned Deficit **£3.4m**
Prior Month Forecast **£5.9m**

Savings Identification Gap

£2.4m



Savings Target **£3.6m**
Total Identified **£1.2m**

Savings Delivery Gap

£0.0m



Savings Delivery **£1.2m**
Prior Month Delivery **£0.9m**

Core Operational Variation

£0.2m



Prior Month Variation **£(0.6)m**

Year to Date

Reported Position

£11.5m



Planned Deficit **£6.8m**

Savings Identification Gap

£5.0m



Savings Target **£7.1m**
Total Identified **£2.1m**

Savings Delivery Gap

£0.0m



Savings Delivery **£2.1m**
Prior Month Delivery **£0.9m**

Core Operational Variation

£(0.3)m



Prior Month Variation **£(0.6)m**

End of Year

Reported Position

£41.0m



Planned Deficit **£41.0m**
Prior Annual Forecast **£41.0m**

Savings Identification Gap

£34.1m



Savings Target **£42.8m**
Total Identified **£8.7m**

Savings Delivery Gap

£0.0m



Savings Delivery **£8.7m**
Prior Month Delivery **£7.2m**

Core Operational Variation

£(13.2)m



Prior Month Variation **£(13.0)m**

Gross Forecast

£61.9m



Prior Gross Forecast **£63.6m**
Mitigating Actions **£20.9m**

Net Risks / (Opportunities)

£6.3m



Prior Month **£6.1m**

Capital Position

£34.6m



Annual Plan **£34.6m**
Prior Annual Forecast **£34.1m**

Underlying Deficit

£71.5m



Annual Plan **£40.8m**
Recognised as Unsustainable

Total Pay Insights



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In-Month Actual

£59.6m



Variance to Plan £(0.2)m

YTD Actual

£118.9m



Variance to Plan £(0.6)m

EOY Forecast

£706.1m



Variance to Plan £(18.6)m

3-Year Growth

17.5%

2023-24 Outturn £600.9m*

In-Year Growth

6.5%

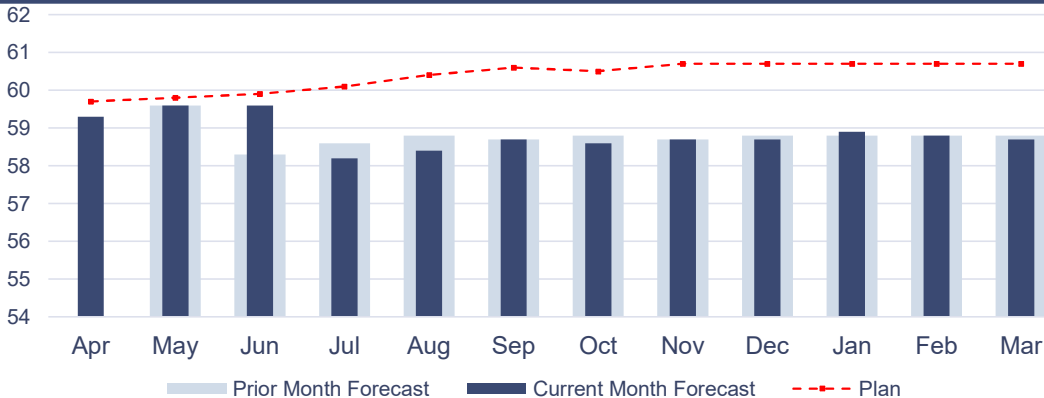
2025-26 Outturn £662.9m*

YTD Extrapolation

£713.1m

Risk / (Opp) £7.0m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Substantive	97.8	53.8	55.0	108.9	653.1	653.1		0.0
Administration and Estates	20.7	11.8	12.1	23.9	143.3	142.5		0.9
Allied Health, Scientists and Other	12.8	7.1	7.2	14.3	85.9	85.6		0.3
Medical and Dental	19.4	11.0	11.3	22.3	133.6	134.4		(0.8)
Nursing, Midwifery and Clinical Support	44.9	23.9	24.5	48.4	290.3	290.6		(0.3)
Variable	4.9	4.3	3.8	8.1	48.7	44.7		4.1
Administration and Estates	0.6	0.4	0.3	0.7	4.0	3.9		0.1
Allied Health, Scientists and Other	0.2	0.2	0.2	0.4	2.1	1.9		0.2
Medical and Dental	2.6	1.7	1.8	3.5	21.0	18.8		2.1
Nursing, Midwifery and Clinical Support	1.5	2.0	1.6	3.6	21.6	20.1		1.6
Agency (Premium)	0.9	1.1	0.7	1.9	11.3	8.3		2.9
Administration and Estates	-	-	-	-	-	-		-
Allied Health, Scientists and Other	-	0.1	(0.1)	0.1	0.3	0.6		(0.3)
Medical and Dental	0.5	0.7	0.5	1.1	6.7	4.7		2.0
Nursing, Midwifery and Clinical Support	0.4	0.4	0.3	0.7	4.2	3.0		1.2
Total Expenditure	103.6	59.3	59.6	118.9	713.1	706.1		7.0
Plan	101.5	59.7	59.8	119.5	716.8	724.6		
Variance to Plan	2.1	(0.4)	(0.2)	(0.6)	(3.7)	(18.6)		

Key Information

Month 1, April, reduction from prior month due to 9.4% National Pension Resource £42.8m expenditure being recognised in Month 12, offset by a slight increase from prior month relating to the FY26-27 3.3% Agenda for Change pay award with a corresponding increase in future months.

Month 4, July, onwards includes a reduction in expenditure due to unplanned mitigating actions of £11.3m anticipated within Substantive £6.1m, Variable £3.5m and Agency Pay £1.7m to deliver from Month 4 to 12, with the reduction in Variable and Agency largely anticipated within Medical and Allied Health. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date expenditure levels seen, in particular within Nursing and Medical Variable and Agency pay.

Note a significant deviation from prior month forecast in Month 3 as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

*Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m

Substantive Insights



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In-Month Actual

£55.0m



Variance to Plan £(3.4)m

YTD Actual

£108.9m



Variance to Plan £(7.6)m

EOY Forecast

£653.1m



Variance to Plan £(52.1)m

In-Year Growth

6.8%

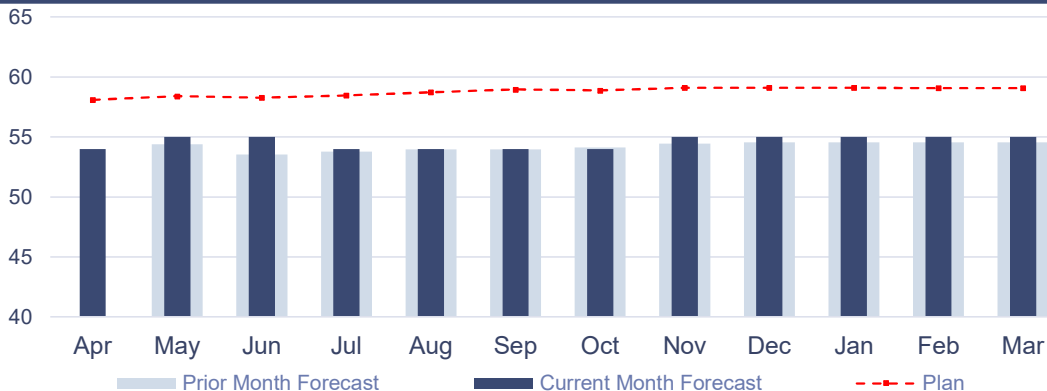
2024-25 Outturn £611.7m

YTD Extrapolation

£653.1m

Risk / (Opp) £0.0m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	97.8	53.8	55.0	108.9	653.1	653.1		0.0
Administration and Estates	20.7	11.8	12.1	23.9	143.3	142.5		0.9
Allied Health, Scientists and Other	12.8	7.1	7.2	14.3	85.9	85.6		0.3
Medical and Dental	19.4	11.0	11.3	22.3	133.6	134.4		(0.8)
Nursing, Midwifery and Clinical Support	44.9	23.9	24.5	48.4	290.3	290.6		(0.3)
Functions	97.8	53.8	55.0	108.9	653.1	653.1		0.0
Chief Operating Officer Management	0.6	0.7	1.2	1.9	11.2	9.6		1.6
Community and Integrated Medicine	17.1	16.6	16.9	33.5	200.7	205.7		(5.0)
Mental Health and Learning Disabilities	5.8	6.1	6.1	12.2	73.0	72.9		0.0
Operational Allied Health and Health Sciences	5.6	5.7	5.8	11.6	69.5	69.0		0.5
Planned and Specialist Care	13.5	13.6	13.7	27.4	164.2	165.9		(1.7)
Primary Care	1.2	1.2	1.3	2.6	15.3	15.4		(0.1)
Executive Functions	54.0	9.9	10.0	19.9	119.3	114.6		4.7
Total Expenditure	97.8	53.8	55.0	108.9	653.1	653.1		0.0
Plan	99.4	58.1	58.4	116.5	698.8	705.1		
Variance to Plan	(1.6)	(4.3)	(3.4)	(7.6)	(45.7)	(52.1)		

Key Information

Month 1, April, reduction from prior month due to 9.4% National Pension Resource £42.8m expenditure being recognised in Month 12, offset by an increase from prior month relating to the FY26-27 3.3% Agenda for Change pay award with a corresponding increase in future months.

Month 4, July, onwards includes a reduction in expenditure due to unplanned mitigating actions of £6.1m anticipated within Substantive Pay to deliver from Month 4 to 12. Mitigating actions result in a risk for Substantive pay within Executive Functions due to the future months forecast being lower than year to date expenditure levels seen. Note a significant deviation from prior month forecast in Month 3 as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 8, November, recognises an increase in Substantive expenditure due to International Educated Nurses recruitment, reducing reliance on Nursing variable pay and agency. This results in a significant opportunity within Community and Integrated Medicine due to future expenditure forecast increasing significantly from year to date levels.

Variable Insights



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In-Month Actual
£3.8m ●
Variance to Plan **£2.6m**

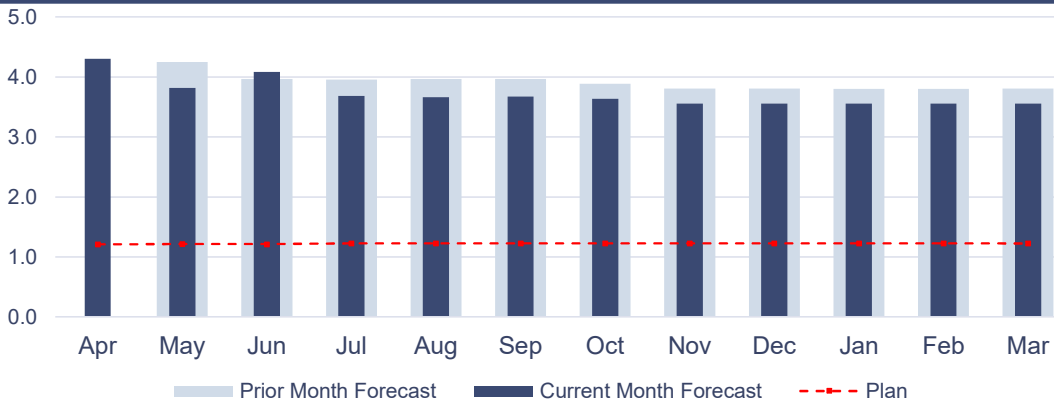
YTD Actual
£8.1m ●
Variance to Plan **£5.7m**

EOY Forecast
£44.7m ●
Variance to Plan **£30.0m**

In-Year Growth
(15.6)%
2025-26 Outturn **£53.2m**

YTD Extrapolation
£48.7m
Risk / (Opp) **£4.1m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	4.9	4.3	3.8	8.1	48.7	44.7	●	4.1
Administration and Estates	0.6	0.4	0.3	0.7	4.0	3.9	●	0.1
Allied Health, Scientists and Other	0.2	0.2	0.2	0.4	2.1	1.9	●	0.2
Medical and Dental	2.6	1.7	1.8	3.5	21.0	18.8	●	2.1
Nursing, Midwifery and Clinical Support	1.5	2.0	1.6	3.6	21.6	20.1	●	1.6
Functions	4.9	4.3	3.8	8.1	48.7	44.7	●	4.0
Chief Operating Officer Management	(0.1)	-	-		0.1	0.1	●	0.0
Community and Integrated Medicine	1.7	1.6	1.5	3.2	19.1	18.7	●	0.4
Mental Health and Learning Disabilities	0.2	0.3	0.2	0.5	2.9	3.1	●	(0.2)
Operational Allied Health and Health Sciences	0.4	0.2	0.3	0.5	3.0	2.8	●	0.3
Planned and Specialist Care	1.9	1.4	1.2	2.6	15.3	14.8	●	0.5
Primary Care	0.6	0.5	0.3	0.8	4.7	5.3	●	(0.5)
Executive Functions	0.3	0.3	0.3	0.6	3.5		●	3.5
Total Expenditure	4.9	4.3	3.8	8.1	48.7	44.7	●	4.1
Plan	1.8	1.2	1.2	2.4	14.5	14.6		
Variance to Plan	3.1	3.1	2.6	5.7	34.2	30.0		

Key Information

Month 1, April, reduction from prior month due to Medical Waiting List Initiative Sessions increase in prior month within Planned and Specialist Care in line with activity. Month 2, May, reduction in Bank expenditure due to inability to fill shifts within Community and Integrated Medicine and reduction in patient acuity within Mental Health, alongside reduction in Waiting List Initiative activity within Planned and Specialist Care.

Month 4, July, onwards includes a reduction in expenditure due to unplanned mitigating actions of £3.5m anticipated within Variable Pay to deliver from Month 4 to 12, with the reductions anticipated mainly within Medical and Dental for Physiotherapy and Planned and Specialist Care. Mitigating actions result in a risk for Variable Pay within Executive Functions due to the future months forecast being lower than year to date expenditure levels seen. Note a significant deviation from prior month forecast in Month 3 as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Reduction in variable pay expenditure anticipated against prior month forecast within Community and Integrated Medicine due to the recruitment of International Educated Nurses into substantive posts anticipated in Month 7, October, and less reliance on variable pay within Mental Health. Additional variable pay mitigating actions anticipated compared to prior month.

Agency Insights



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In-Month Actual

£0.7m



Variance to Plan £0.6m

YTD Actual

£1.9m



Variance to Plan £1.3m

EOY Forecast

£8.3m



Variance to Plan £3.5m

3-Year Growth

(74.9)%

2023-24 Outturn £33.1m

In-Year Growth

(20.2)%

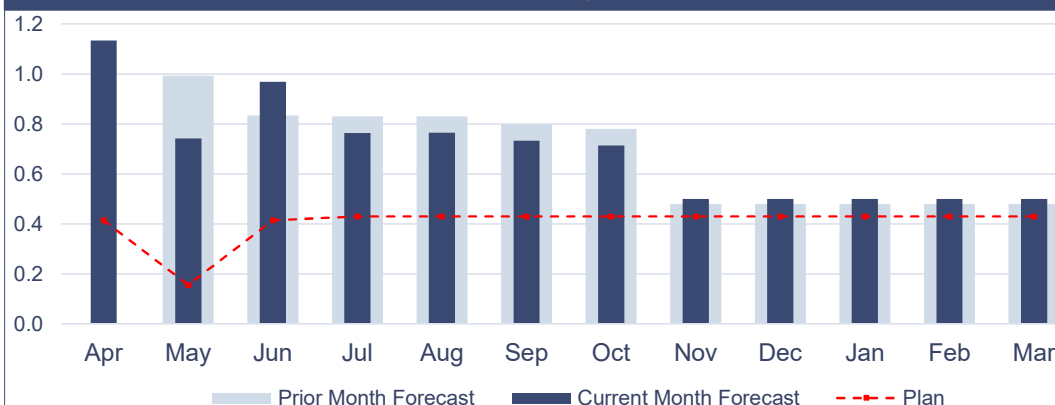
2025-26 Outturn £10.4m

YTD Extrapolation

£11.3m

Risk / (Opp) £2.9m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	0.9	1.1	0.7	1.9	11.3	8.3	0	2.9
Administration and Estates	-	-	-	-	-	-	0	-
Allied Health, Scientists and Other	-	0.1	(0.1)	0.1	0.3	0.6	0	(0.3)
Medical and Dental	0.5	0.7	0.5	1.1	6.7	4.7	0	2.0
Nursing, Midwifery and Clinical Support	0.4	0.4	0.3	0.7	4.2	3.0	0	1.2
Functions	0.9	1.1	0.7	1.9	11.3	8.3	0	2.9
Chief Operating Officer Management	-	-	-	-	-	-	0	-
Community and Integrated Medicine	0.5	0.7	0.7	1.3	8.0	6.1	0	1.9
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.1	0.8	0.7	0	0.1
Operational Allied Health and Health Sciences	0.2	0.2	0.2	0.4	2.3	2.2	0	0.1
Planned and Specialist Care	0.2	0.2	0.1	0.3	1.7	1.4	0	0.3
Primary Care	-	-	-	-	-	(0.1)	0	0.1
Executive Functions	-	-	(0.3)	(0.3)	(1.6)	(2.0)	0	0.5
Total Expenditure	0.9	1.1	0.7	1.9	11.3	8.3	0	2.9
Plan	0.3	0.4	0.2	0.6	3.4	4.8		
Variance to Plan	0.6	0.7	0.6	1.3	7.8	3.5		

Key Information

Month 1, April, increase in reliance of Allied Health and Medical Locum agency from prior month mainly within Community and Integrated Medicine, due to increase in filled shifts.

Month 2, May, reduction in Agency expenditure from prior month and against forecast within Medical and Nursing across various areas.

Month 4, July, onwards includes a reduction in expenditure due to unplanned mitigating actions of £1.7m anticipated within Agency Pay to deliver from Month 4 to 12, with the reductions anticipated mainly within Medical and Dental for Pathology and Community and Integrated Medicine. Note a significant deviation from prior month forecast in Month 3 as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 8, November, recognises a reduction in Agency expenditure due to the recruitment of International Educated Nurses into substantive posts anticipated in Month 7, October, therefore reducing reliance on agency usage within Nursing.

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In-Month Actual
£4.3m ●
Variance to Plan **£0.3m**

YTD Actual
£8.1m ●
Variance to Plan **£0.3m**

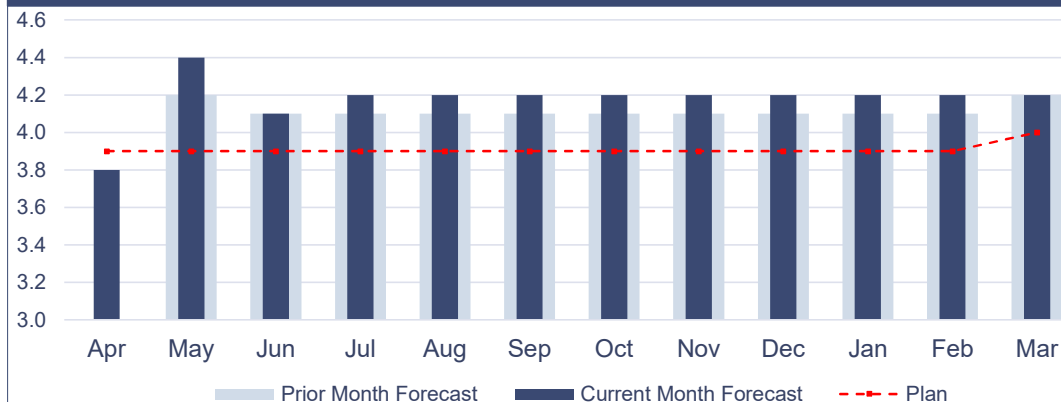
EOY Forecast
£50.0m ●
Variance to Plan **£2.8m**

3-Year Growth
11.1%
2023-24 Outturn **£45.0m**

In-Year Growth
(3.3)%
2025-26 Outturn **£51.7m**

YTD Extrapolation
£49.1m
Risk / (Opp) **£(0.8)m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EOY Forecast	EOY Var	Risk / (Opp)
Functions	4.5	3.7	4.3	8.1	49.1	50.0	●	(0.8)
Chief Operating Officer Management	-	-	-	0.1	0.4	0.4	●	-
Community and Integrated Medicine	1.6	1.1	1.2	2.3	14.0	14.0	●	-
Mental Health and Learning Disabilities	-	-	-	-	0.3	0.2	●	-
Operational Allied Health and Health Sciences	1.0	1.0	1.1	2.2	12.9	13.9	●	(0.9)
Planned and Specialist Care	2.4	1.6	2.0	3.6	21.5	21.1	●	0.4
Primary Care	-	-	-	0.1	0.3	0.3	●	0.1
Executive Functions	(0.5)	(0.1)	-	(0.1)	(0.3)	-	●	(0.3)
Total Expenditure	4.5	3.7	4.3	8.1	49.1	50.0	●	(0.8)
Plan	4.1	3.9	3.9	7.8	46.8	47.1		(0.4)
Variance to Plan	0.4	(0.1)	0.3	0.3	2.4	2.8		(0.5)

Key Information

Month 1, April, reduction due to consumables and insourcing of recovery activity within Planned and Specialist Care in prior month in addition to insulin pump purchases and joint equipment stores within Community and Integrated Medicine.

Month 2, May, reflects an increase from prior month driven by Planned and Specialist Care operating theatre consumables including loan kits and theatres insourcing of activity. Expenditure is expected to remain at an increased level going forward, although below Month 2 levels.

Future months deviation to forecast largely relating to increased Radiology outsourcing costs anticipated within Operational Allied Health and further theatre consumables and insourcing of activity within Planned and Specialist Care.

Commissioned Healthcare Services Insights

In-Month Actual

£37.6m



Variance to Plan £(0.1)m

YTD Actual

£74.8m



Variance to Plan £(0.3)m

EOY Forecast

£446.1m



Variance to Plan £(3.1)m

3-Year Growth

15.6%

2023-24 Outturn £385.9m

In-Year Growth

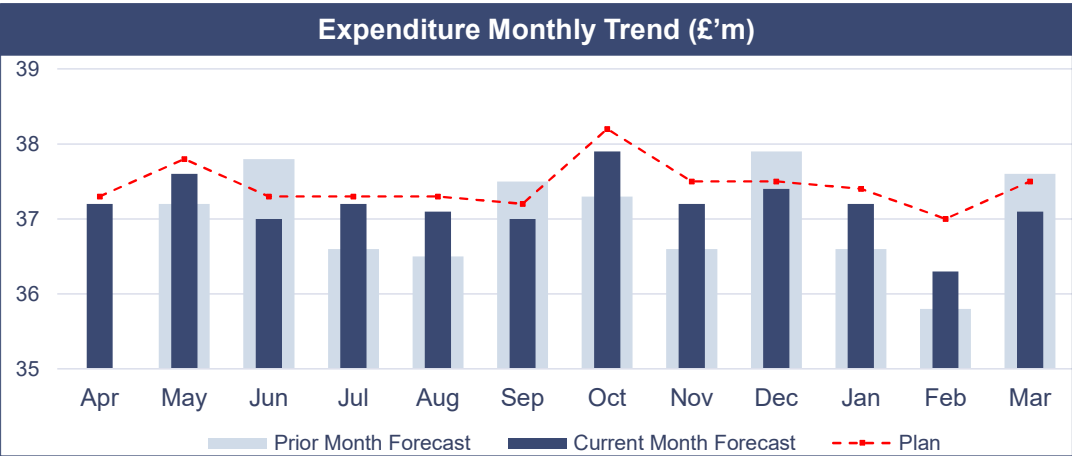
2.7%

2025-26 Outturn £434.2m

YTD Extrapolation

£449.1m

Risk / (Opp) £2.9m



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	40.1	37.2	37.6	74.8	449.1	446.1		2.9
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	2.9	2.9	2.8	5.7	34.4	35.0		(0.6)
Mental Health and Learning Disabilities	3.6	3.9	4.1	8.0	47.7	47.7		-
Operational Allied Health and Health Sciences	0.5	0.5	0.4	0.9	5.5	5.6		(0.1)
Planned and Specialist Care	4.0	0.5	0.7	1.3	7.8	6.4		1.4
Primary Care	10.1	10.5	10.4	20.9	125.5	123.9		1.6
Executive Functions	19.0	18.8	19.2	38.0	228.2	227.6		0.6
Total Expenditure	40.1	37.2	37.6	74.8	449.1	446.1		2.9
Plan	41.1	37.3	37.8	75.1	450.8	449.2		1.6
Variance to Plan	(1.0)	(0.1)	(0.1)	(0.3)	(1.8)	(3.1)		1.3

Key Information

Month 1, April, reduction from prior month due to theatres outsourcing for Waiting List Initiative Activity within Planned and Specialist Care in prior month, and year to date Pharmaceuticals Joint Commissioning Committee expenditure recognised in prior month.

Note monthly deviations to prior month forecast largely relating to Pharmaceuticals Joint Commissioning Committee expenditure previously assumed as quarterly now anticipated monthly with year to date expenditure recognised in Month 2, May.

Monthly fluctuations in expenditure largely relating to number of days in the month and therefore the corresponding expenditure of Continuing Healthcare packages, with significant reduction in Month 11, February, and a corresponding increase in Month 12, March. Month 7, October, includes an increase largely relating to Primary Care vaccination programmes.

Note an overall increase in expenditure from prior month forecast due to previously assumed Continuing Healthcare mitigating actions of £1.8m now anticipated to deliver within Pay.

Drugs and Prescribing Insights

In-Month Actual

£12.4m

Variance to Plan £(0.6)m

YTD Actual

£25.5m

Variance to Plan £(0.8)m

EOY Forecast

£161.1m

Variance to Plan £(5.2)m

3-Year Growth

8.3%

2023-24 Outturn £148.7m

In-Year Growth

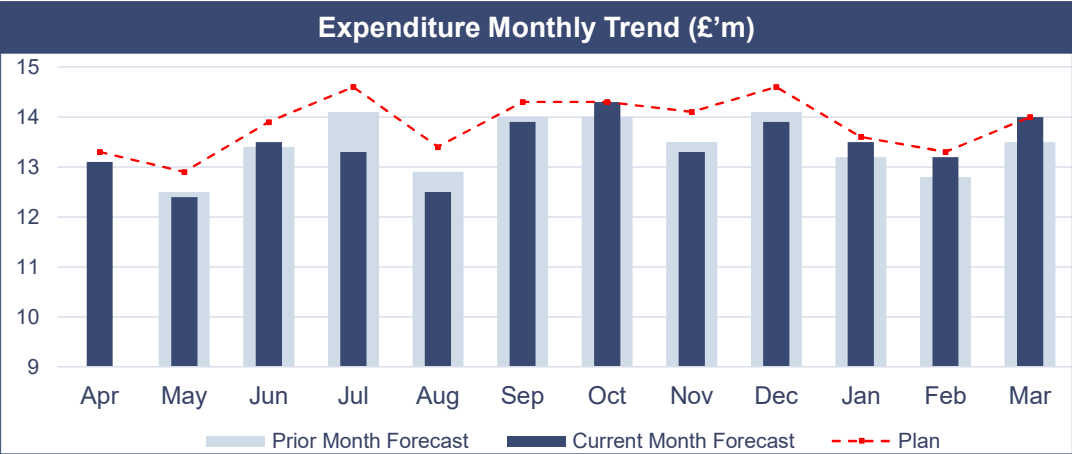
8.3%

2025-26 Outturn £148.8m

YTD Extrapolation

£153.1m

Risk / (Opp) £(8.0)m



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	13.5	13.1	12.4	25.5	153.1	161.1		(8.0)
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	1.7	1.6	1.6	3.1	18.9	18.8		0.1
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.2	1.2	1.4		(0.2)
Operational Allied Health and Health Sciences	0.5	0.5	0.4	0.8	5.1	5.7		(0.6)
Planned and Specialist Care	3.3	3.2	2.9	6.1	36.7	38.2		(1.5)
Primary Care	-	-	-	-	0.2	0.2		-
Executive Functions	7.9	7.8	7.4	15.2	91.0	96.8		(5.8)
Total Expenditure	13.5	13.1	12.4	25.5	153.1	161.1		(8.0)
Plan	13.3	13.3	12.9	26.2	157.5	166.3		(8.8)
Variance to Plan	0.2	(0.2)	(0.6)	(0.8)	(4.4)	(5.2)		0.9

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.

Forecast drugs underspend largely relating to Ophthalmology differing operating model for outsourcing Intravitreal drugs as opposed to providing the service in-house due to recruitment challenges, Public Health reduction in vaccination programmes uptake and expenditure, and Dapagliflozin spend reduction due to reduction in price and volume compared to plan, with increases anticipated later in the year highlighted as a significant opportunity above.

A further opportunity is recognised above for drugs expenditure anticipated within Pharmacy and Medicines Management due year to date expenditure based on £8.05 average price, compared to future expenditure anticipated at £8.14 average price per item in line with the latest Prescribing Audit Report.

Other Non-Pay Insights



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In-Month Actual

£9.6m



Variance to Plan £3.1m

YTD Actual

£18.5m



Variance to Plan £13.0m

EOY Forecast

£103.0m



Variance to Plan £24.7m

3-Year Growth

(5.3)%

2023-24 Outturn £108.8m

In-Year Growth

3.9%

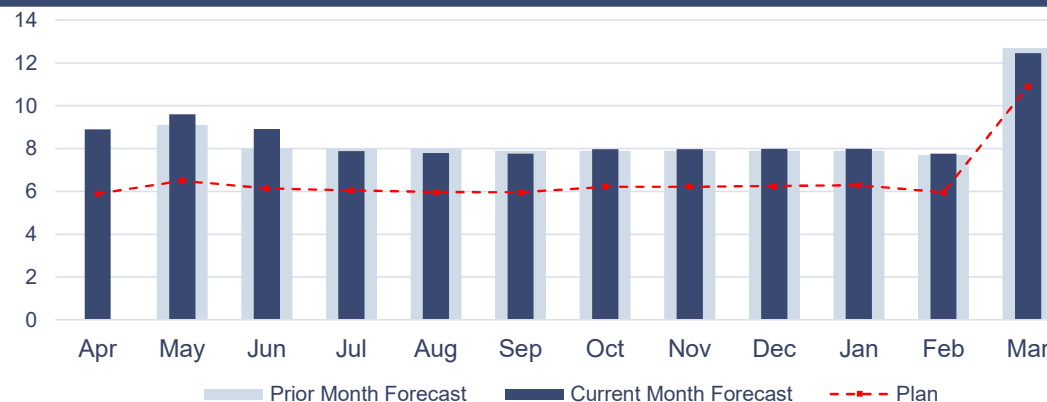
2025-26 Outturn £99.1m

YTD Extrapolation

£111.1m

Risk / (Opp) £8.1m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	25.6	8.9	9.6	18.5	111.1	103.0		8.1
Chief Operating Officer Management	0.1	0.2	0.1	0.3	1.8	1.9		(0.1)
Community and Integrated Medicine	1.3	0.9	0.8	1.7	10.2	9.7		0.5
Mental Health and Learning Disabilities	0.4	0.2	0.2	0.4	2.5	2.4		0.1
Operational Allied Health and Health Sciences	0.5	0.2	0.2	0.4	2.4	2.2		0.3
Planned and Specialist Care	0.7	0.3	0.4	0.7	4.0	3.9		-
Primary Care	0.3	0.1	0.1	0.3	1.6	1.2		0.4
Executive Functions	22.4	7.1	7.7	14.7	88.5	81.6		6.9
Total Expenditure	25.6	8.9	9.6	18.5	111.1	103.0		8.1
Plan	20.6	5.9	6.5	12.4	74.3	78.3		(4.0)
Variance to Plan	5.0	3.0	3.1	6.1	36.8	24.7		12.1

Key Information

Month 1, April, reduction in non-pay expenditure from prior month due to Depreciation and Amortisation Impairment increases of £13.8m recognised in Month 12.

Month 2, May, increase in expenditure from prior month largely relating to Digital Strategic Partnership Contract phasing and Losses claims increase of 13 additional cases compared to average of 7.

Month 4, July, onwards includes a reduction in expenditure due to unplanned mitigating actions of £9.6m anticipated within Non-Pay to deliver from Month 4 to Month 12. Note a significant deviation from prior month forecast in Month 3 as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £5.0m, with a corresponding increase in Revenue Resource Limit.

Income Insights



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In-Month Actual
£6.9m ●
Variance to Plan **£0.1m**

YTD Actual
£13.7m ●
Variance to Plan **£0.3m**

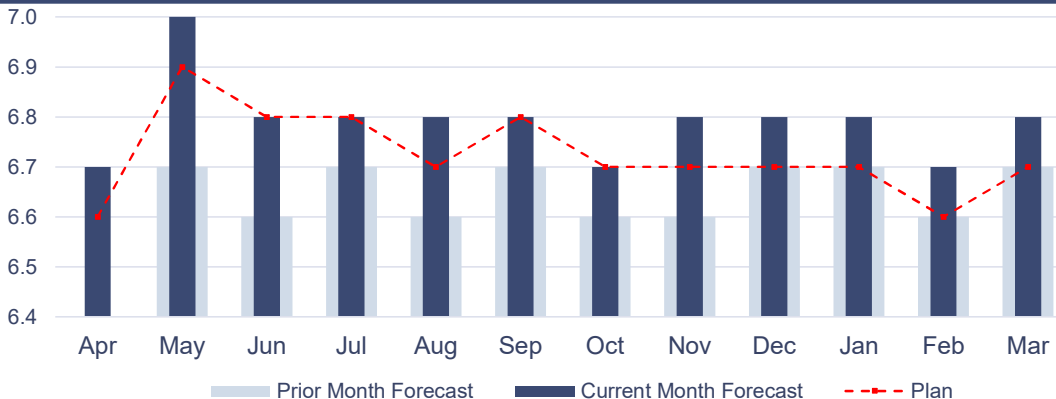
EOY Forecast
£81.3m ●
Variance to Plan **£0.7m**

3-Year Growth
10.4%
2023-24 Outturn **£73.7m**

In-Year Growth
(1.9)%
2025-26 Outturn **£82.9m**

YTD Extrapolation
£82.2m
(Risk) / Opp **£0.8m**

Income Monthly Trend (£'m)



Income Trajectory Analysis (£'m)	P12-26	P01-27	P02-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	10.4	6.7	6.9	13.7	82.2	81.3	●	0.8
Chief Operating Officer Management	0.1	-	-	0.1	0.4	0.4	●	-
Community and Integrated Medicine	0.7	0.3	0.3	0.7	3.9	3.8	●	0.1
Mental Health and Learning Disabilities	0.4	0.3	0.3	0.5	3.2	2.8	●	0.4
Operational Allied Health and Health Sciences	0.7	0.3	0.3	0.6	3.4	3.3	●	0.1
Planned and Specialist Care	0.6	0.5	0.5	1.0	6.1	6.0	●	0.1
Primary Care	0.3	0.2	0.2	0.4	2.3	2.3	●	-
Executive Functions	7.7	5.2	5.3	10.5	62.9	62.8	●	0.2
Total Income	10.4	6.7	6.9	13.7	82.2	81.3	●	0.8
Plan	7.6	6.6	6.9	13.4	80.7	80.6		
Variance to Plan	2.8	0.1	0.1	0.3	1.6	0.7		0.9

Key Information

Month 1, April, reduction in income from prior month due to additional year to date income being received in Month 12 for Housing with Care Funds projects expenditure.

Month 2, May, increase in income from prior month due to additional Health Education and Improvement Wales, Non-Contracted activity income and Drug rebates income.

Monthly deviation against prior month forecast is largely relating to increased Health Education Improvement Wales income anticipated.

Income overachievement of £0.7m is forecast largely relating to Central Income Non-Contracted Activity income, Health Education and Improvement Wales income overachievement within Occupational Therapy and Radiology, secondment income within Therapies and Pathology, Planned and Specialist Care Bowel Screening Income,, offset by underachievement of Dental Income due to reduced activity and termination of Dental practices contracts.

End of Year – Key Drivers vs Plan



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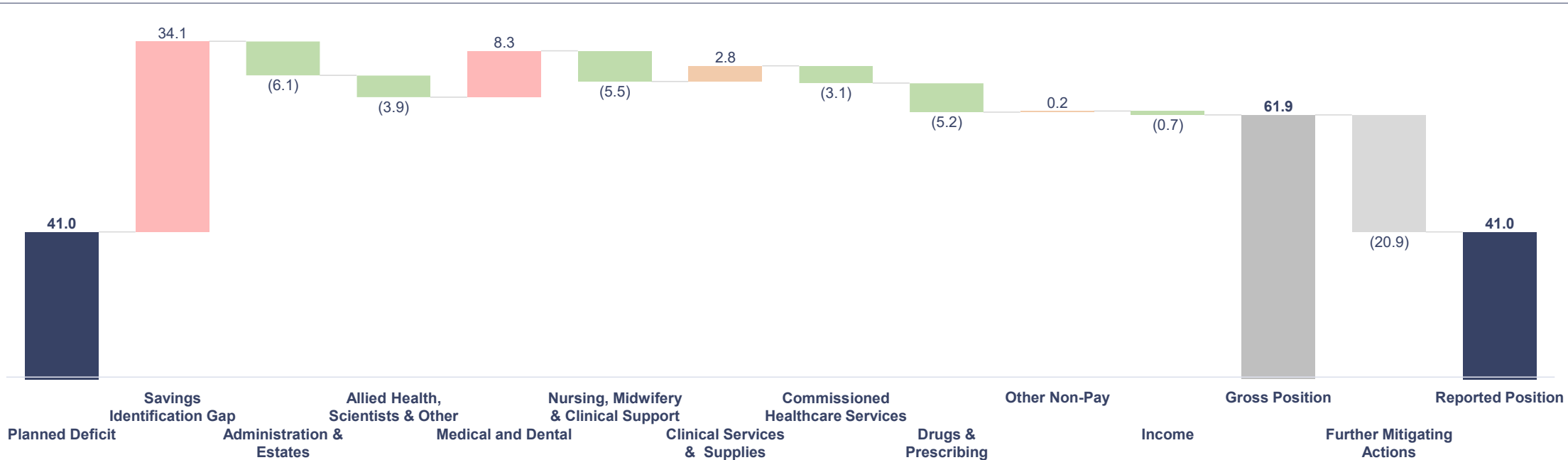
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Key Information

Savings Identification Gap – Savings identification of £8.7m against savings target of £42.8m, leaving a savings identification gap of £34.1m.

Administration & Estates – Pay vacancies mainly within Workforce, Community and Integrated Medicine, Planned and Specialist Care, Estates and Facilities and Public Health.

Medical and Dental – Planned and Specialist Care Medical locum rate card within Anaesthetics, dual running of Medical staff within Bronglais Obstetrics, Gynaecology and Paediatrics. Community and Integrated Medicine high locum usage to cover rota gaps, sickness, retrospective shifts and vacancies mainly within Pembrokeshire Accident and Emergency unit.

Nursing and Midwifery – Pay vacancies mainly within Community and Integrated Medicine, Mental Health, Planned and Specialist Care and Public Health.

Drugs and Prescribing – Drugs underspend within Ophthalmology due to different operating model for outsourcing Intravitreal drugs as opposed to providing the service in-house due to recruitment challenges. Further drugs underspend within Pharmacy and Medicines Management relating to reduction in Dapagliflozin expenditure and volume due to reduced availability.

End of Year – Key Deviations to Plan



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Key Deviation		£'m	Key Information
Gross Planned Deficit		83.8	Before savings requirement of £42.8m
Savings Delivery		(8.7)	Green and Amber savings plans delivering. Gap of £34.1m vs plan requirement of £42.8m
Unplanned Overspends	Medical Stabilisation improvements not delivered	8.3	BGH W&C absence and restricted duties (£2.0m), Anaesthetist rate card extended (£1.4m), agency impact for WGH absence and restricted duties (£2.8m), MH&LD 4 premium agency (£0.9m)
	Diabetes pathway demand	0.7	Further service demand relating to insulin pumps above annual plan assumptions
	Band 2/3 banding assumption changes	0.9	Increase in national framework assumptions and additional establishment conversion
	Continuing Healthcare	5.6	Demand increases on CHC packages (£4.3m), Out of Area Mental Health placements (£1.3m)
	Swansea Bay LTA	2.1	Non-elective short stay episodes attracting a disproportionate flat rate tariff
Unplanned Underspends	Primary Care	(12.4)	Increased dental underspend and cluster projects plans not yet put forward
	Administrative vacancies	(6.1)	Across the majority of services – consideration for recurrent vacancy factor saving required
	Primary Care Prescribing and Drugs	(2.5)	Annual Plan assumed increases not yet materialising – consideration for savings
	Clinical fill rates (non-medical)	(7.5)	Vacancies and reduced fill rates
	Income	(2.3)	Central Income saving (£0.7m), Other income across services (£1.6m). Convert to savings
Gross Position		61.9	Report £41.0m to Welsh Government, with full mitigating actions assumed
Further Mitigating Actions		(20.9)	Robust plans are yet to be confirmed, but opportunities exceeding the value are being reviewed
Reported Position		41.0	

End of Year – Key Performance vs Plan



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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	
Chief Operating Officer Management	0.8	0.0	0.8	1.6	Pay costs within Nursing, and Allied Health Scientists transferred from Allied Health for Physiotherapy First Contact Point service.
Community and Integrated Medicine	10.9	0.0	3.0	13.9	Savings non delivery plus increase in Continuing Healthcare packages and continued use of premium medical locums to cover sickness.
Mental Health and Learning Disabilities	4.6	0.0	0.8	5.4	Savings non delivery plus Continuing Healthcare packages increase, purchase of outsourced Psychiatric Intensive Care beds and Medical locum usage, offset by Allied Health and Nursing vacancies.
Operational Allied Health & Health Sciences	4.9	0.0	0.1	5.0	Savings non delivery plus pay vacancies within Radiology due to delayed recruitment, offset by outsourcing contracts for Radiology services. First Contact Point Therapists transfer to Chief Operating Officer Management.
Planned and Specialist Care	5.6	0.0	2.1	7.7	Savings non delivery plus medical locum rate card within Anaesthetics, dual running of Medical staff within Bronglais, Ophthalmology outsourcing for Intravitreal injection therapy, offset by Ophthalmology drugs reduction.
Primary Care	0.0	0.0	(12.4)	(12.4)	Dental contacts hand back, General Medicine Services Supplementary Services underspend and delay in Cluster projects.
Executive Functions	7.3	0.0	(7.6)	(0.3)	See next slide for breakdown.
Sub Total	34.1	0.0	(13.2)	20.9	
Gross Position				61.9	
Further Mitigating Actions				(20.9)	Conversion of opportunities to robust plans required as not yet confirmed
Reported Position				41.0	

End of Year – Key Performance vs Plan Executive



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Executive Function (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Chief Executive	(0.1)	0.0	(0.2)	(0.3)	Over-achievement of savings target, and Admin pay vacancies.
Digital	0.4	0.0	0.0	0.4	Under-achievement of savings target.
Estates and Facilities	2.7	0.0	0.3	3.0	Under-achievement of savings target and maintenance expenditure
Executive Allied Health	0.0	0.0	0.0	0.0	No material deviation.
Finance	(0.3)	0.0	(0.3)	(0.6)	Over-achievement of savings target, and Admin pay vacancies.
Health Board Wide	1.0	0.0	(2.0)	(1.0)	Under-achievement of savings target and VAT recovery reviews.
LTA's	2.0	0.0	2.1	4.1	Under-achievement of savings target. Swansea Bay emergency activity.
Medical	(0.1)	0.0	(1.0)	(1.1)	Unconfirmed plans for Value Based Health Care and SIFT funding
Nursing	0.0	0.0	0.0	0.0	No material deviation.
Pharmacy and Medicines Management	4.3	0.0	(2.4)	1.9	Under-achievement of savings target, drugs reduction and pay vacancies.
Public Health	0.1	0.0	(2.3)	(2.2)	Pay vacancies £(1.8)m, Drugs vaccinations reduction £(0.3)m
Strategy and Planning	(0.4)	0.0	(0.2)	(0.6)	Over-achievement of savings target. Capital design recharge income.
Workforce	(2.3)	0.0	(1.6)	(3.9)	Over-achievement of savings target, and Admin pay vacancies.
Sub Total	7.3	0.0	(7.6)	(0.3)	

End of Year – Key Performance vs Prior Month



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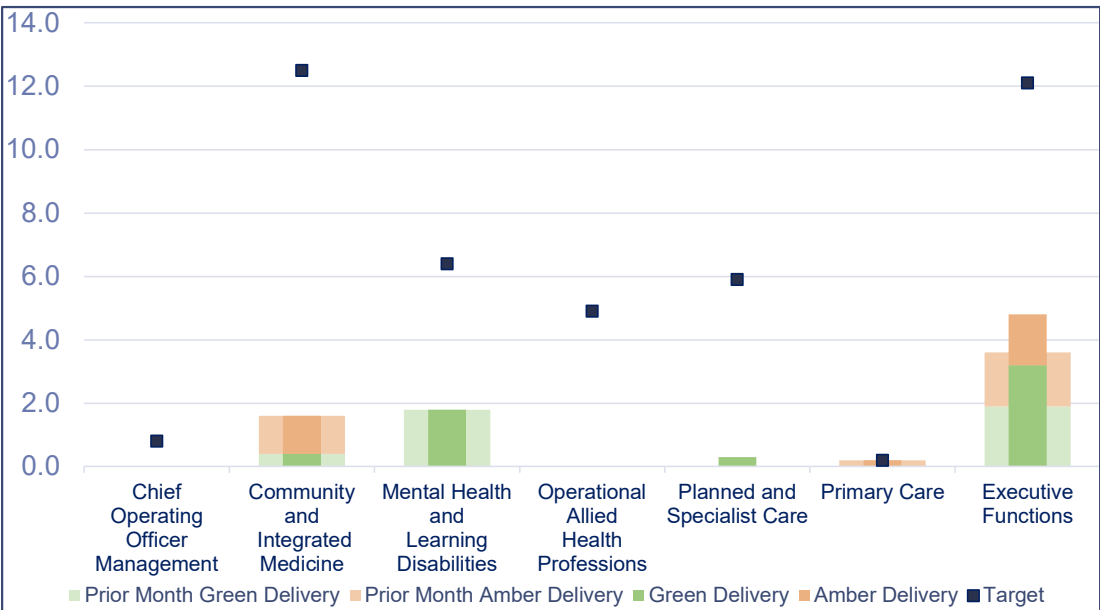
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Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target Movement	Savings Delivery vs Plan Movement	Core Operational Variation Movement	Total Movement	Key Information
Prior Month Forecast				41.0	
Chief Operating Officer Management	0.0	0.0	0.8	0.8	Additional administration and nursing pay costs relating to organisational change and Physiotherapy First Contact Point costs from Allied Health.
Community and Integrated Medicine	0.0	0.0	1.1	1.1	High usage of medical agency and locums to cover sickness and vacancies. Increase in Continued Healthcare packages.
Mental Health and Learning Disabilities	0.0	0.0	(0.6)	(0.6)	Reduction of Continuing Healthcare packages anticipated following change of anticipated packages forecast approach.
Operational Allied Health & Health Sciences	0.0	0.0	(0.1)	(0.1)	Continuation of vacancies, offset by increase Medical locum agency usage, and reduction in Pathology drug costs due to reduced activity.
Planned and Specialist Care	(0.3)	0.0	0.8	0.5	Theatre consumables increase relating to loan kits, and worsening of Oncology drugs due to increased activity of 8.4% as opposed to 5.1% plan.
Primary Care	0.0	0.0	0.0	0.0	No material deviation.
Executive Functions	(1.2)	0.0	(2.2)	(3.4)	Additional savings relating to Workforce contract saving. VAT Recovery review £(1.3)m, additional pay vacancies within Estates, Finance, and Strategy and Planning £(0.7)m
Sub Total	(1.5)	0.0	(0.2)	(1.7)	
Gross Position				(1.7)	
Further Mitigating Actions				1.7	
Reported Position				41.0	

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	0.0	0.0	0.8
Community and Integrated Medicine	12.5	1.6	1.6	10.9
Mental Health and Learning Disabilities	6.4	1.8	1.8	4.6
Operational Allied Health and Health Sciences	4.9	0.0	0.0	4.9
Planned and Specialist Care	5.9	0.3	0.3	5.6
Primary Care	0.2	0.2	0.2	0.0
Executive Functions	12.1	4.8	4.8	7.3
Grand Total	42.8	8.7	8.7	34.1

Key Information

Overall, savings schemes of £8.7m have been identified, all forecast to fully deliver, resulting in a £34.1m savings under-identification against the £42.8m target with variations across Clinical Care Groups.

The under-identification of savings against target largely relate to Community and Integrated Medicine, Planned and Specialist Care, Operational Allied Health and Mental Health, with the key under-identified Executive functions largely relating to Pharmacy and Medicines Management £4.3m, Estates and Facilities £2.7m and Long Term Agreements £2.0m.

Of the schemes identified, £5.7m relate to green schemes, with £3.0m relating to amber schemes. £2.5m are recurrent savings with £6.2m being non-recurrent savings.

End of Year – Saving Delivery Performance



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Savings

Savings Target

£42.8m

Recurrent = £42.8m
Non-Recurrent = £0.0m

In-Year Recurrent Gap

£40.3m

Target = £42.8m
Delivery = £2.5m



In-Year Non-Recurrent Gap

£(6.2)m

Target = £0.0m
Delivery = £6.2m



Full Year Recurrent Gap

£40.2m

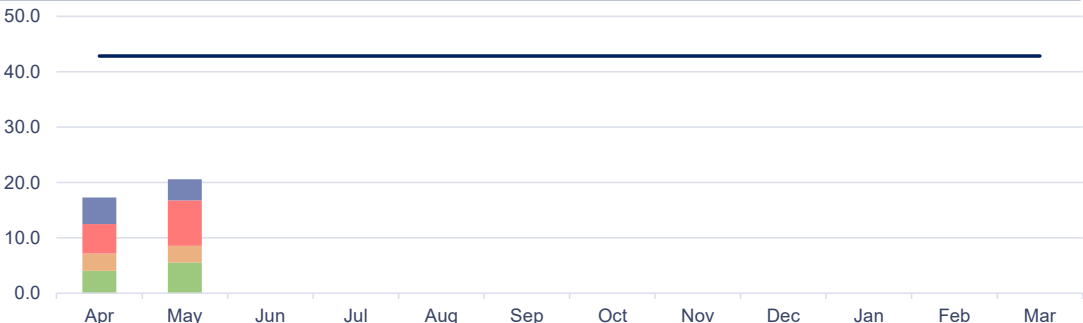
Target = £42.8m
Delivery = £2.6m



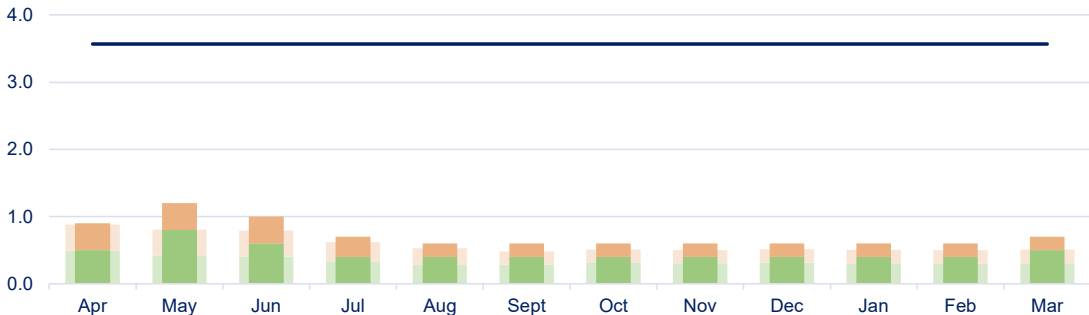
Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



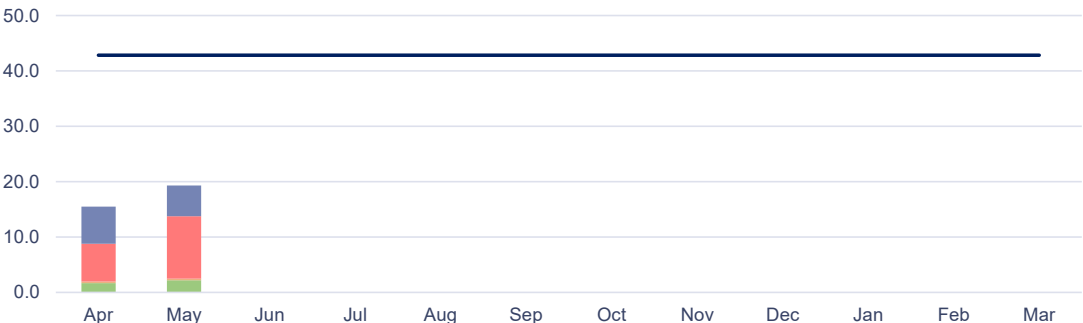
Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)



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



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



End of Year – Core Operational Variation



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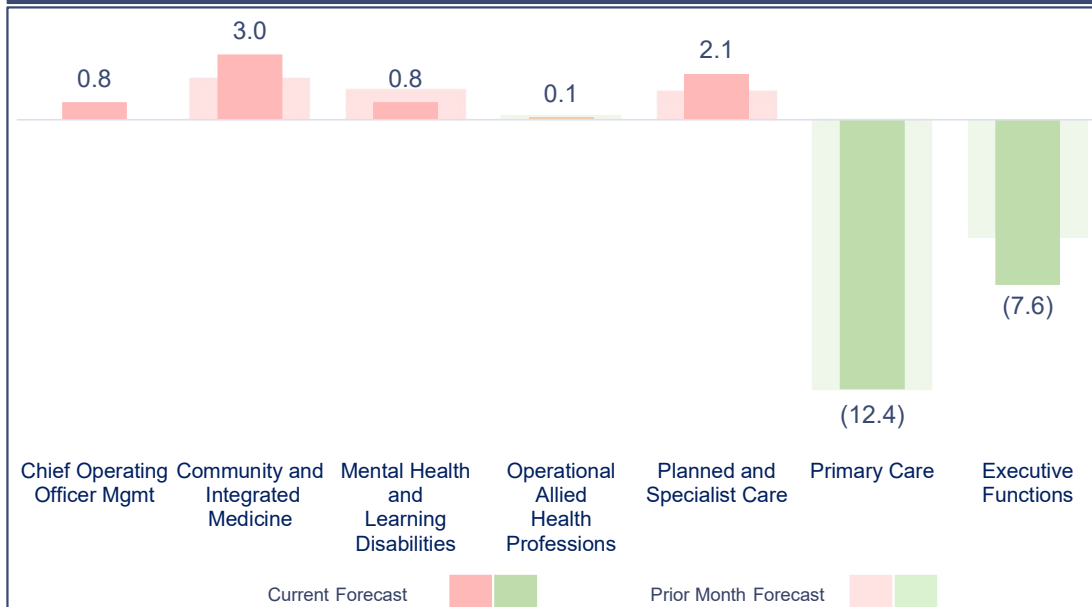
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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Portfolio	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.8	(0.1)	0.1	0.8
Community and Integrated Medicine	(0.5)	3.7	(0.2)	3.0
Mental Health and Learning Disabilities	(2.0)	2.8	0.0	0.8
Operational Allied Health and Health Sciences	(1.5)	2.2	(0.6)	0.1
Planned and Specialist Care	1.9	1.1	(0.9)	2.1
Primary Care	(0.5)	(13.7)	1.8	(12.4)
Executive Functions	(5.5)	(1.2)	(0.9)	(7.6)
Total	(7.3)	(5.2)	(0.7)	(13.2)

Key Information

Community and Integrated Medicine – Continuing Healthcare increase in monthly average of commissioned care days due to additional packages and increase in expenditure relating to insulin pumps. Continued medical locum usage to cover sickness and vacancies, offset by Nursing and Admin vacancies across the service.

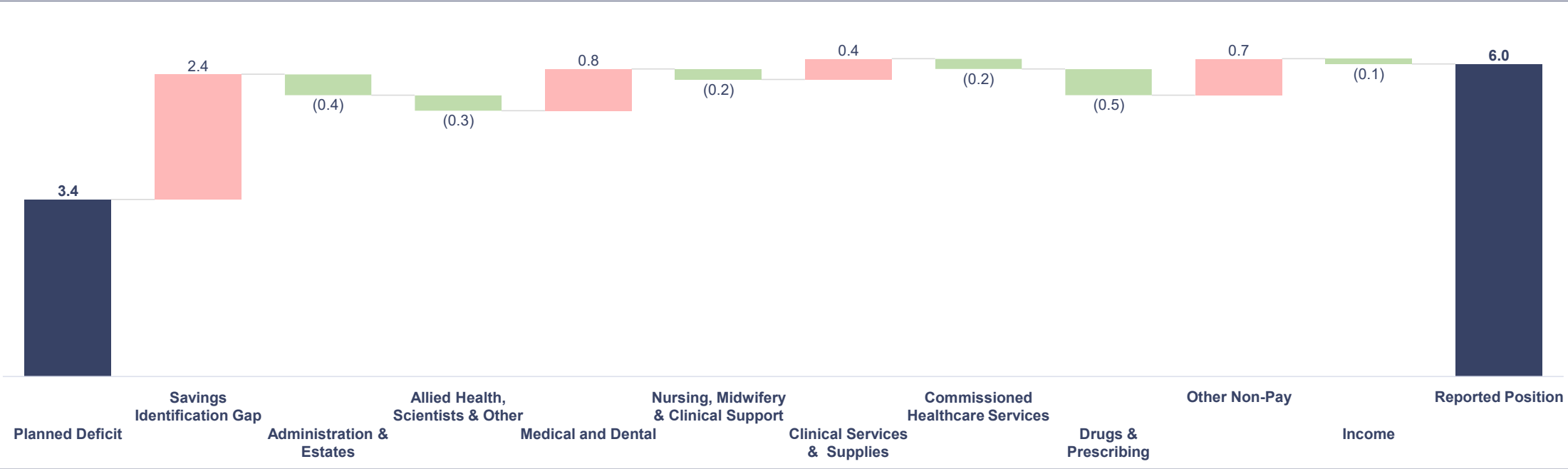
Mental Health – Continuing Healthcare increase in monthly average commissioned care days due to additional packages, outsourcing of Psychiatric Intensive Care Beds, Medical locum agency usage, offset by pay vacancies with Nursing and Allied Health due to delayed recruitment plans.

Planned and Specialist Care – Medical locum rate card within Anaesthetics, dual running of Medical staff within Bronglais Obstetrics, Gynaecology and Paediatrics and increased operating theatres consumables including loan kits and theatres insourcing. Ophthalmology outsourcing increase for Intravitreal injection therapy, offset by Ophthalmology drugs reduction.

Primary Care – Dental contacts hand back, General Medicine Services Supplementary Services underspend and delay in Cluster projects offset by underachievement of Dental income.

Executive Functions – Pay vacancies mainly within Estates, Public Health and Workforce £(5.5)m. VAT recovery reviews identified £(1.3)m, Pharmacy biosimilar drugs savings £(1.8)m, unconfirmed Medical Value Based Healthcare plans £(1.2)m, offset by Estates maintenance increase £1.3m and Swansea Bay Long Term Agreement Emergency activity increase £2.1m.

In-Month – Key Drivers vs Plan



Key Information

Savings Identification Gap – Savings identification of £1.2m against savings target of £3.6m, leaving a savings unidentified gap of £2.4m.

Medical and Dental – Medical locum agency usage including dual-running across Bronglais Obstetrics, Gynaecology and Paediatrics within Planned and Specialist Care. Community and Integrated Medicine high-cost agency usage to cover sickness and vacancies, with anticipated recruitment across the service to mitigate future use of Medical agency.

Clinical Services & Supplies – Planned and Specialist Care theatre consumables purchases relating to loan kits and implants, and outsourcing of Radiology activity including MRI vans.

Commissioned Healthcare Services – Primary Care Dental contracts hand back £(0.9)m, offset by sustained increase of Continuing Healthcare packages within Mental Health and Community and Integrated Medicine £0.3m, purchase of outsourced Psychiatric Intensive Care Unit Beds £0.2m, Swansea Bay Long Term Agreement increase in emergency activity £0.2m.

Drugs & Prescribing – Rheumatology biosimilar drugs underspends, and reduction in Ophthalmology drugs due to outsourcing of activity and lower uptake of vaccinations within Public Health.

Other Non-Pay – Digital Strategic Partnership Contract phasing £0.2m, Building and Estates maintenance expenditure £0.2m, and 13 additional losses cases compared to average of 7 £0.2m.

In-Month – Key Performance vs Plan



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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	0.4	0.5	Voluntary Early Retirement Scheme payments
Community and Integrated Medicine	0.9	0.0	0.3	1.2	Under-achieved savings target. Sustained increase in the number of Continuing Healthcare packages, increase in premium medical agency usage, offset by nursing vacancies.
Mental Health and Learning Disabilities	0.2	0.0	0.2	0.4	Under-achieved savings target. Sustained increase in the number of Continuing Health Care packages and purchase of outsourced Psychiatric Intensive Care Unit beds.
Operational Allied Health & Health Sciences	0.4	0.0	0.1	0.5	Under-achieved savings target. Increase in premium medical agency within Pathology. Pay vacancies within Radiology due to delayed recruitment, offset by outsourcing contracts for Radiology services.
Planned and Specialist Care	0.5	0.0	0.4	0.9	Under-achieved savings target. Medical locum agency usage, purchase of Theatre loan kits consumables, Ophthalmology outsourcing of activity, offset by reduction in Ophthalmology drugs.
Primary Care	0.0	0.0	(0.9)	(0.9)	Underspends relating to Dental contracts hand back, General Medical Services and delay in primary care and cluster projects.
Executive Functions	0.3	0.0	(0.3)	0.0	Swansea Bay Long Term Agreement emergency activity and underachieved savings £0.4m. Estates and Facilities maintenance and underachieved savings £0.3m. Workforce overachievement of pay savings £(0.4)m. Public Health vacancies and lower vaccination uptake £(0.3)m.
Sub Total	2.4	0.0	0.2	2.6	
Gross Position				6.0	

In-Month – Key Performance vs Plan Executive



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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	Digital Strategic Partnership Contract phasing
Estates and Facilities	0.2	0.0	0.1	0.3	Under-achieved savings target, Building & Estates maintenance
Executive Allied Health	0.0	0.0	0.0	0.0	No material deviation to plan
Finance	0.0	0.0	0.0	0.0	No material deviation to plan
Health Board Wide	(0.2)	0.0	0.0	(0.2)	Over-achieved savings target
LTA's	0.2	0.0	0.2	0.4	Under-achieved savings target, Swansea Bay emergency activity increase
Medical	0.0	0.0	0.0	0.0	No material deviation to plan
Nursing	0.0	0.0	0.0	0.0	No material deviation to plan
Pharmacy and Medicines Management	0.4	0.0	(0.3)	0.1	Under-achieved savings target, pay vacancies and further drugs rebate
Public Health	0.0	0.0	(0.3)	(0.3)	Pay vacancies and reduction in vaccination programme uptake
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)	Overachievement of pay savings against target, with further pay vacancies
Sub Total	0.3	0.0	(0.3)	0.0	

In-Month – Key Performance vs Prior Month



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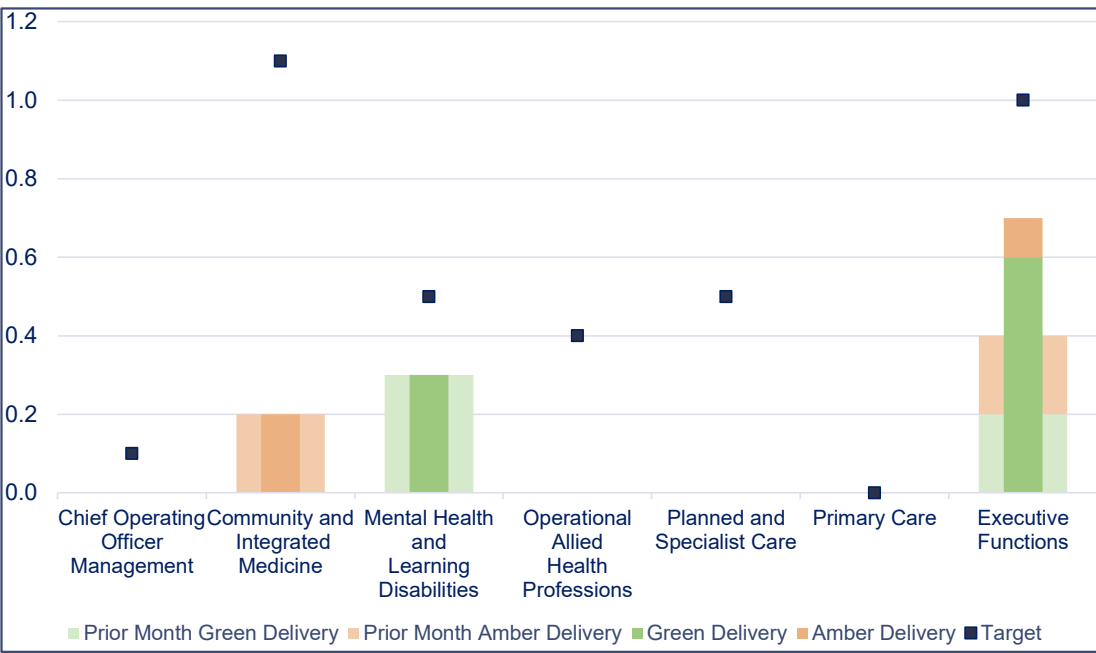
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Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target Movement	Savings Delivery vs Plan Benefits Movement	Core Operational Variation Movement	Total Movement	Key Information
				0.0	
Chief Operating Officer Management	0.0	0.0	0.4	0.4	Voluntary Early Retirement Scheme payments
Community and Integrated Medicine	0.0	0.0	0.0	0.0	No material movement from prior month.
Mental Health and Learning Disabilities	0.0	0.0	0.0	0.0	Increase in the number of Continuing Health Care packages, including a high-cost backdated package, offset by reduction in pay bank spend.
Operational Allied Health & Health Sciences	0.0	0.0	0.2	0.2	Increase in premium medical agency within Pathology, with an increase to the outsourced contracts in-month within Radiology.
Planned and Specialist Care	0.0	0.0	0.4	0.4	Purchase of theatre consumables and equipment including loan kits and implants, and theatres insourcing of activity.
Primary Care	0.0	0.0	(0.3)	(0.3)	One-off recovery payments recognised in prior month
Executive Functions	(0.3)	0.0	0.1	(0.2)	Savings identified in-month relating to Workforce contracts and Medical Agency reduction. Digital Strategic Partnership Contract phasing.
Sub Total	(0.3)	0.0	0.8	0.5	
Gross Position				0.5	

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	0.2	0.2	0.9
Mental Health and Learning Disabilities	0.5	0.3	0.3	0.2
Operational Allied Health and Health Sciences	0.4	0.0	0.0	0.4
Planned and Specialist Care	0.5	0.0	0.0	0.5
Primary Care	0.0	0.0	0.0	0.0
Executive Functions	1.0	0.7	0.7	0.3
Grand Total	3.6	1.2	1.2	2.4

Key Information

Overall, savings delivery of £1.2m has been achieved in Month 2, resulting in a £2.4m under-delivery against £3.6m target. Of the savings delivered in-month, £0.2m relate to recurrent schemes and £1.0m relate to non recurrent schemes.

The £2.4m under identification of savings largely relates to Community and Integrated Medicine £0.9m, Operational Allied Health £0.4m, Planned and Specialist Care £0.5m and Executive functions £0.3m. Executive functions underachievement largely relates to Pharmacy and Medicines Management £0.4m, Estates and Facilities £0.2m and Long-Term Agreements £0.2m, offset by overachievement within Workforce £(0.3)m and Health Board Wide £(0.2)m.

Newly identified schemes in-month largely relates to reduction in expenditure with Medical Agency pay £(0.2)m and Workforce contract saving £(0.1)m.

In-Month – Core Operational Variation



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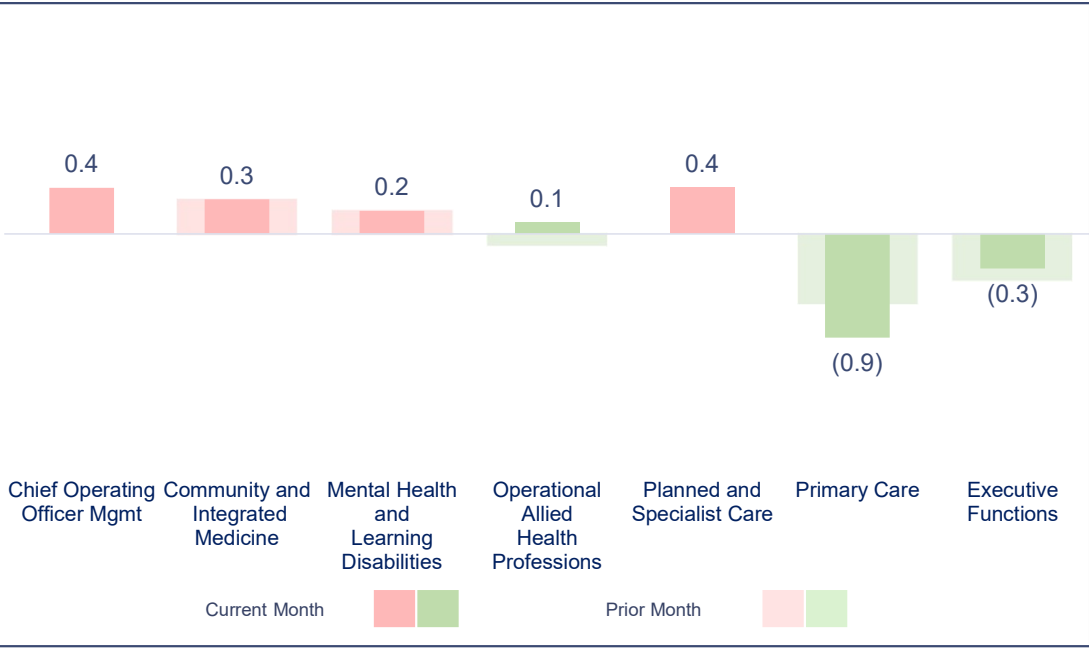
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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.4	0.0	0.0	0.4
Community and Integrated Medicine	0.0	0.3	0.0	0.3
Mental Health and Learning Disabilities	(0.1)	0.3	0.0	0.2
Operational Allied Health and Health Sciences	0.0	0.1	0.0	0.1
Planned and Specialist Care	0.2	0.3	(0.1)	0.4
Primary Care	(0.1)	(0.9)	0.1	(0.9)
Executive Functions	(0.6)	0.4	(0.1)	(0.3)
Total	(0.2)	0.5	(0.1)	0.2

Key Information

- Chief Operating Officer Management** – Voluntary Early Retirement Scheme payments.
- Community and Integrated Medicine** – Increase in Continuing Healthcare packages volume with the increase largely relating to Elderly Mentally Infirm nursing and Palliative Care packages.
- Mental Health** – Mental Health Continuing Healthcare packages increase, including a high-cost backdated package, and purchase of outsourced Psychiatric Intensive Care units beds.
- Planned and Specialist Care** – Purchase of theatre consumables and equipment including loan kits and implants, theatres insourcing of activity, and increase in Medical premium usage.
- Primary Care** – Dental contracts hand back underspend, General Medical Services underspend, and delay in Primary Care Cluster projects, offset by underachievement of Dental income.
- Executive Functions** – Pay underspends across various Executive functions. Digital commissioning contracts, Estates and Facilities maintenance and Swansea Bay LTA emergency activity.

Year to Date – Key Drivers vs Plan



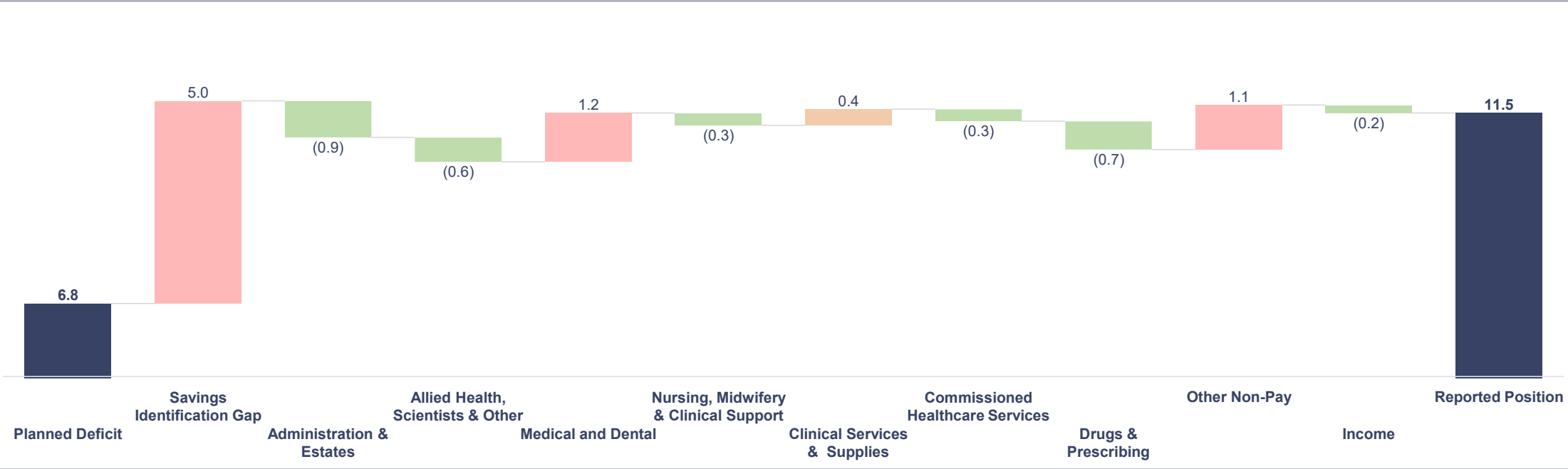
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Key Information

- Administration & Estates** – Admin and Clerical vacancies within Community and Integrated Medicine, Planned and Specialist Care, Public Health, Workforce and Estates and Facilities.
- Medical & Dental** – Medical locum agency usage including dual-running across Bronglais Obstetrics, Gynaecology and Paediatrics within Planned and Specialist Care, with continued use of premium rate card. Community and Integrated Medicine high-cost agency usage to cover sickness and vacancies, with anticipated recruitment to mitigate future use of Medical agency.
- Drugs & Prescribing** – Rheumatology biosimilar drugs underspends, reduction in Ophthalmology drugs due to outsourcing of activity and lower uptake of vaccinations within Public Health.
- Other Non-Pay** – Digital Strategic Partnership Contract phasing, Estates maintenance contract uplifts and other utilities relating to water and heating oil expenditure being higher than anticipated, and 13 additional losses cases compared to average of 7 £0.2m.

Year to Date – Key Performance vs Plan



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Clinical Care Groups and Executive Functions (£'m)	Savings Gap to Target	Savings Delivery vs Plan Benefits	Core Operational Variation	Total	Key Information
Planned Deficit				6.8	
Chief Operating Officer Management	0.1	0.0	0.4	0.5	Voluntary Early Retirement Scheme payments.
Community and Integrated Medicine	1.8	0.0	0.6	2.4	Under-achieved savings target, increase in Continuing Healthcare packages volume and Medical locum agency usage.
Mental Health and Learning Disabilities	0.5	0.0	0.5	1.0	Under-achieved savings target, Continuing Healthcare packages increase and purchase of Psychiatric Intensive Care Unit beds.
Operational Allied Health & Health Sciences	0.8	0.0	0.0	0.8	Under-achieved savings target. Radiology vacancies due to delayed recruitment, offset by outsourcing contracts for Radiology services.
Planned and Specialist Care	1.0	0.0	0.4	1.4	Under-achieved savings target. Medical locum agency usage, Ophthalmology outsourcing of activity, offset by reduction in Ophthalmology drugs.
Primary Care	(0.1)	0.0	(1.4)	(1.5)	Underspend relating to Dental contracts, General Medical Services supplementary services and delay in cluster projects.
Executive Functions	0.9	0.0	(0.8)	0.1	Under-achieved savings target. Pay vacancies largely within Public Health and Workforce £(1.1)m, offset by Swansea Bay Emergency Activity £0.4m, Digital contracts phasing £0.2m and Estates maintenance contract uplift £0.3m.
Sub Total	5.0	0.0	(0.3)	4.7	
Gross Position				11.5	

Year to Date – Savings Performance Breakdown



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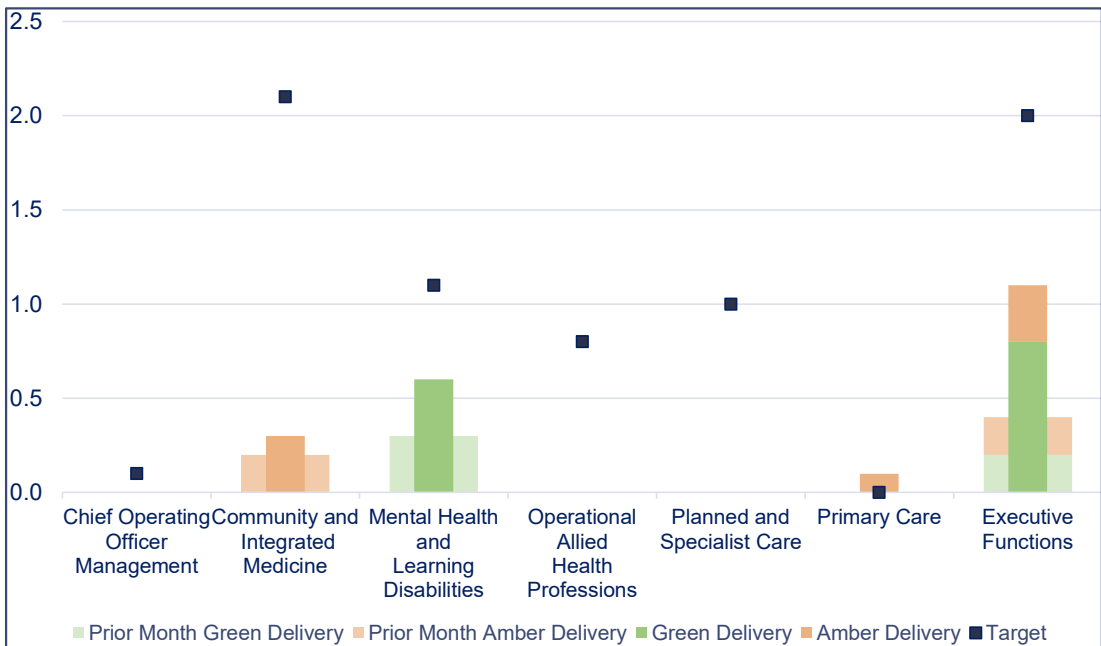
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Savings Delivery vs Target (£'m)



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	2.1	0.3	0.3	1.8
Mental Health and Learning Disabilities	1.1	0.6	0.6	0.5
Operational Allied Health and Health Sciences	0.8	0.0	0.0	0.8
Planned and Specialist Care	1.0	0.0	0.0	1.0
Primary Care	0.0	0.1	0.1	(0.1)
Executive Functions	2.0	1.1	1.1	0.9
Grand Total	7.1	2.1	2.1	5.0

Key Information

Overall savings identification of £2.1m has been identified, resulting in a £5.0m savings under-identification against £7.1m target, with variations across Clinical Care Groups.

This under delivery largely relates to relates to Community and Integrated Medicine £1.8m, Operational Allied Health £0.8m, Planned and Specialist Care £1.0m and Executive functions £0.9m. Executive functions underachievement largely relates to Pharmacy and Medicines Management £0.7m, Estates and Facilities £0.4m and Long-Term Agreements £0.3m, offset by overachievement within Workforce £(0.4)m.

The identified savings are mainly non-recurrent pay savings £1.8m, with £0.3m recurrent savings relating to Dapagliflozin drugs reduction in price.

Year to Date – Core Operational Variation



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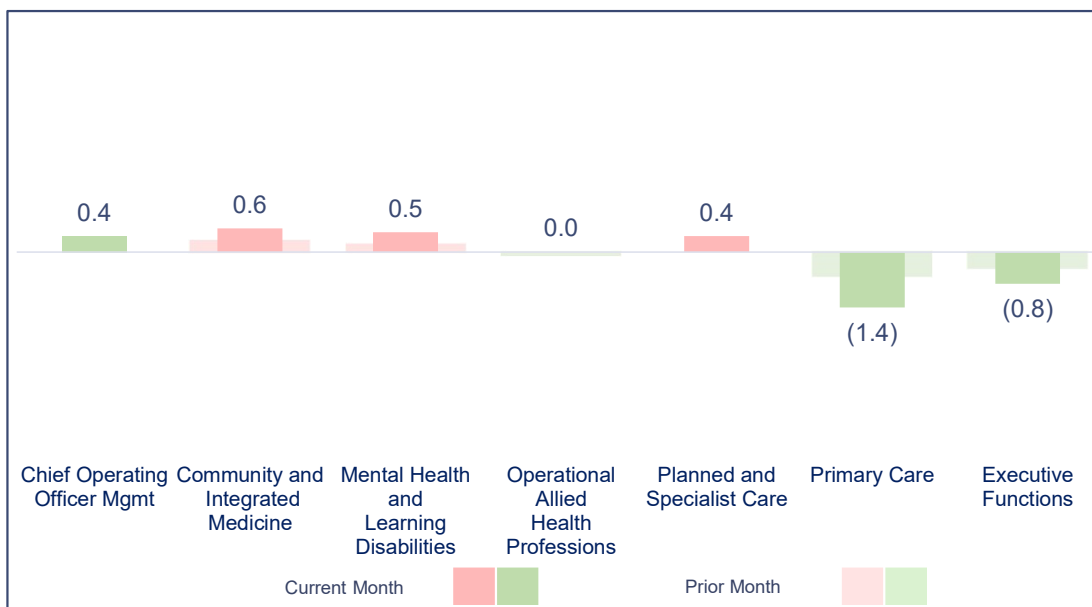
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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.4	0.0	0.0	0.4
Community and Integrated Medicine	(0.1)	0.7	0.0	0.6
Mental Health and Learning Disabilities	(0.1)	0.6	0.0	0.5
Operational Allied Health and Health Sciences	(0.1)	0.2	(0.1)	0.0
Planned and Specialist Care	0.4	0.1	(0.1)	0.4
Primary Care	(0.1)	(1.6)	0.3	(1.4)
Executive Functions	(1.0)	0.5	(0.3)	(0.8)
Total	(0.6)	0.5	(0.2)	(0.3)

Key Information

Chief Operating Officer Management Voluntary Early Retirement Scheme payments.

Community and Integrated Medicine Increase in Continuing Healthcare packages volume with the increase largely relating to Elderly Mentally Infirm nursing and Palliative Care packages.

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

Planned and Specialist Care Medical locum agency usage including dual-running across Bronglais within Planned and Specialist Care, with continued use of premium rate card.

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

Executive Functions Pay vacancies within Workforce and Public Health, offset by Swansea Bay Emergency activity, Digital contracts phasing and Estates maintenance contract uplift.

Capital Performance

Capital

Total Capital Performance

£34.6m



Annual Plan £34.6m

All Wales Capital

£26.6m



Annual Plan £26.5m

Discretionary Capital

£8.0m



Annual Plan £8.1m

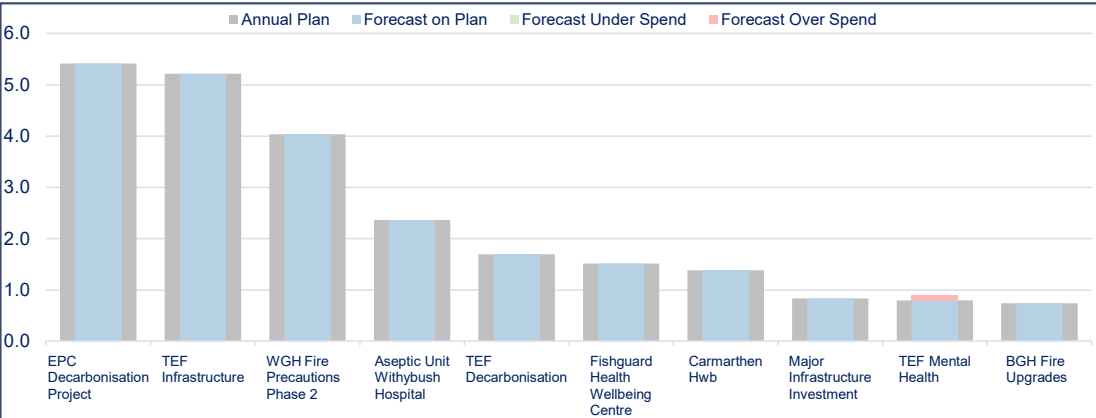
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£0.0m

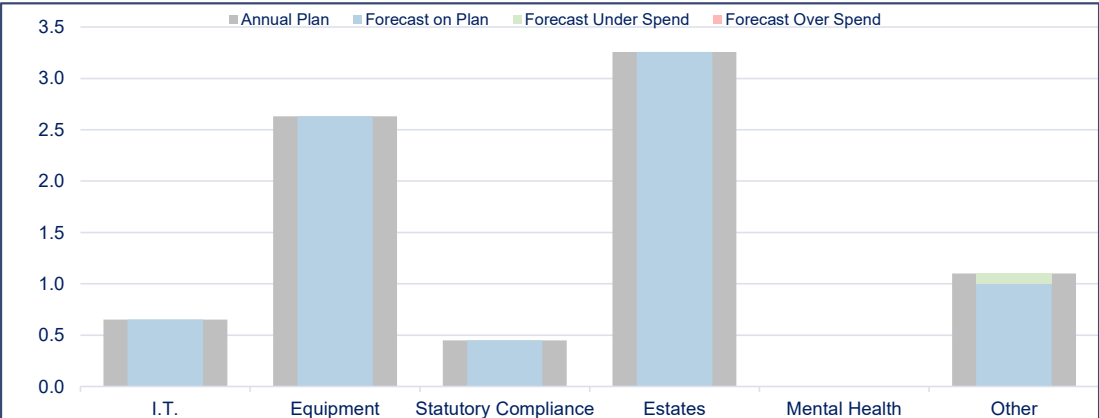


Capital Resource Limit £0.0m

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 low risk. Capital projects are currently expected to deliver the Capital Resource Limit; this assessment will be kept under review as the year progresses.

The Capital Programme for the year is comprised of £26.6m All Wales Capital Programme funding and £8.0m 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. Currently Targeted Estates Fund Mental Health and Other Discretionary Capital Programmes are forecasting slight underspends.

Trend Analysis – Non-Pay and Income



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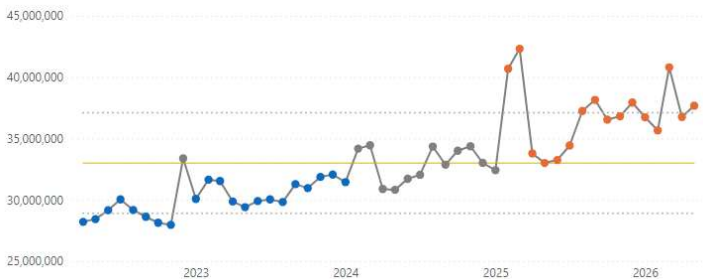
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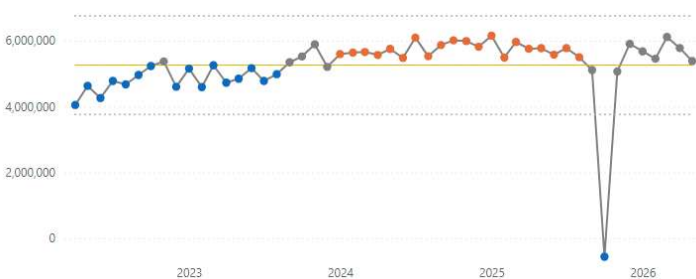
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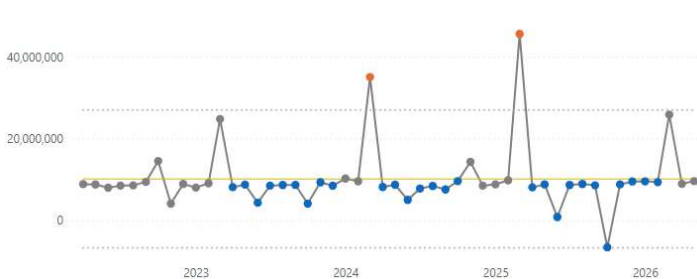
Commissioned Healthcare Services (£)



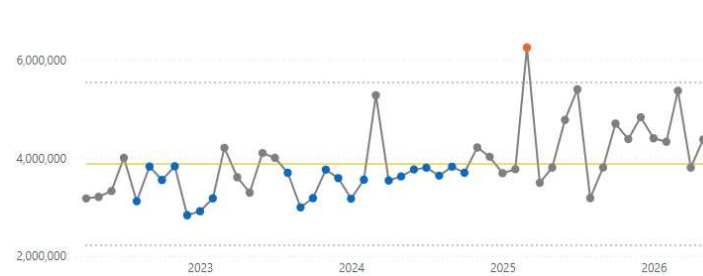
Secondary Care Drugs (£)



Other Non-Pay (£)



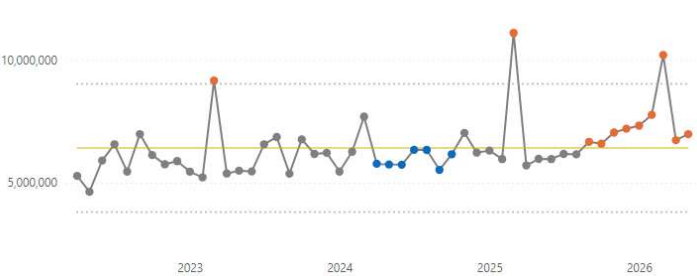
Clinical Services and Supplies (£)



Primary Care Prescribing (£)



Income (£)



Key Information

Commissioned Healthcare Services – Increase in-month relating to year to date Pharmaceuticals Joint Commissioning Committee pass through expenditure, offset by additional funding.

Secondary Care Drugs – Reduction in drugs within Cancer and Scheduled Care relating to Rheumatology drugs biosimilar impact, and Ophthalmology drugs reduction due to outsourcing of service.

Clinical Services & Supplies – Increase from prior month relating to Planned and Specialist Care operating theatre consumables including loan kits and theatres insourcing of activity.

Primary Care Prescribing – Price reduction in Dapagliflozin drugs due to loss of exclusivity from generic availability.

Trend Analysis – Pay Agenda for Change



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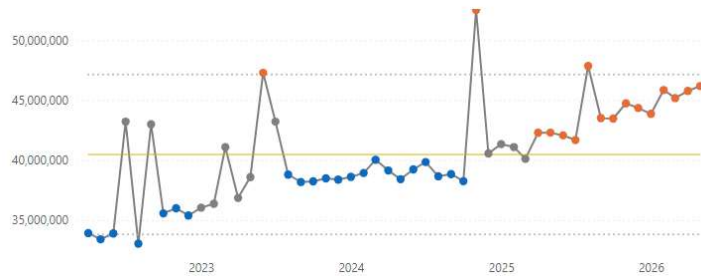
Income and Expenditure
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Financial Performance

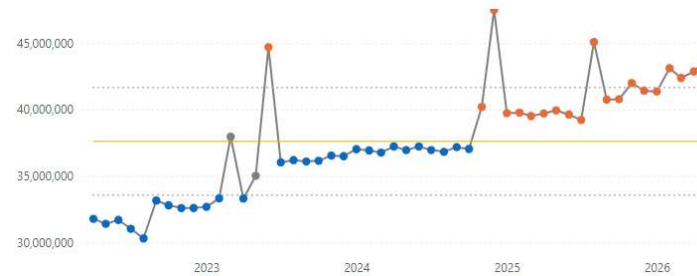
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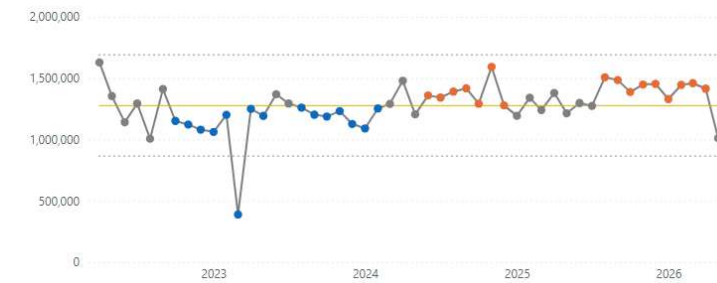
Total (£)



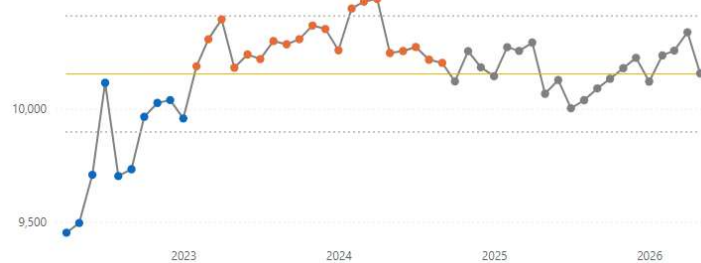
Substantive (£)



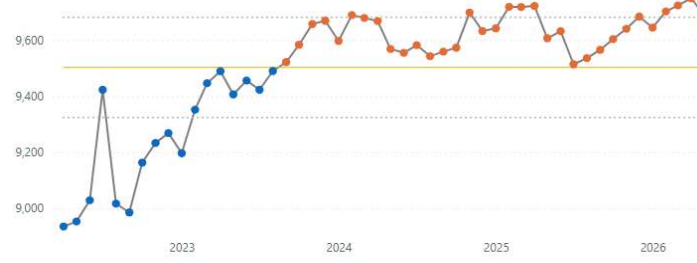
Bank (£)



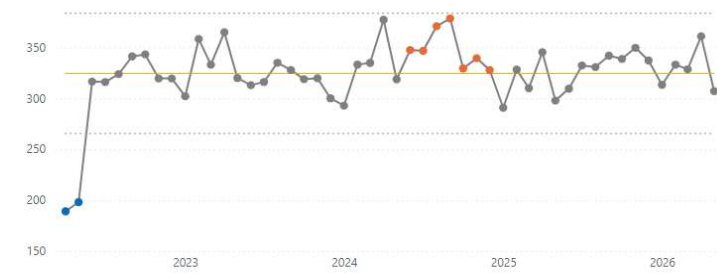
Total (WTE)



Substantive (WTE)



Bank (WTE)



Key Information

Substantive £ – Increase in substantive pay expenditure within Community and Integrated Medicine, Planned and Specialist Care due to increased Bank Holiday Enhanced and On Call Availability supplement payments, despite reduction in Whole Time Equivalents.

Bank £ and WTE – Reduction of 53.76 Bank WTE largely relating to Nursing and Healthcare Support Workers within Community and Integrated Medicine and Mental Health due to inability to fill shifts within Ceredigion, and reduction of patient acuity within Mental Health.

Total WTE – Reduction in Total WTE relating to reductions in Whole Time Equivalents across Substantive, Bank, Overtime and Waiting List Initiative from prior month.

Trend Analysis – Pay Agenda for Change



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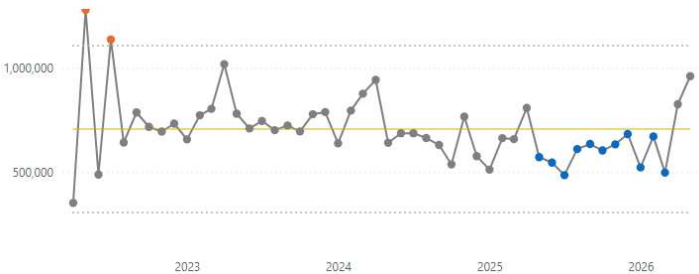
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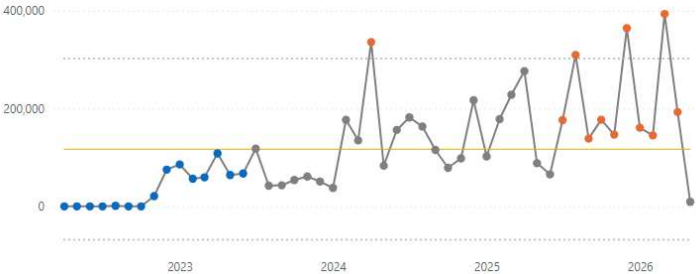
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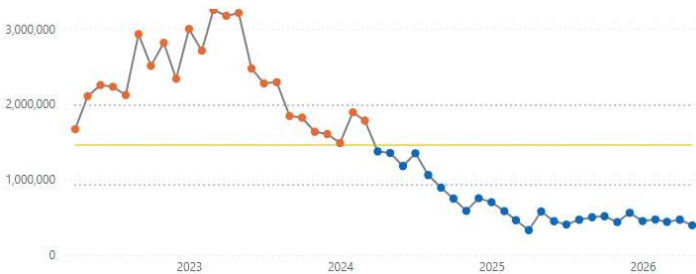
Overtime (£)



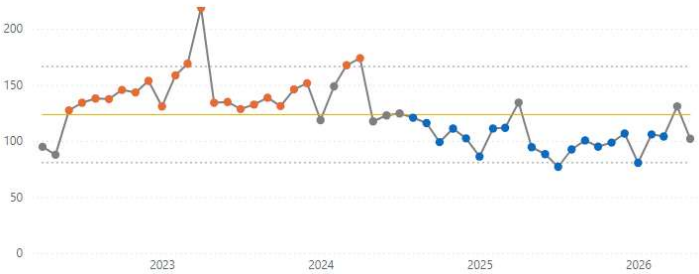
WLI (£)



Agency (£)



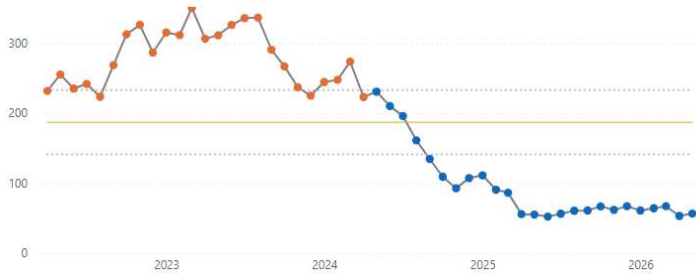
Overtime (WTE)



WLI (WTE)



Agency (WTE)



Key Information

- Overtime £** - Increase in Overtime expenditure from prior month despite reduction in Whole Time Equivalents, due to retrospective claims.
- Waiting List Initiative £ and WTE** - Reduction from prior month due to significantly less Waiting List Initiative activity being undertaken within Planned and Specialist Care compared to prior year.

Trend Analysis – Pay Medical and Dental



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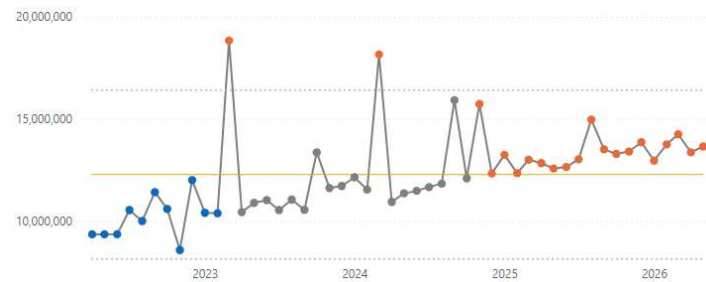
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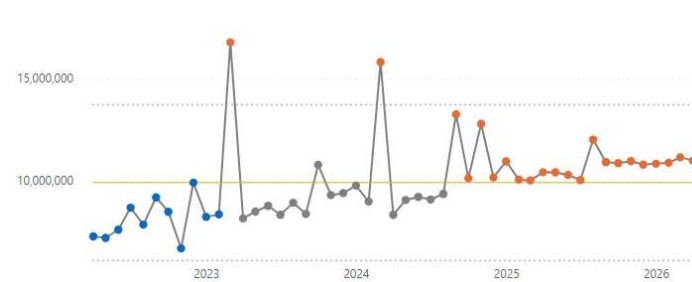
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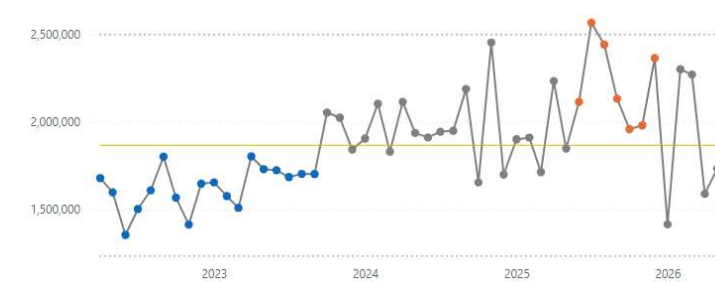
Total (£)



Substantive (£)



Additional Hours (£)



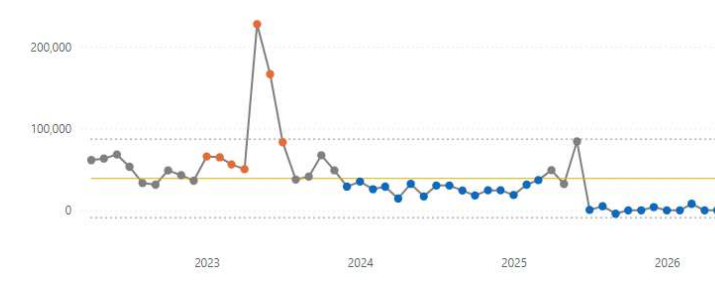
WLI (£)



On Contract Agency Premium (£)



Off Contract Agency Premium (£)



Key Information

Total £ - Increase in expenditure from prior month largely in Community and Integrated Medicine and Operational Allied Health due to increase reliance on Medical locum usage.

Additional Hours £ - Increase in Additional Duty Hours from prior month largely within Planned and Specialist Care and Operational Allied Health due to additional agency locum usage within Pathology, and dual-running within Bronglais to cover vacancies and sickness.

Waiting List Initiative £ - Reduction from prior month due to significantly less Waiting List Initiative activity being undertaken within Planned and Specialist Care compared to prior year.

On Contract Agency Premium £ - Agency pay expenditure reduction across various areas.

Staffing Establishment Reports



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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%	2,637	2,316	(288)	266	49	31
Community and Integrated Medicine	103.2%	1,877	1,641	(224)	191	41	11
Carmarthenshire Integrated System	103.5%	1,137	998	(111)	120	17	27
Ceredigion Integrated System	107.5%	319	268	(53)	34	16	(2)
Pembrokeshire Integrated System	99.4%	421	375	(60)	37	8	(14)
Mental Health and Learning Disabilities	104.7%	287	236	(38)	50	1	13
Planned and Specialist Care	96.6%	473	439	(26)	25	7	7
Cancer and Scheduled Care	94.6%	171	151	(11)	12	7	8
Children, Women and Family Health	97.6%	302	288	(15)	13	-	(1)
Grand Total	102.2%	2,637	2,316	(288)	266	49	31

All Other Staffing Levels (WTE) Excluding Medical and Ward Nursing & HCSWs	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Executive	90.6%	89	89	-	-	-	-
Chief Operating Officer	93.7%	5,226	5,106	(531)	111	5	(411)
Chief Operating Officer Management	81.6%	120	117	(11)	3	-	(8)
Community and Integrated Medicine	97.0%	1,413	1,373	(161)	36	3	(121)
Mental Health and Learning Disabilities	90.3%	909	900	(117)	8	-	(108)
Operational Allied Health and Health Sciences	97.2%	1,128	1,098	(72)	29	-	(42)
Planned and Specialist Care	95.0%	1,458	1,425	(132)	30	2	(100)
Primary Care	87.2%	198	193	(38)	5	-	(32)
Executive Director of Allied Health Professions and Health Sciences	95.2%	860	815	(91)	44	-	(47)
Executive Director of Finance	89.9%	432	426	(31)	6	-	(25)
Executive Director of Nursing, Quality and Patient Experience	90.9%	180	180	(9)	-	-	(8)
Executive Director of Public Health	87.6%	139	139	(41)	-	-	(41)
Executive Director of Strategy and Planning	93.9%	48	48	(1)	-	-	(1)
Executive Director of Workforce and Organisational Development	74.6%	223	222	(69)	1	-	(68)
Executive Medical Director	87.0%	321	321	(36)	-	-	(35)
Grand Total	92.7%	7,518	7,346	(809)	162	5	(636)

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



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Clinical Care Group and Executive Functions (£'k)	Pay				Non-Pay				Income	Grand Total
	Administration and Estates	Allied Health, Scientists and Other	Medical and Dental	Nursing, Midwifery and Clinical Support	Clinical Services and Supplies	Commissioned Healthcare Services	Drugs and Prescribing	Other Non-Pay	Income	
Chief Executive	(1)							(6)	(3)	(9)
Chief Operating Officer	(62)	(223)	770	(74)	466	(281)	(357)	274	10	524
Chief Operating Officer Management	131	(22)	5	326	19	(3)	0	(61)	7	403
Community and Integrated Medicine	(53)	(7)	311	(200)	96	104	(27)	117	(4)	337
Mental Health and Learning Disabilities	12	(55)	71	(153)	(1)	353	(21)	7	0	212
Operational Allied Health and Health Sciences	(16)	(195)	145	70	153	(50)	(78)	104	(59)	74
Planned and Specialist Care	(60)	46	244	(63)	213	218	(250)	91	(87)	351
Primary Care	(74)	10	(6)	(54)	(14)	(903)	19	16	153	(852)
Executive Director of Allied Health Professions and Health Sciences	(98)	(15)		5	1	0	4	174	(15)	55
Estates and Facilities	(111)			5	1		4	174	(15)	58
Executive Allied Health Professions and Health Sciences	12	(15)				0				(3)
Executive Director of Finance	(84)	23	0	22	0	(88)		227	(5)	96
Digital	(61)	23	0	22	0	(87)		235	(6)	127
Finance	(23)					(1)		(8)	1	(31)
Executive Director of Nursing, Quality and Patient Experience	3	(9)		(46)	(0)	2		21	39	11
Executive Director of Public Health	(64)	(18)	(8)	(64)	3	(13)	(99)	(4)	(0)	(268)
Executive Director of Strategy and Planning	(36)	(0)	8		(0)	212	0	(19)	5	170
LTAs with other NHS Providers	2				(0)	213	0	(0)		214
Strategy and Planning	(39)	(0)	8			(1)		(18)	5	(45)
Executive Director of Workforce and Organisational Development	(116)	(3)		(26)	6	20	(3)	24	(15)	(115)
Executive Medical Director	(2)	(71)	(7)	4	(40)	16	(76)	(65)	(38)	(278)
Medical	4	(5)	(7)	20	0		0	(51)	19	(20)
Pharmacy and Medicines Management	(6)	(66)		(15)	(41)	16	(76)	(14)	(56)	(258)
Health Board Wide	0	0	(10)	25	3	(17)	(15)	116	(85)	17
Planned Deficit								3,417		3,417
Savings Identification								2,358		2,358
Grand Total	(460)	(315)	753	(155)	438	(149)	(546)	6,517	(106)	5,977

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



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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	(4)							(24)	(0)	(28)
Chief Operating Officer	(255)	(397)	1,262	(228)	446	(463)	(483)	470	43	396
Chief Operating Officer Management	152	(41)	10	341	47	(6)	0	(86)	1	419
Community and Integrated Medicine	(150)	(6)	477	(419)	134	347	21	248	(20)	632
Mental Health and Learning Disabilities	17	(111)	122	(175)	8	638	(56)	5	8	456
Operational Allied Health and Health Sciences	(32)	(357)	168	105	197	(38)	(124)	166	(103)	(19)
Planned and Specialist Care	(145)	55	503	(23)	112	240	(346)	117	(139)	373
Primary Care	(97)	63	(18)	(58)	(52)	(1,644)	22	20	297	(1,467)
Executive Director of Allied Health Professions and Health Sciences	(124)	(29)		3	(2)	0	4	348	12	212
Estates and Facilities	(150)			3	(2)		4	348	12	216
Executive Allied Health Professions and Health Sciences	26	(29)				0		0		(3)
Executive Director of Finance	(147)	46	1	43	0	(173)		261	(10)	20
Digital	(101)	46	1	43	0	(171)		245	(12)	51
Finance	(46)					(2)		15	2	(31)
Executive Director of Nursing, Quality and Patient Experience	(4)	(16)		(38)	(1)	12		30	17	0
Executive Director of Public Health	(135)	(38)	(20)	(130)	5	(26)	(91)	(12)	2	(445)
Executive Director of Strategy and Planning	1	(0)	17		(0)	383	0	(51)	(94)	255
LTAs with other NHS Providers	6				(0)	384	0	(1)		389
Strategy and Planning	(5)	(0)	17			(2)		(50)	(94)	(134)
Executive Director of Workforce and Organisational Development	(213)	(6)		(54)	6	(9)	(7)	(32)	(26)	(341)
Executive Medical Director	(24)	(150)	(7)	39	(68)	13	(142)	(61)	(105)	(504)
Medical	(12)	(9)	(9)	33	1		0	(75)	(7)	(77)
Pharmacy and Medicines Management	(12)	(141)	2	6	(69)	13	(142)	14	(98)	(427)
Health Board Wide	6	2	(19)	7	7	(34)	(9)	159	(98)	20
Planned Deficit								6,833		6,833
Savings Identification								5,044		5,044
Grand Total	(898)	(588)	1,233	(358)	393	(297)	(728)	12,964	(259)	11,462

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



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	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	(207)							(26)	(0)	(233)
Chief Operating Officer	(2,252)	(3,011)	8,330	(4,804)	3,168	(5,282)	(3,144)	1,247	171	(5,576)
Chief Operating Officer Management	208	271	(41)	447	299	(34)	0	(411)	79	817
Community and Integrated Medicine	(757)	22	3,023	(2,809)	828	2,669	(394)	617	(182)	3,017
Mental Health and Learning Disabilities	(0)	(1,193)	924	(1,700)	19	2,933	(155)	(48)	35	815
Operational Allied Health and Health Sciences	(173)	(2,676)	678	600	2,122	(132)	(549)	738	(558)	50
Planned and Specialist Care	(803)	276	3,354	(890)	284	2,186	(1,982)	676	(967)	2,134
Primary Care	(726)	290	391	(453)	(383)	(12,903)	(64)	(324)	1,764	(12,408)
Executive Director of Allied Health Professions and Health Sciences	(810)	(178)		15	(10)	1	0	1,256	0	274
Estates and Facilities	(962)			15	(10)		0	1,254	0	296
Executive Allied Health Professions and Health Sciences	152	(178)				1		2		(22)
Executive Director of Finance	(803)	279	3	260	1	(26)		(1)	11	(275)
Digital	(542)	279	3	260	1	(14)		13	1	1
Finance	(261)					(11)		(14)	10	(276)
Executive Director of Nursing, Quality and Patient Experience	41	(97)		(192)	(3)	73		91	93	6
Executive Director of Public Health	(775)	(215)	(97)	(775)	31	(157)	(247)	(107)	13	(2,330)
Executive Director of Strategy and Planning	(62)	(0)	93		(0)	2,072	0	(19)	(141)	1,943
LTAs with other NHS Providers	28				(0)	2,082	0	(6)		2,104
Strategy and Planning	(90)	(0)	93			(10)		(14)	(141)	(161)
Executive Director of Workforce and Organisational Development	(1,222)	(39)	0	(321)	41	166	(40)	(194)	(0)	(1,610)
Executive Medical Director	(63)	(678)	96	253	(411)	75	(1,781)	(763)	(141)	(3,412)
Medical	8	(57)	94	209	4		0	(1,188)	(31)	(961)
Pharmacy and Medicines Management	(71)	(621)	2	44	(415)	75	(1,781)	426	(111)	(2,451)
Health Board Wide	(1,289)	(973)	(6,405)	(2,657)	21		(21)	(10,865)	(700)	(22,888)
Planned Deficit								41,000		41,000
Savings Identification								34,103		34,103
Grand Total	(7,442)	(4,911)	2,020	(8,222)	2,837	(3,078)	(5,233)	65,722	(694)	41,000

End of Year – Savings Detail (£'k)



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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)	124	0	124	124	(149)	3.7%	0	(25)	0.0%
Chief Operating Officer	30,676	3,901	275	3,626	3,901	26,775	0.6%	275	30,401	0.0%
Chief Operating Officer Management	749	0	0	0	0	749	0.0%	0	749	0.0%
Community and Integrated Medicine	12,524	1,542	0	1,542	1,542	10,982	0.6%	0	12,524	0.0%
Mental Health and Learning Disabilities	6,442	1,845	0	1,845	1,845	4,597	1.8%	0	6,442	0.0%
Operational Allied Health and Health Sciences	4,849	0	0	0	0	4,849	0.0%	0	4,849	0.0%
Planned and Specialist Care	5,889	275	275	0	275	5,614	0.1%	275	5,614	0.1%
Primary Care	223	239	0	239	239	(16)	2.1%	0	223	0.0%
Executive Director Of Allied Health Professions and Health Sciences	2,714	9	9	0	9	2,705	0.0%	35	2,679	0.1%
Estates and Facilities	2,705	9	9	0	9	2,696	0.0%	35	2,670	0.1%
Executive Allied Health Professions and Health Sciences	9	0	0	0	0	9	0.0%	0	9	0.0%
Executive Director Of Finance	239	119	119	0	119	120	0.5%	119	120	0.5%
Digital	373	0	0	0	0	373	0.0%	0	373	0.0%
Finance	(134)	119	119	0	119	(253)	2.0%	119	(253)	2.0%
Executive Director Of Nursing, Quality and Patient Experience	0	0	0	0	0	0	0.0%	0	0	0.0%
Executive Director Of Public Health	131	0	0	0	0	131	0.0%	0	131	0.0%
Executive Director Of Strategy and Planning	2,035	454	74	380	454	1,581	0.7%	74	1,961	0.1%
LTAs With Other NHS Providers	1,961	0	0	0	0	1,961	0.0%	0	1,961	0.0%
Strategy and Planning	74	454	74	380	454	(380)	12.2%	74	0	2.0%
Executive Director Of Workforce and Organisational Development	(481)	1,886	302	1,584	1,886	(2,367)	12.4%	302	(783)	2.0%
Executive Medical Director	5,951	1,701	1,520	181	1,701	4,250	1.7%	1,520	4,431	1.5%
Medical	72	152	75	77	152	(80)	3.4%	75	(3)	1.7%
Pharmacy and Medicines Management	5,879	1,549	1,445	104	1,549	4,330	1.6%	1,445	4,434	1.5%
Health Board Wide	1,560	503	244	259	503	1,057	1.4%	244	1,316	0.7%
Grand Total	42,800	8,697	2,544	6,154	8,697	34,103	0.9%	2,570	40,230	0.3%

5.2

11:15, 15 Mins

5.2 - FINANCE DEEP DIVE: ALERTS (MEDICAL)

Mark Henwood
(Hywel Dda UHB -
Executive Medical
Director)

| For assurance

Attachments

[Finance Deep Dive - Medical FPC 30 June 2026.pdf](#)

[Appendix 1 Key Drivers.pdf](#)

[Appendix 2 Medical Workforce Stabilisation Internal Audit Report.pdf](#)

[Appendix 3 Action Plan.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Finance Deep Dive - Medical
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Carly Hill, Assistant Director, Medical Directorate

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 is currently incurring significant and sustained financial pressure driven by medical workforce spend, with a substantial proportion of predictable activity delivered through variable pay (locum, agency, additional sessions) rather than substantive job plans.

This creates:

- Reduced financial control
- Ongoing cost escalation
- Misalignment between workforce capacity and service demand

Current position:

- Variable pay is being used to sustain core, recurring activity
- Workforce models are not consistently aligned to demand
- Medical staffing remains a primary driver of financial pressure

The recent All-Wales Agency and Locum and Variable Pay Expenditure Analysis 2025/26 undertaken by NHS Performance and Improvement has reported that Hywel Dda University Health Board (HDdUHB) is less reliant on agency locums than some Health Boards however this is negated by the Health Board having one of the highest levels of internal medical variable pay in Wales.

Cefndir / Background

Medical workforce spend continues to be a significant driver of the Health Board's financial position, with ongoing reliance on locum, agency, and additional session payments to sustain

core services. This has arisen not solely from workforce shortages, but from how services are configured and job planned, with predictable activity frequently delivered through variable pay rather than substantive capacity.

A targeted deep dive has therefore been undertaken to understand the structural drivers of this position and identify opportunities to shift to a more planned, cost-controlled workforce model.

The focus is on enabling financial recovery and sustainable service delivery through better alignment of workforce capacity to demand.

Asesiad / Assessment

Current Position

- Workforce configuration does not consistently match demand patterns
- Predictable activity (for example, Collaborative Effort for Patient Outcome Development (CEPOD) Theatre work, elective work) is delivered as additional paid activity rather than core contracted work
- Certain specialties and sites (for example the Bronglais Hospital (BGH) anaesthetics services) show systematic reliance on variable pay models

This results in:

- Higher cost for activity (hidden cost)
- Limited transparency of true workforce requirement
- Persistent overspend driven by structural factors

£1.1m medical agency expenditure incurred to end of May (P02), with full year forecast of c.£6.5m.

- Forecast represents a £1.9m increase (+41%) compared to 2025/26 baseline
- Current trajectory is £3.3m above the 30% reduction target for agency spend

Overall position masks variation across services:

- Planned and Specialist Care: forecast 30% reduction (on target)
- Pathology (Operational Allied Health Professions and Health Science): +38% increase
- Community and Integrated Medicine: +128% (+£1.9m), driven primarily by Pembrokeshire rota gaps and front-door pressures

Monthly run rate expected to stabilise at ~£0.5m per month, with only marginal reduction from early-year levels

Key Drivers (Appendix 1)

Job planning misalignment

- Recurrent work not embedded in job plans
- Dependence on additional sessions to deliver planned activity

Job planning for medical staff in NHS Wales is a contractual requirement and a core mechanism for aligning workforce capacity with service demand. Consultant job plans are agreed on an annual basis, with interim reviews where service needs change, and must comply with national terms and conditions.

The process is explicitly a mutual and collaborative one between the consultant and the employer, setting out agreed programmed activities (PAs) across direct clinical care, supporting professional activities, and any additional responsibilities. Health Boards are required to ensure that job plans are up to date, reflect actual activity, and are consistent with organisational priorities, including service delivery, waiting list recovery, and financial sustainability.

Compliance therefore requires full annual completion, clear documentation of all activity (including any additional or variable sessions), and active management of job plans through governance arrangements within the Medical Directorate. Robust job planning is a key lever for reducing unwarranted variation, ensuring equity, and supporting the shift from variable pay to substantive contracted activity.

Workforce model design issues

- Annualised/flexible job plans leading to elective work being paid variably
- On-call models enabling high earnings without corresponding throughput

Variable pay embedded as default

- Locum and agency used to deliver known demand, not just gaps

Metric	Benchmark	Current position	Variance (midpoint)	Opportunity
Agency spend (% of total pay)	<2-3%	4.2%	+1.7%	Indicates a reliance on external staffing & provides an opportunity to strengthen workforce planning
Total temporary staffing (% of workforce cost)	<5-8%	17.2%	+10.7%	Suggests structural workforce gap and over reliance on variable pay
Consultant variable pay (% of consultant spend)	<10-15%	26.5%	+14.0%	Indicates misalignment of job plans and recurrent activity not embedded in core contracts

The Health Board rate card is a key control to standardise payments for additional clinical activity and reduce unwarranted variation. Embedding requires clear expectations and alignment with Allocate e-rostering so all additional sessions are approved and paid at agreed rates.

Negotiated rates continue to be used where there are service-critical gaps, workforce shortages, or urgent cover requirements.

The full rollout of Allocate is now complete and correct use by services will strengthen compliance through improved visibility, controls, and monitoring; however, full implementation is limited in anaesthetics, where the CLW rota remain in use. Addressing this is essential to achieving consistent application and financial control.

Consistent use of the rate card will improve financial control, equity, and transparency, supporting better forecasting and oversight via the Medical Directorate. Failure to embed it risks continued reliance on negotiated rates, cost escalation, inequity, and reduced visibility, undermining financial recovery.

Impact

If unchanged, the current model will:

- Sustain structural overspend
- Prevent delivery of financial recovery plans
- Limit ability to invest in substantive workforce solutions

Internal Audit – Variable pay (Appendix 2)

The recent internal audit concluded reasonable assurance over the management of medical variable pay within the Medical Workforce Stabilisation programme, with substantial assurance over reporting and governance.

Strong oversight arrangements are in place, supported by comprehensive reporting, implementation of the Allocate rostering system, and introduction of a standardised medical rate card, all of which have improved transparency and control.

However, key control weaknesses remain at an operational level, including retrospective recording of shifts, inconsistent approval practices, and variable justification of additional shifts. These issues are primarily driven by the absence of a dedicated medical variable pay policy/procedure, resulting in inconsistent application of controls across services. A high-priority action has been agreed to implement a formal policy and strengthen compliance, to ensure a consistent, timely, and well-controlled approach to managing medical workforce costs.

Financial Opportunity

Analysis indicates that a material proportion of the £31.8m variable pay spend in 2025/26 relates to recurrent, predictable activity, particularly within:

- Planned Care (e.g. elective delivery, non-resident on-call rotas)
- Diagnostic services (e.g. Radiology, Pathology)
- Integrated Medicine models across counties

Below are the potential opportunities to be worked through with the Clinical Care Groups (CCGs):

Quarter	Action	Potential Impact (£m)
Q2 2026/27	Immediate Grip Rate card enforcement Allocate compliance, rota scheduling (6-4-2) Reduction of retrospective shift approvals	1-2m
Q3 2026/27	Stabilisation Job planning Recruitment into known gaps Reduction in temporary agency	2-4m
Q4 2026/27	Structural Changes Workforce redesign NROC review Embed new models	3-5m
FY End Position	Sustained reduction in variable pay and agency	6-11m

Clinical Care Group	Variable pay (£m)	Vacancy %	Key issues	Opportunity type
Planned Care & Specialist Services	13.1	28%	Service design Elective delivery Job planning	Workforce re-design Establishment control group Job Planning Structural opportunities International recruitment Portfolio pathway
Mental Health & Learning Disabilities	1.5	31%	Premium spend on agency due to service fragility and recruitment gaps	
Community & Integrated Medicine	8.7	36%	Rota fragility in ED, recruitment gaps	
Operational Allied Health & Health Science	2.3	14%	Premium spend on agency due to service fragility and recruitment gaps	

Immediate actions within organisational control:

- Rate card enforcement
- Job planning compliance
- Rota review vs Royal College standards

Actions requiring service-led change:

- Targeted recruitment in high-vacancy specialties
- Sickness management and Occupational Health restrictions
- Service redesign and alternative workforce models

Not all variable pay is releasable:

- A proportion remains required to manage service fragility, recruitment gaps, and demand instability
- Delivery plans therefore need to focus on the achievable element of conversion, not total elimination
- Service design doesn't align with the current budget / funded posts

Based on current modelling:

- Targeted reduction focus is on high-spend areas (particularly across CIM and Planned Care)
- Initial trajectory assumes phased reduction through job planning, workforce redesign, and agency control
- Residual spend will be actively aligned to justified service risk

This approach enables a targeted response, focusing immediate controls for releasable opportunity, while addressing the structural gap. Service redesign will be required in some areas to achieve sustainable improvement, particularly where current workforce models do not align with demand or represent value for money.

Action Plan (Appendix 3)

The financial trajectory set out in this report is directly aligned to the Action Plan (**Appendix 3**) and reflects a phased delivery of the interventions identified through the deep dive.

The trajectory has been developed by mapping each action to its specific impact on the underlying drivers of variable pay, as identified within the assessment and supporting appendices (for example, job planning misalignment, workforce model design, and reliance on agency for core service delivery).

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **NOTE** the current position;
- **ENDORSE** the priority actions and trajectory to shift from variable pay to planned workforce models;
- **ENDORSE** an annual medical workforce review, that feeds into the annual planning cycle;
- **AGREE** that future reporting will focus on delivery of measurable outcomes, specifically:
 - Reduction in variable pay
 - Reduction in agency spend
 - Improved alignment between workforce capacity and demand; and
- **REQUIRE** routine monitoring of progress against defined metrics and trajectory

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

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.15 Seek assurance on the development and implementation of a comprehensive approach to performance delivery and quality management, to incorporate all performance requirements set by the Board, WG, regulators and inspectors, that enables all staff with managerial responsibility to strive for excellence whilst effectively delivering the basics. 3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	1978 'Risk of insufficiently skilled workforce to deliver services due to limited labour market', which includes medical workforce. 2326 'Risk to achieving 26/27 Target Control Total due to underlying deficit, insufficient savings & reliance on non recurrent funding'
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	2. Culture and valuing people 5. Whole systems perspective
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 2. Working together to be the best we can be 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation 2 Financial recovery and route map 6 Clinical services plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable

Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Medical Pay and Rostering



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Context

- Ongoing medical workforce instability driven by inconsistent rostering practices, rota gaps, and reliance on variable pay
- Limited standardisation across care groups and fragmented rota coordination
- Current processes (incl. paper-based additional duties claims) create delay, cost risk and lack of oversight
- Allocate e-rostering system not fully embedded, limiting visibility and control

Decision

- Mandate use of Allocate rostering system
- Standardise rota coordination through a 6–4–2 model across all care groups
- Establish centralised rota coordination function to support delivery and compliance
- Move to fully electronic pay processes via Loop (eliminate paper-based claims)

Next Steps

- Mandate 6–4–2 model:
 - 6 weeks – rota publication
 - 4 weeks – leave finalisation
 - 2 weeks – gap closure/escalation
- Identify and deploy central rota coordinators (cross-site support where required)
- Identify Full transition to Allocate (decision required on CLW for Anaesthetics due to service fragility):
- Enforce compliance across all specialties
- Training and rapid implementation support
- Cease paper forms for additional duties:
- All claims via Loop electronic system only

Position

- This is a non-negotiable stabilisation programme to improve safety, cost control and workforce sustainability
- Standardisation and digital adoption are essential to reduce reliance on premium pay and temporary staffing
- Care groups will be held to account for compliance, with central support provided to enable delivery
- Forms part of wider Medical Stabilisation and workforce programme



- Significant dependency on agency across acute and specialist services
- Immediate exit possible in limited cases only
- Multiple services at risk of unsafe staffing if agency removed

Risk Rating and Definition



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RAG Rating	Number	Definition of risk of exit	Common themes
Red	19	- Compromise patient safety - Create rota gaps or service instability - Risk service closure or failure to deliver core activity - Inability to deliver statutory services	- Recruitment unsuccessful or stalled - Consultant-led service dependency - Recurrent “unsafe service” statements
Amber	10	- Exit is possible but only once replacements are fully inducted - Requires time-limited extension - Risk is transitional, not structural	- Recruitment underway or offers made - Onboarding delays (visa, notice periods) - Known replacement but not yet in post
Green	3	- Replacement is confirmed and starting / started - Role is naturally ending - Service has confirmed safe withdrawal	

Conclusion



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Position	Opportunity / Risk
3 workers safe to exit	Immediate cost reduction opportunity Minimal risk Quick wins, but limited
10 workers can be exited with conditions	Exit achievable but delayed Requires recruitment completion Dependent on onboarding timescales
19 workers are deemed unsafe to exit due to service delivery	Core service dependant on agency Consultant-level risk within acute, Emergency Department (ED), Haematology and Mental Health and Learning Disabilities (MHLDD)

Agency workforce is sustaining core service delivery. Large scale immediate reduction is unsafe if we continue to deliver services in the same way, but targeted and controlled reduction is achievable

Anaesthetics Rate Card – Temporary Extension



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Context

- Weekend emergency theatre cover not embedded in job plans; reliant on voluntary cover (longstanding issue)
- Rate card changes have exposed fragility in weekend provision
- Immediate risk highlighted due to unplanned sickness

Decision

- Agreed time-limited derogation from rate card to maintain safe emergency service cover
- Decision taken to mitigate patient safety risk in the immediate term

Next Steps

- Confirm rota coverage for upcoming period (focus: next weekend gaps)
- Provide timeline to embed weekend emergency work into core job plans (no extensions expected)
- Set out workforce deficit position across emergency & elective pathways
 - Include plan to reduce reliance on variable pay
 - Outline sustainable workforce model and delivery timeline

Position

- This is an interim measure only
- Future decisions (including Bank Holiday) dependent on receipt of above



Context

- An Acute Medical Workforce Review has been completed in line with Royal College of Physicians (RCP) guidance, providing a benchmarked assessment of consultant capacity, job planning, and service demand
- Review confirms misalignment between current workforce configuration and predicted demand patterns
- Variation exists in programmed activity (PA) allocation, with reliance on variable pay mechanisms to sustain delivery
- Output has been validated and shared with Finance for costing against current variable pay expenditure

Decision

- Note findings of the review and endorse use as the baseline for workforce redesign and financial planning
- Support transition from reactive variable pay models to planned, substantive workforce capacity aligned to demand

Next Steps

- Complete financial modelling to quantify gap between substantive workforce capacity and required activity
- Identify opportunities to reduce variable pay where activity is recurrent and predictable
- Develop aligned workforce plans to rebalance PA allocation and reduce reliance on non-substantive staffing
- Integrate findings into wider medical workforce planning and IMTP processes

Position

- This provides a validated, evidence-based foundation for workforce and financial planning
- Establishes a clear link between workforce capacity, demand, and variable pay expenditure
- Represents a key step toward a more sustainable, planned workforce model, though further work is required to translate findings into delivery

Understanding Key Drivers of Variable Pay



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Context

- Analysis of variable pay identifies key service areas where expenditure is driven by structural job planning issues rather than unplanned demand
- **Anaesthetics – Carmarthenshire:**
 - Emergency CEPOD and Trauma lists delivered as additional activity attracting variable pay
 - Activity is predictable and recurrent but not embedded within core job plans
- **Anaesthetics – Bronglais:**
 - Annualised job plans cover emergency/on-call work only
 - All elective activity delivered as additional work via variable pay
 - Fully consultant-delivered model increases exposure to higher individual earnings

Decision

- Acknowledge that current variable pay reflects misalignment between job planning and known demand rather than true demand volatility
- Support re-job planning approach to embed predictable activity into substantive workforce capacity

Next Steps

- Undertake re-job planning across both sites to align contracted activity with actual service delivery
- Embed recurrent emergency and elective activity within core job plans
- Reassess workforce model following changes to determine:
 - Whether a genuine workforce deficit exists
 - Or whether current activity can be delivered within existing establishment
- Use findings to inform wider work on reducing variable pay and improving cost control

Position

- Current variable pay is artificially inflated due to structural job planning arrangements
- Significant opportunity exists to reduce spend and improve transparency through realignment of workforce capacity
- Re-job planning is a critical enabler to understanding true workforce requirement

a sustainable model

High Earners and Service Dynamics



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Context

- Analysis of high earners shows concentration in:
 - Trauma and Orthopaedics
 - Paediatrics
 - Obstetrics
 - Predominantly within Bronglais Hospital
- Services operate within a low-intensity demand environment, with relatively limited activity pressures
- Consultants can undertake:
 - Multiple non-resident on-call (NROC) shifts
 - Additional paid activity alongside core roles
- Limited waiting list or demand pressure reduces the requirement to expand substantive workforce

Decision

- Acknowledge that high earnings are not driven by service demand, but by workforce model design and job planning flexibility
- Support review of on-call arrangements and job planning structures to improve alignment between pay, activity, and demand

Next Steps

- Review NROC arrangements and utilisation to assess alignment with actual service demand
- Assess opportunities to rebalance job plans and reduce layering of additional paid activity
- Evaluate whether current workforce models deliver value in terms of throughput and outcomes
- Incorporate findings into broader work on variable pay reduction and workforce optimisation
- Consider alternative workforce models where appropriate to improve efficiency and transparency

Position

- High levels of earnings reflect structural and contractual arrangements rather than demand pressures
- Current model presents a financial inefficiency, with limited correlation between spend and service output
- Creates complexity in workforce planning, where expenditure remains high despite low demand indicators
- Targeted redesign of job plans and on-call structures represents a key opportunity to improve value and sustainability

The deep-dive highlights a consistent theme:

Variable pay is often being used to deliver predictable, recurring activity that should be job planned and costed within substantive workforce models.

Key next steps:

1. Complete financial modelling of the RCP-aligned workforce review.
2. Undertake systematic job plan redesign, prioritising:
 - Anaesthetics (Carmarthenshire and Bronglais)
 - High variable-pay specialties
3. Reduce structural reliance on variable pay, shifting to:
 - Transparent, planned activity,
 - Improved cost control,
 - Better alignment between workforce and demand.
4. Review NROC models in low-intensity services, ensuring value for money and equity.

This work provides a clear opportunity to:

- Improve financial grip and control,
- Enhance workforce sustainability,
- And ensure equitable and efficient use of consultant capacity.

While some underlying workforce gaps may remain, a significant proportion of current expenditure is likely to be releasing efficiency rather than requiring new investment, contingent on effective job planning reform.



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Medical Workforce Stabilisation (Variable Pay)

Draft Internal Audit Report 2025/26

Hywel Dda University Health Board



Reasonable Assurance

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Review Reference

Fieldwork

Executive Sign Off

Audit Committee

Executive Lead

Audit Team

HDU-2526-06

April - May 2026

June 2026

Mark Henwood, Medical Director

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit



Partneriaeth
Cydwasaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services
Partnership
Audit and Assurance Services



Executive Summary

Purpose

The overall objective of this audit was to provide assurance of the key controls of managing medical variable pay as part of the Medical Workforce Stabilisation programme.

Overview

The reporting and scrutiny of medical variable pay has been embedded within the governance arrangements of the Health Board from budget holders viewing live financial information on the Qlik system through to the Clinical Care Groups and statutory committee of the Board. A Medical Workforce Planning Steering Group has also been established as part of the Medical Workforce Stabilisation programme to review the organisation's medical workforce position and performance, including variable pay through the triangulation of data.

We also noted the implementation of the Allocate rostering system across all wards and specialties (as part of the Medical Workforce Stabilisation programme) to capture shifts that have incurred variable pay, whilst a new rate card was introduced in March 2026 to ensure consistency in pay arrangements across all medical shifts. The matter requiring management attention include is the lack of a dedicated policy or procedure for use and management of medical variable pay that was evident in the inconsistent approaches within wards and specialties that has led to instances of retrospective recording of requests and approval of shifts, no segregation of the requesting and approving officer, incorrect reasoning of requested shifts, whilst some approvers were not always the budget holders.

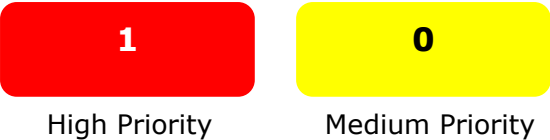
We have concluded **reasonable** assurance on this area. Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

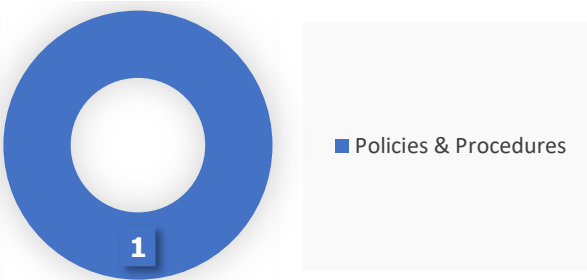
Objectives¹

	Related Findings	Assurance
1 The use of medical variable pay is scrutinised and challenged with actions taken to address any areas of concern	1	Reasonable
2 Medical variable pay is regularly reported through to the Health Board	-	Substantial

Management Actions



Themes



Risk Types

Financial Loss

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Findings & Agreed Action Plan

Objective 1: The use of medical variable pay is scrutinised and challenged with actions taken to address any areas of concern

Reasonable

Overview / Summary of Observations

Testing of 100 shifts worked during 2025-26 across five cost centres (Glangwili General Hospital – A&E, Anaesthetics, Ophthalmology, General Surgery & Withybush General Hospital – A&E) was selected from the Allocate rostering system.

In March 2026, a Finance Report submitted to the Health Board identified that *"there is a concerning trend that not all shifts are reported promptly on the Allocate rostering system and monthly spend is showing month on month variations due to retrospective shifts"*. Testing during this review corroborated this issue with 47% of the shifts retrospectively submitted to bank and approved/ finalised by an officer taking 10 days or more to be recorded on Allocate after the shift had been worked.

Instances were also identified where there was no segregation of duties between the requesting and approving/ finalising officers, whilst many of the approving/ finalising officers were not the budget holders. Discussion with the various rota coordinators and service delivery managers noted due circumstances (e.g. vacancies, sickness, annual leave, etc.) it was not always possible to have that separation of duties. In addition, instances were noted of staff approving/ finalising shifts on behalf of the budget holder and incorrect reasoning for some shifts were identified.

The Health Board has several policies and procedures that support elements of medical variable pay such as the *Budgetary Control Procedure* and *Study Leave Policy for Medical and Dental Staff*. However, there is no explicit policy or procedure in place dedicated to medical variable pay. The lack of a policy or procedural document has contributed to the inconsistent approaches taken by staff within wards and specialties that have been identified above. To ensure a clear and consistent approach is embedded within Hywel Dda, the Health Board should consider introducing a financial control and/ or standard operating procedure as noted with another NHS Wales Health Board that provides an overview of the controls and processes for the use and management of variable pay for medical and dental staff. **[Finding 1]**

The Finance Department provide regular reports to the Clinical Care Groups (CCGs) that outline key elements relating to variable pay such as monthly and year-end budget and trends, end of year forecast, pay analysis and summary narrative for each county and directorate within the CCG portfolio (including the categorisation of medical and dental variable pay breakdowns), actions, savings plans and targets.

All additional duty hours (ADH) or bank shifts are set in line with the medical rate card 2017 unless a negotiate rate had been agreed between the individual medical employee and the ward/ specialty management, with many rates historically agreed. Testing of 100 shifts worked during 2025-26 noted that only 11 shifts were set against the medical rate card, whilst 89 were negotiated between the individual and management.

A new medical rate card was developed by the Health Board with engagement from the British Medical Association (BMA) representatives as part of the Medical Workforce Stabilisation programme. The new medical rate card was implemented in March 2026 that covers all specialties and grades with clear definitions for in hours, out of hours, resident and non-resident rates. Any requests for negotiated rates are required to be submitted to the Medical Workforce Planning Steering Group for consideration and approval rather than dealt with locally. This new internal control mitigates the variable and inconsistent approach to negotiated rates identified in our testing above.

Key Findings		Risk & Impact	Agreed Management Action
1	Medical Variable Pay Policy and Procedure Whilst there are policies and procedures in place that impact on medical variable pay, there is no explicit policy or procedure in place on the use and management of medical variable pay. This should include the prompt submission and approval of shift requests (to mitigate retrospective actions when possible), segregation of duties, the correct assignment of reasoning for the requested shift and the assignment of approval on behalf of budget holders.	Inaccurate or inconsistent approaches taken by staff impacting medical variable pay due to the lack of a dedicated policy or procedure	Agreed Action: Develop, approve and implement a Medical Variable Pay Policy and Procedure which clearly defines: • Governance and accountability for requesting, approving and recording medical variable pay • Requirements for prospective approval of shifts (with clear escalation where retrospective approval is unavoidable) • Segregation of duties to ensure appropriate separation between requestor and approver • Standardised categories for reasoning/justification of additional shifts • Defined approval hierarchy, including delegated authority arrangements on behalf of budget holders • Timely submission and processing expectations • Monitoring, reporting and audit arrangements The policy will be developed in line with organisational policy frameworks and subject to appropriate stakeholder consultation prior to formal approval through governance committees.
		High Priority	Expected Evidence of Implementation: Approved Medical Variable Pay Policy and Procedure document Evidence of consultation (e.g. tracked changes, stakeholder Sample audit demonstrating: • prospective approvals in place • correct use of justification categories • appropriate authorisation levels applied Monitoring report or dashboard showing compliance
Theme: Policies & Procedures		Control Design	Officer: Carly Hill – Assistant Director Target Implementation Date: October 2026

Objective 2: Medical variable pay is regularly reported through to the Health Board

Substantial

Overview / Summary of Observations

A key element of the Medical Workforce Stabilisation programme was the full implementation of the Allocate rostering system to all wards and specialties. Allocate allows teams to plan individuals working arrangements and identify any gaps in the rota that are filled through additional duty hours (ADH) or by bank staff.

Budget holders have access to their live financial information via the All-Wales Qlik system that allows users to access a personalised dashboard with the ability to drill down on various financial elements including medical variable pay.

A review of Clinical Care Group (CCG) and statutory committees of the Board for the period 2025-26 confirmed the regular reporting of medical variable pay including breakdowns of current performance and year-end forecast positions. Medical variable pay was also identified as a 'top priority alert' within the financial reports submitted to the Finance and Performance Committee.

The Medical Workforce Planning Steering Group has been established to review the organisation's medical workforce position and performance, including variable pay. The aim of the group is to triangulate key data including (but not limited to) as the financial performance of cost centres, establishment WTE positions, job plans and sickness absence rates. The group is chaired by the Assistant Director Medical Directorate.

The Medical Workforce Planning Steering Group also review ward and specialty rotas on a weekly basis to ensure rosters have been planned six weeks in advance to identify unfilled shifts. In addition, all wards and specialties are required to adhere to the new medical rate card introduced in March 2026. Any negotiation of medical rates is now required to go via the Medical Workforce Planning Steering Group rather than be agreed locally by management.

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

Disclaimer

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The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained.

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Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.



Appendix 3 – Action Plan

Opportunity	Actions	Outcome	Measure of success	Trajectory	Delivery ownership	Governance method
Job plan redesign (priority specialties: anaesthetics, high-spend areas)	Undertake systematic job plan reviews in priority specialties Benchmark PAs against activity and demand Shift appropriate activity from additional sessions into core contracts Standardise job planning principles across CCGs	Alignment of workforce capacity with service demand and improved cost control	Reduction in additional session spend (£ and %) % of job plans reviewed Increase in activity delivered within core contracts	6 months from start of review Anaesthetics – Oct 2026	Clinical Directors General Managers Service Delivery Managers	Medical Director oversight Monthly review via Medical Workforce Planning Group Monthly job planning escalation meetings
Embed predictable activity into baseline workforce	Identify recurrent activity currently delivered via variable pay Convert into substantive roles, expanded PAs, or annualised job plans Align workforce establishment to demand projections	Improved workforce-demand alignment and reduced reliance on variable pay	% reduction in variable pay for recurrent activity Increase in substantive workforce capacity Reduction in ad hoc sessions	Progressive reduction across financial year	Clinical Directors CCG Directors General Managers Service Delivery Managers Clinical Leads	Deputy Medical Director oversight Bi-monthly monitoring through Medical Workforce Planning Group
Reduce agency reliance via internal bank and control processes	Expand internal bank utilisation Strengthen agency approval controls Improve forward rostering (6-4-2)	Lower cost delivery of care while maintaining safe staffing	Reduction in agency spend (£ and %) Improved internal bank fill rates	Immediate and ongoing	General Managers Rostering Leads Service Delivery Managers	Monthly reporting and exception escalation via Medical Workforce Planning Group

	scheduling) Enforce compliance with agency caps		Compliance with agency controls			
Review and standardise high-cost workforce models (e.g. non-resident on-call)	Review NROC and other premium pay arrangements Benchmark across services and against best practice Standardise frameworks where appropriate Address high-earning outliers via job planning	Equitable and sustainable pay aligned with workload and demand	Reduction in high-earning outliers Standardisation of pay models Improved cost predictability	Review Q1, plan for reduction Q2, implementation from Q3	CCG Directors Clinical Directors General Managers Service Delivery Managers Clinical Leads	Medical Director oversight Medical Workforce Planning Group Exception approval for deviations
Apply RCP workforce modelling to planning decisions	Apply RCP modelling tools across key specialties Quantify required vs funded vs actual workforce Use outputs to inform recruitment, job planning, and service redesign Integrate into annual planning processes	Evidence-based workforce planning aligned to population need	Reduction in workforce gap (required vs funded) Improved planning accuracy Alignment between workforce and activity demand	Q1 modelling, Q2–Q4 application and refinement	AMD's Clinical Directors Clinical Leads General Managers Service Delivery Managers	Medical Director oversight Quarterly reporting Finance & Performance Committee

5.3

11:30, 15 Mins

5.3 - FINANCE DEEP DIVE: ALERTS (CONTINUING HEALTHCARE)

*Keith Jones (Hywel
Dda UHB - Director
of Operational
Planning &
Performance)*

| For assurance

Attachments

[Finance Deep Dive - CHC FPC 30 June 2026.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Continuing Healthcare (CHC)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: REPORTING OFFICER:	Matthew Richards, Head of Commissioning Mental Health and Learning Disabilities and Head of Substance Misuse Services Julia McCarthy, Head of Long-Term Care Richard Jenkins, Assistant Finance Director Commissioning, BI and Value

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides assurance to the Finance and Performance Committee (FPC) regarding the measures and controls in place to ensure that all Continuing Healthcare (CHC) expenditure is necessary and aligned with agreed criteria. It also outlines the underlying factors contributing to the 2026/27 Month 1 and 2 financial position, together with the mitigating actions being implemented.

Cefndir / Background

CHC is a statutory responsibility of the Health Board, delivered in accordance with the *Continuing NHS Healthcare: The National Framework for Implementation in Wales* (for adults) and the *Children's Continuing Care Guidance for Wales*. In addition, NHS funding is provided under Section 117 of the Mental Health Act, which places a joint responsibility on Health Boards and Local Authorities to meet the aftercare needs of individuals with mental health conditions.

These services are delivered through three core teams:

- Long Term Care Team
- Mental Health and Learning Disabilities Commissioning Team
- Children's Continuing Care Team

Summary	Total Budget 26/27
Carmarthenshire Total	11,730,580
Ceredigion Total	4,825,043
Pembrokeshire Total	11,714,705
LTC Total	28,270,328
Children Total	871,692
Mental Health Total	14,214,082
Learning Disability Total	25,824,458
MHLD Total	40,038,540
GRAND TOTAL	69,180,561

CHC represents a significant area of expenditure, with a total budget of £69.1 million for 2026/27. It operates within a complex, system-wide context and is influenced by all areas of healthcare delivery, particularly in relation to inpatient flow and the management of risk within community settings.

The service is delivered within a comprehensive statutory and legislative framework, alongside regulatory oversight from Care Inspectorate Wales (CIW) and Healthcare Inspectorate Wales (HIW), resulting in extensive governance requirements. Expenditure is inherently variable, reflecting the high cost and complexity of individual care packages, which are often associated with significant clinical risk.

In addition, CHC encompasses a broad range of commissioning responsibilities, including market development, partnership working, financial management, and robust quality assurance arrangements. These functions are integral to the effective operation of the wider health and care system.

Commissioning of CHC services is required to comply with the following policies and frameworks:

NHS Continuing Healthcare (CHC) Framework

(National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care)

Sets out the process for assessing, determining, and commissioning fully funded NHS care for individuals with a primary health need. It places a legal duty on health boards to ensure eligibility decisions are consistent, evidence-based, and person-centred.

Children's Continuing Care (Children's CC)

(National Framework for Children and Young People's Continuing Care)

Provides guidance on assessing and meeting the complex health needs of children and young people. Emphasises multi-agency working, timely assessment, and ensuring packages of care are tailored, equitable, and regularly reviewed.

Mental Health Act 1983 – Section 117 Aftercare

Places a joint statutory duty on health boards and local authorities to provide aftercare services to eligible individuals discharged from hospital under certain sections of the Act. Aftercare must meet needs arising from mental disorder and is free of charge, requiring ongoing review and coordination.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

Provides the legal framework for decision-making on behalf of individuals who lack capacity. DoLS ensures that any deprivation of liberty in care settings is lawful, proportionate, and subject to appropriate authorisation and review.

Commissioning Code of Practice

(NHS Wales Commissioning Framework / Code of Practice, where applicable)

Sets out the expectations for safe, effective, and value-based commissioning of services as well as expectations on transparent and fair fee setting and uplift processes. It requires robust quality assurance, responsible use of resources, and alignment with population needs and prudent healthcare principles.

Responsible Body Guidance (Commissioning Responsibility Framework)

Provides clarity on which organisation holds responsibility for commissioning and funding an individual's care.

Sustainable Care Planning Policy (CHC)

Sets out the principles for developing and maintaining care packages that are safe, effective, equitable, and make best use of resources. It requires that care is person-centred whilst also being proportionate, deliverable, and sustainable over time, balancing individual needs with wider system responsibilities.

The provision of services to meet the healthcare needs of an individual is typically through commissioning an independent or third sector provider.

Categories of care are set into 4 areas:

1. Care Homes - this includes Nursing and Residential Care at standardised rates.
2. Domiciliary Care/Supported Living – this includes agencies who provide care in peoples' own homes.

3. Placements/Services with individual costs – these are bespoke packages of care specific to an individual, generally more Complex/Specialist.
4. Independent sector hospitals - mainly Mental Health secure placements

Eligibility

The organisation fulfils its statutory CHC duties by implementing a structured, standardised assessment pathway aligned to the National Framework.

- All individuals with a potential CHC need are identified with the completion of a nursing assessment.
- Where indicated, a full multidisciplinary team (MDT) assessment is undertaken using the Decision Support Tool (DST), considering the nature, intensity, complexity, and unpredictability of need.
- For individuals with rapidly deteriorating conditions, a Fast Track pathway is in place to ensure immediate access to funding and care.
- Joint funding decisions are supported by an MDT recommendation with supporting evidence of assessed health needs.
- S117 mental health aftercare needs are clearly identified and evidenced.

CHC Decision-Making and Sign-Off Arrangements

The organisation operates a robust governance framework for eligibility and commissioning decisions:

- Funding requests are scrutinised and quality assured.
- Recommendations are submitted to a panel for formal ratification.
- Panels review and confirm:
 - Quality and completeness of evidence
 - Consistency with the National Framework
 - Appropriateness of MDT recommendations
 - Outcomes required
 - Application of the sustainable care planning policy
 - Provider selection and suitability
 - Cost and timescales for review
- Commissioning authority is provided as outlined below:

Level 1	General Manager	£0 - £384 / week
Level 2	Service Director	£384.01 - £961 / week
Level 3	Deputy COO	£961.01 - £1442 / week
Level 4	COO	£1442.01 - £1923 / week
Level 5	CEO	£1923.01 + / week

This layered approach ensures:

- Consistency and defensibility of decisions
- Appropriate oversight of financial and clinical risk
- Clear audit trail for challenge and appeal processes

Quality Assurance, Review and Package Management

The organisation has established robust processes for the ongoing quality assurance and management of funded packages:

- Routine reviews are undertaken at three months post-placement and annually thereafter, or sooner if care needs change.
- High-cost, complex, or time-limited placements are reviewed more frequently, in line with initial agreements.
- Ongoing case management ensures packages remain aligned to current needs, with timely adjustments made in response to deterioration or improvement.
- A proactive focus is maintained on progression and step-down opportunities at the earliest appropriate point.

Financial Position

In Month 1 the level of expenditure on CHC, Long Term Care (LTC), Mental Health and Learning Development (MHLD) care increased significantly when compared to the latter half of 2025/26. The expenditure by month in 2025/26 and Month 1 2026/27 is detailed in the table over:

	2025/26												2026/27
	MTH 01	MTH 02	MTH 03	MTH 04	MTH 05	MTH 06	MTH 07	MTH 08	MTH 09	MTH 10	MTH 11	MTH 12	MTH1
Funded Nursing Care	£279,423	£288,860	£278,520	£272,203	£347,537	£299,345	£306,410	£301,694	£345,682	£314,554	£262,735	£334,723	£313,340
General Nursing	£533,274	£517,819	£519,115	£524,813	£610,581	£537,017	£580,539	£550,536	£591,438	£577,111	£530,705	£595,251	£585,987
Elderly Mentally Ill Nursing Home	£813,858	£912,974	£851,989	£903,809	£1,067,849	£970,080	£971,894	£937,706	£1,026,834	£1,034,577	£870,389	£1,002,805	£1,094,789
Community Based/Home Care Support	£306,728	£323,771	£311,205	£352,332	£316,476	£334,230	£315,266	£414,445	£385,301	£138,677	£295,095	£330,477	£371,866
Adult Palliative Care	£82,016	£87,549	£94,270	£114,186	£114,994	£81,108	£78,821	£82,466	£101,297	£107,340	£148,015	£181,095	£131,509
Respite	£4,514	£1,746	£5,813	£19,668	£14,203	£9,144	£12,770	£14,365	£7,748	£8,120	£1,836	£6,040	£10,250
Children	£100,708	£108,195	£350,619	£67,203	£116,602	£114,105	£146,772	£80,734	£852,308	£75,934	£58,246	£243,830	£76,163
Mental Health	£1,002,411	£1,008,313	£1,006,309	£1,057,917	£1,119,422	£1,180,246	£1,296,484	£1,251,236	£1,343,138	£1,172,391	£1,209,129	£861,697	£1,268,890
Learning Disability	£1,912,242	£2,050,291	£1,946,993	£2,071,916	£2,014,745	£2,223,845	£2,097,219	£2,052,252	£2,132,725	£2,297,856	£1,978,045	£2,036,959	£2,233,437
Grand Total	£5,035,174	£5,299,518	£5,364,834	£5,384,046	£5,722,410	£5,749,119	£5,512,631	£5,685,436	£5,081,857	£5,726,560	£5,350,524	£5,592,878	£6,086,232

This was due to growth in some areas during 25/26 which would have had part year effect on the projection in that year but has translated into a full year effect impact in the opening position for 26/27.

In addition, a new approach to growth allocation of budget identified in the IMTP annual plan did not wholly reflect the actual pressures seen.

Annual Plan 2026/27

The new approach for the 2026/27 annual plan for CHC was:

- To identify likely demand based upon a 5-year average across each type of care rather than basing demand on previous year's growth as had been done previously.

- To allocate that funding to counties, MHL D at the start of the financial year rather than to hold it centrally and allocate in year (this change in approach to allocating at the start of the financial year does not alter the total level of funding allocated to service areas)

The table below compares 2025/26 outturn with the M1 2026/27 Forecast Out-turn (FOT) based upon packages in place at the end of M1 2026/27 (excluding inflation) this is the historical forecasting basis and has been revised at M2 2026/27 to reflect 12 month rolling average.

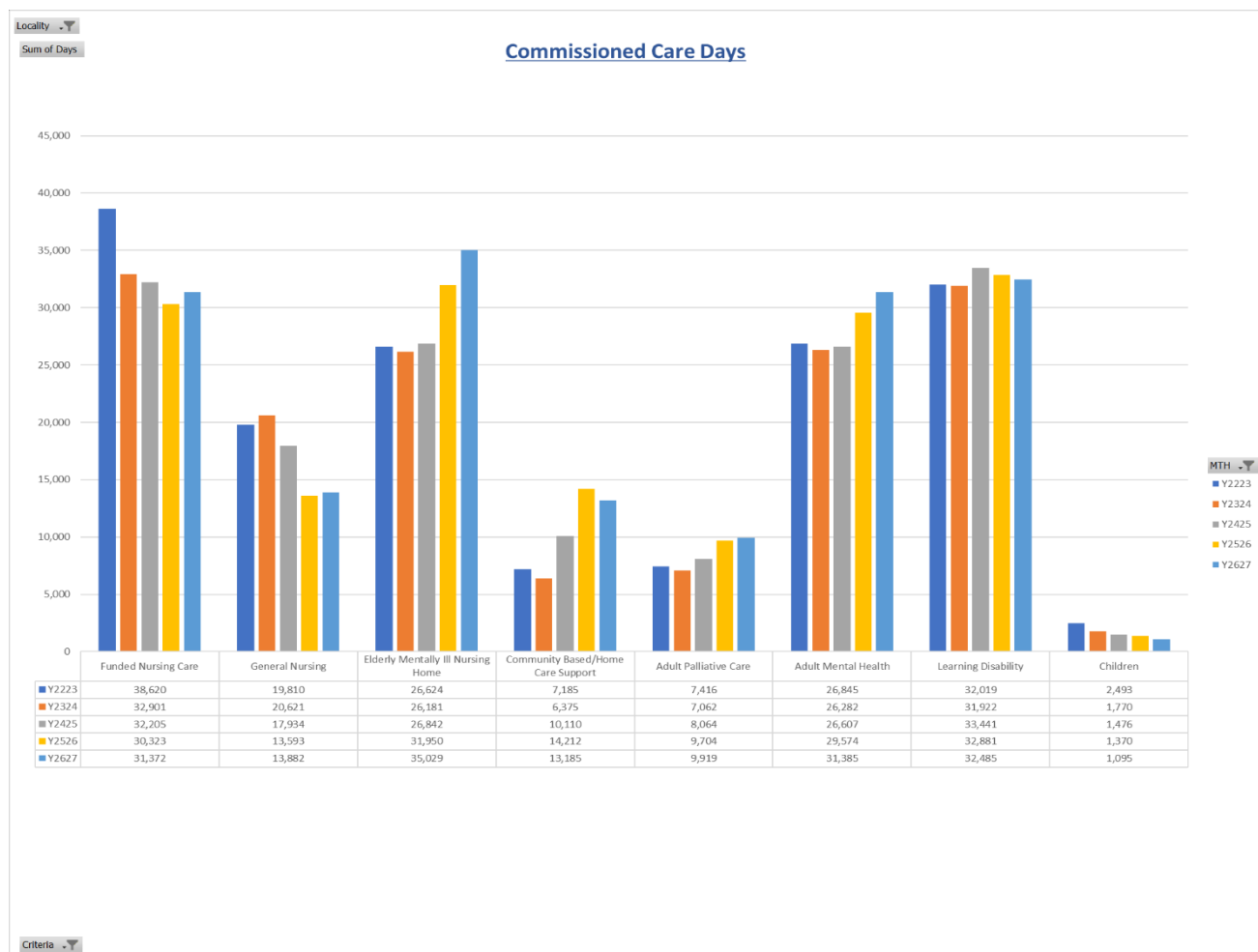
	EOY2526	M1 EOY 2627	FYE Increase 25/26 - 26/27	Notes
Carmarthenshire	£11,090,936	£12,340,888	£1,249,952	In FY26/27, based on the active packages in the DB, we are forecasting costs for Carm's LTC will be £12.3M (exc inflation). This is a 11.27% (£1.2M) increase on 25/26 FY costs and consistent with the increase in commissioned care days seen from FY24/25 to FY25/26. The main areas where costs have increased is EMI, 17.94% increase and General Nursing 7.73%.
EMI			£967,000	EMI increase is £1,250.60, with 5,410 additional days, 100% HB funded. FY cost increase £967K.
General Nursing			£223,000	This is due to part year effect in 25/26 compared to FY Impact 26/27 (additional 295 days commissioned, FY Impact £396K offset by £173K for packages ended in 25/26) resulting in a net £223K additional cost in 26/27.
Ceredigion	£4,093,622	£3,916,234	-£177,388	
Pembs	£11,652,098	£12,528,450	£876,351	Pembs EMI commissioned care days has reduced for base rate packages by 14%, However bespoke commissioned care days have increased 61.2%.
EMI - JF Bespoke			£568,536	9 new JF Bespoke packages were commissioned in April 26, 3,628 additional care days increasing costs by £413K, 1,383 less care days than 25/26 reducing costs by £152K and 2,077 additional due to FY effect of packages starting mid year 25/26, increasing costs by £307K.
EMI - HB Bespoke			£301,076	6 new packages 1,453 additional care days increasing costs by £254K, 745 less care days than 25/26 (ended packages in 25/26) reducing costs by £174K and 1198 additional due to FY impact of packages starting mid year 25/26, increasing costs by £221K.
LTC Total	£26,836,657	£28,785,572	£1,948,915	
Adult Mental Health	£13,563,308	£14,518,755	£955,447	In FY26/27, based on the active packages in the DB, we are forecasting costs for Adult Mental Health will be £14.5M (exc inflation). This is a 7.04% (£955K) increase on 25/26 FY costs.
CCAPS - Care provided within independent sector specialist facility/low secure (in or out of area)			£662,714	MH CCAPS costs have increased by £663K, due to 2 new packages of care £483K and the net effect of commissioning an additional 220 days of care increasing costs by £187K.
Residential & Nursing placements			£193,864	9 new packages of care commissioned in 26/27 increasing FY costs by £452K, offset by a reduction in cost of (£259K) which is the net effect of the ended packages versus the FY effect of packages started in 25/26.
Learning Disabilities	£24,842,935	£25,299,575	£456,640	In FY26/27, based on the active packages in the DB, we are forecasting costs for Learning Disabilities will be £25M (exc inflation). This is a 1.84% (£457K) increase on 25/26 FY costs and consistent with the increase in commissioned care days seen from FY24/25 to FY25/26.
CCAPS - Adults with LD receiving care in an independent hospital/specialist facility in or out of area			£234,479	2 new packages of care increasing costs by £625K offset by (£391K) reduction in costs for packages ended in 25/26, forecasted 234 additional days.
Dom Care			£190,436	11 packages starting in FY25/26 (£195K increase) there was also a reduction in FY25/26 of £234K for under utilised packages (not yet reported in FY26/27) offset by a reduction in costs due to 25/26 ended packages (£240K reduction in costs).
MH & LD TOTAL	£38,406,243	£39,818,330	£1,412,087	
Children	£788,591	£786,762	-£1,829	Based on 7 packages of care (3 Carm's, 3 Pembs, 1 Cered), average cost of £112K per year.
Grand Total	£66,031,490	£69,390,664	£3,359,173	

The table also includes the 2026/27 full year effect of packages that were in effect for part of full-year 2025/26 plus any new packages starting since April.

Previous years increased growth and new packages in Month 1 2026/27 impacted on Carmarthenshire, Pembrokeshire, MHL D budget areas by a total of £3,538,390.

Ceredigion and Childrens saw a reduction of £-179,217

There was a movement in packages totalling an additional 4,745 commissioned days of care in 2025/6 which is the equivalent of an additional 13 full-year equivalent (FYE) placements.



During Month 1, the IMTP growth and inflation allocations were also added to the budget lines, and this further impacted the variance between service areas. The table below shows the IMTP growth allocation per service area which totalled £344k but was insufficient to meet the growth seen leaving a £3,800k shortfall. In addition, growth allocation was distributed mainly to Ceredigion and Childrens which were not impacted by actual growth. This was due to the IMTP use of a five-year average to establish growth.

Summary	26/27 Budget	IMTP Growth Allocation	26/27 Budget (Base + Growth)	FY Forecast	Variance	Inflation Budget	Forecast Inflation	Variance	Total Budget	FY Forecast	Variance
Carmarthenshire Total	11,149,721	32,142	11,181,862	12,375,572	1,193,710	548,718	656,682	107,964	11,730,580	13,032,254	1,301,674
Ceredigion Total	4,446,505	166,559	4,613,064	3,916,234	-696,830	211,979	185,754	-26,225	4,825,043	4,101,988	-723,055
Pembrokeshire Total	11,089,999	41,810	11,131,809	12,534,049	1,402,240	582,896	609,557	26,661	11,714,705	13,143,607	1,428,901
Children Total	682,920	140,865	823,785	858,762	34,977	47,907	0	-47,907	871,692	858,762	-12,930
Mental Health Total	13,432,855	54,962	13,487,817	14,530,538	1,042,722	726,265	897,820	171,555	14,214,082	15,428,359	1,214,277
Learning Disability Total	24,567,749	-91,835	24,475,914	25,299,575	823,661	1,348,544	1,555,074	206,530	25,824,458	26,854,650	1,030,191
MHLD Total	38,000,604	-36,873	37,963,731	39,830,114	1,866,383	2,074,809	2,452,894	378,085	40,038,540	42,283,008	2,244,468
GRAND TOTAL	65,369,749	344,503	65,714,252	69,514,731	3,800,479	3,466,309	3,904,888	438,579	69,180,561	73,419,619	4,239,059

There is also shortfall in inflation allocation of £438k due to the inflationary uplift element of additional packages due to growth over and above the Q3 estimates at the time of IMTP being set.

The total shortfall based on above is a £4,239k variance based on the 2025/26 outturn with the M1 2026/27 FOT based upon packages in place at the end of M1 2026/27, this is the historical forecasting basis and has been revised at M2 2026/27 to reflect 12 month rolling average.

Month 2 2026/27 Year-To-Date (YTD) Position

The Month 2 2026/27 YTD financial position (£861k adverse variance to budget) is as per the below table and includes £603k to reflect the anticipated M2 2026/27 YTD impact of 2026/27 inflationary uplift to package rates (2026/27 inflationary uplifts have not yet been paid to providers but 2026/27 inflation funding allocation is already included within budgets).

Summary	MTH 2 YTD Budget (£)	MTH 2 YTD Cost (£)	MTH 2 YTD Variance to Budget (£)
General Nursing	447,333	492,584	45,251
Elderly Mentally Ill Nursing Home	916,943	1,008,542	91,599
Community Based/Home Care Support	201,030	188,899	-12,130
Adult Palliative Care	45,002	71,123	26,121
Respite	12,059	6,364	-5,695
Funded Nursing Care	333,425	340,021	6,596
Shared Patient Pathway - EMI	0	7,272	7,272
Shared Patient Pathway - CBHC	0	57,842	57,842
Carmarthenshire Total	1,955,791	2,172,647	216,855
General Nursing	351,047	266,557	-84,489
Elderly Mentally Ill Nursing Home	280,669	153,568	-127,101
Community Based/Home Care Support	43,405	117,900	74,495
Adult Palliative Care	9,945	32,059	22,113
Respite	0	0	0
Funded Nursing Care	119,438	117,242	-2,195
Shared Patient Pathway - GN	0	0	0
Shared Patient Pathway - EMI	0	0	0
Shared Patient Pathway - CBHC	0	0	0
Ceredigion Total	804,504	687,326	-117,177
General Nursing	593,461	445,022	-148,439
Elderly Mentally Ill Nursing Home	777,816	1,042,719	264,902
Community Based/Home Care Support	306,496	294,524	-11,972
Adult Palliative Care	107,851	154,842	46,991
Respite	1,836	3,077	1,241
Funded Nursing Care	165,636	185,411	19,775
Shared Patient Pathway - GN	0	22,446	22,446
Shared Patient Pathway - EMI	0	14,666	14,666
Shared Patient Pathway - CBHC	0	62,419	62,419
Pembrokeshire Total	1,953,096	2,225,126	272,030
Children Total	145,343	151,466	6,123
Mental Health Total	2,320,360	2,618,893	298,532
Learning Disability Total	4,305,697	4,490,091	184,395
MHLD Total	6,626,057	7,108,984	482,927
GRAND TOTAL	11,484,792	12,345,549	860,757

Forecasting and Trend in Activity Months 1 and 2 2025/26:

Client numbers	No of Current Active Cases M13	No of Current Active Cases M02	YTD variance clients
Carmarthenshire	338	344	6

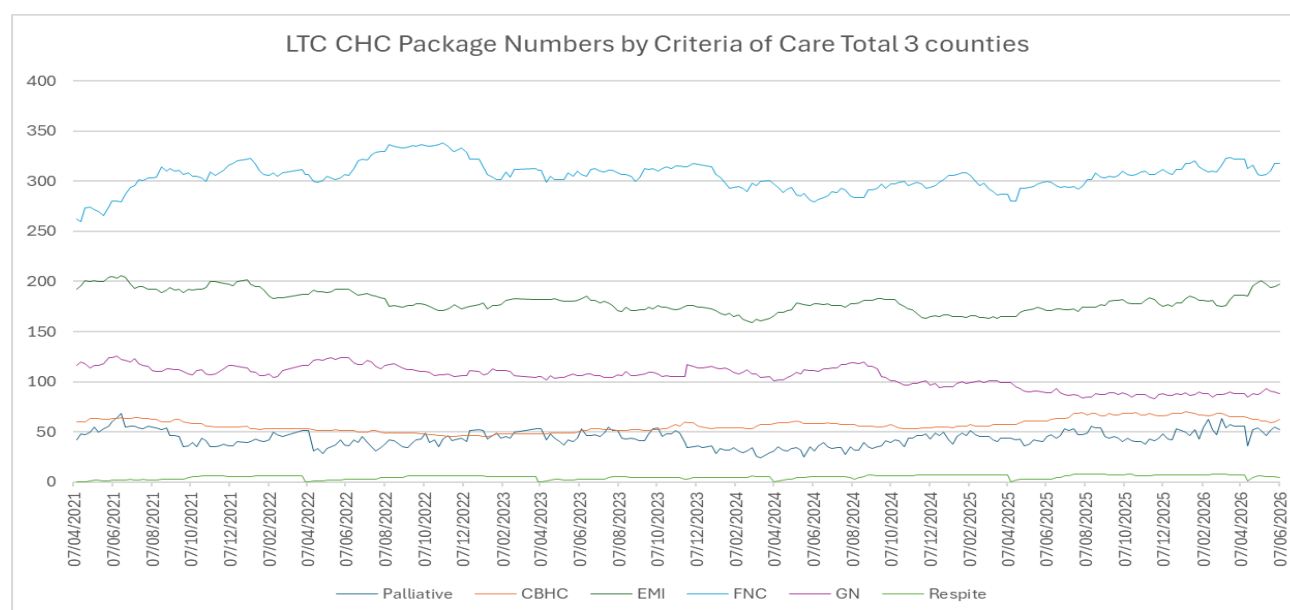
Ceredigion	104	106	2
Pembrokeshire	269	273	4
Mental Health	266	270	4
Learning disabilities	249	248	-1
W&CH	8	11	3
Total	1234	1252	18

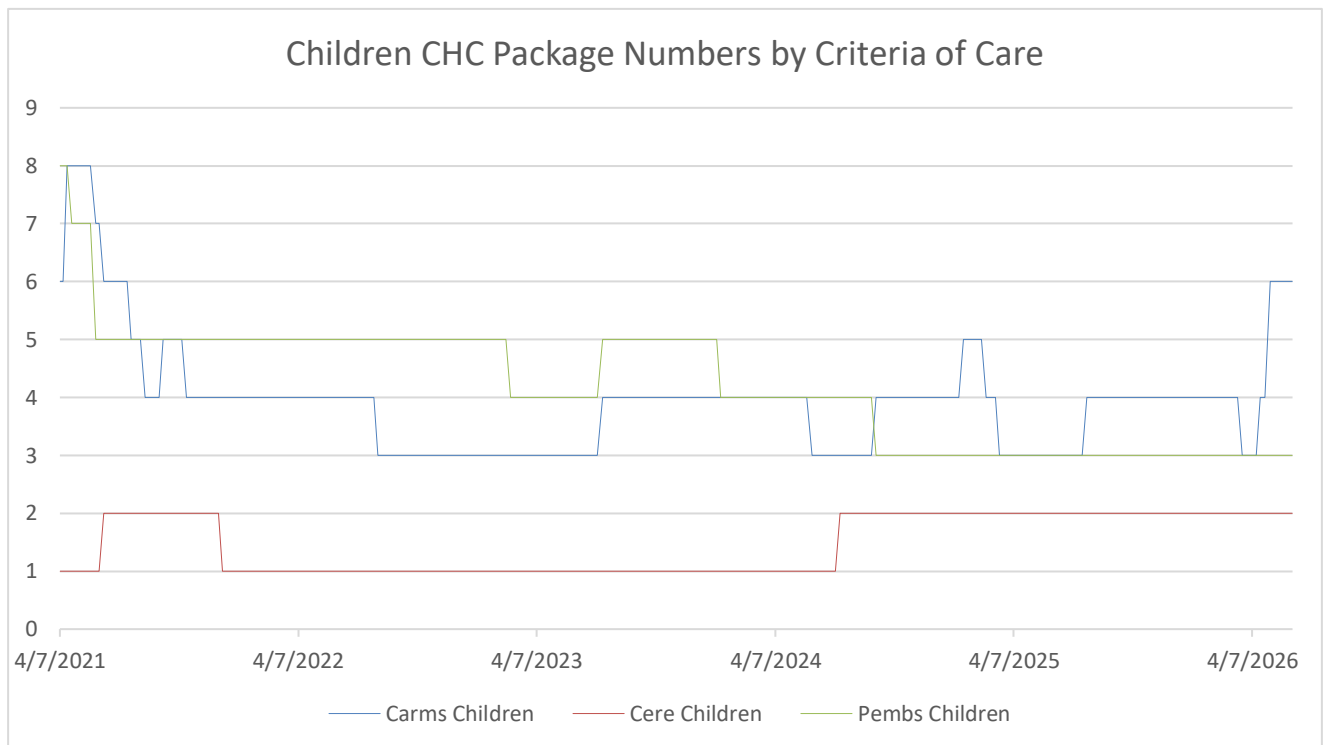
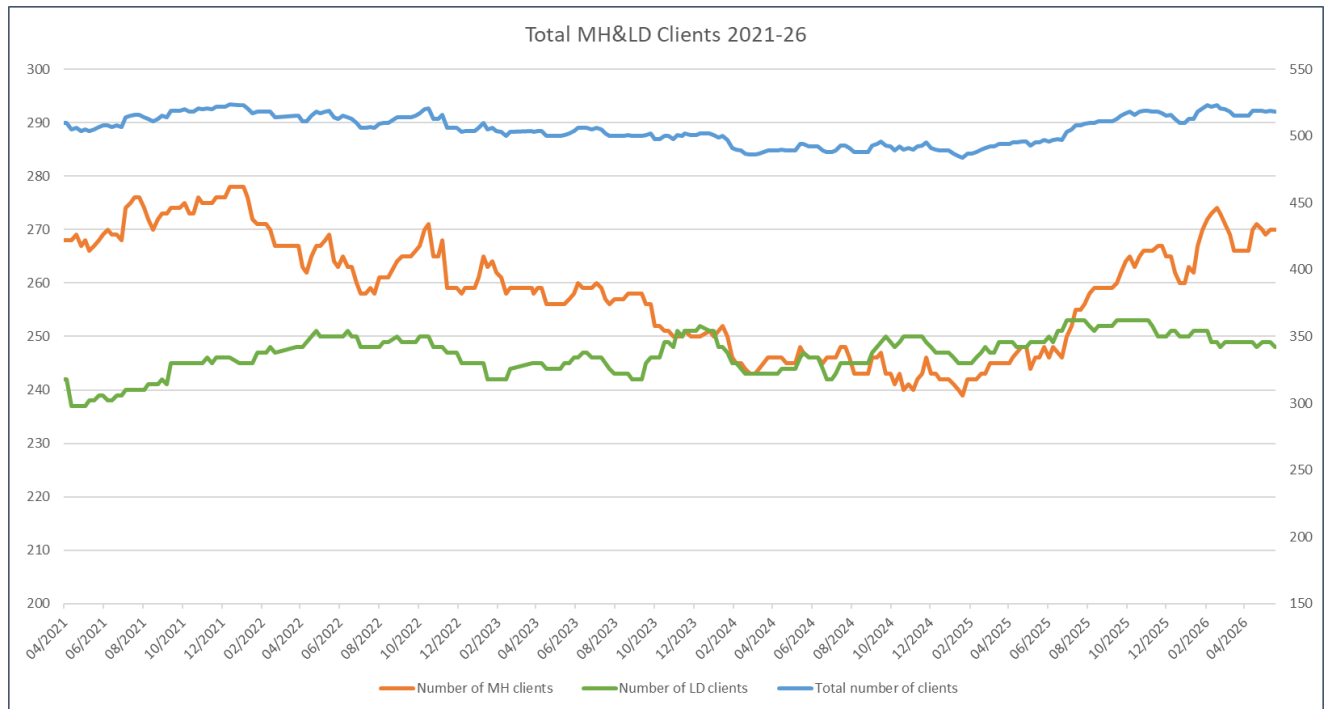
Prior to Month 2 2026/27, the basis of forecasting was to forecast that all packages currently in place continue to be in place for the remainder of the financial year at the current levels of acuity and rates (therefore that demand levels for all types of care remain at the current level for the remainder of the financial year).

However, in M2 the methodology has been changed to better reflect fluctuating demand in previous years for:

- General Nursing,
- Community Homecare and
- Palliative Care.
- Mental Health,
- Learning Disabilities
- Children

Elderly Mentally Infirm (EMI) has seen ongoing increasing levels of demand (high cost/day) and Funded Nursing Care (FNC) has seen an increase in demand (lower cost/day):





Following on from this, the basis of the Month 2 2026/27 FOT has been changed to reflect the twelve month average (Month 3 2025/26 – Month 2 2026/27) and this approach will be rolled forward a month (Month 4 2025/26 – Month 3 2026/27) for the Month 3 2026/27 FOT, etc.

This is with the exception of EMI where there has been continued growth in recent months and is also high-cost care. For EMI we continue to forecast that the current packages will remain in place for the remainder of this financial year.

Overall, the impact of the change in FOT methodology has reduced the Month 2 2026/27 FOT cost by £550k:

Category of care	FOT based on current packages in place (former methodology fye FORECAST)	New 12mth rolling average for M3-12 + M2 YTD	Difference in FOT days	Av £ cost/Day (average HB rate where several rates)	Total change to FOT would be £k
FNC	115,210	110,500	(4,710)	33	(154)
General Nursing	34,379	34,401	22	196	4
EMI (EXCLUDED FROM CHANGE)	74,459	69,877	(4,582)	170	
Community Based	28,534	31,455	2,921	141	412
Adult Palliative Care	20,360	18,194	(2,166)	63	(136)
Sub total counties		264,429			
Adult Mental Health	100,290	95,446	(4,844)	148	(718)
LD	96,360	96,379	19	264	5
Children	2,555	2,677	122	308	38
		Total	(13,217)		(550)

If EMI FOT had also been changed to the 12-month average, the reduction in FOT would have increased to £1,327k.

Table below gives a comparison of bed days FOT from the historical FOT and the new M2 FOT 12 month rolling average.

Continuing Healthcare, Mental Health and Learning Disability FOT review summary (excl. EMI as FOT basis not changed)					
Type of care	5 Yr average days of care (basis of 2026/27 annual plan)	FOT based on current packages in place fye (historic FOT basis)	New FOT basis as of M2. 12mth rolling average for M3-12 25/26 + M2 26/27 YTD	Variance to plan Historic basis of FOT v 5 yr average (26/27 plan basis)	Variance - New FOT basis as of M2, rolling 12 mth average v 5 yr average (26/27 plan basis)
FNC	109,756	115,210	110,500	5,454	744
General Nursing (high cost care)	40,003	34,379	34,401	(5,624)	(5,602)
Community Based	25,740	28,534	31,455	2,794	5,715
Adult Palliative Care (lower cost care)	14,107	20,360	18,194	6,253	4,087
Adult Mental Health (high cost care)	94,620	100,290	95,446	5,670	826
LD	97,556	96,360	96,379	(1,196)	(1,177)
Children	3,862	2,555	2,677	(1,307)	(1,185)

Demographic Changes

The 2025 West Wales Market Stability Report (MSR) highlighted the predicted increase in the number of older adults.

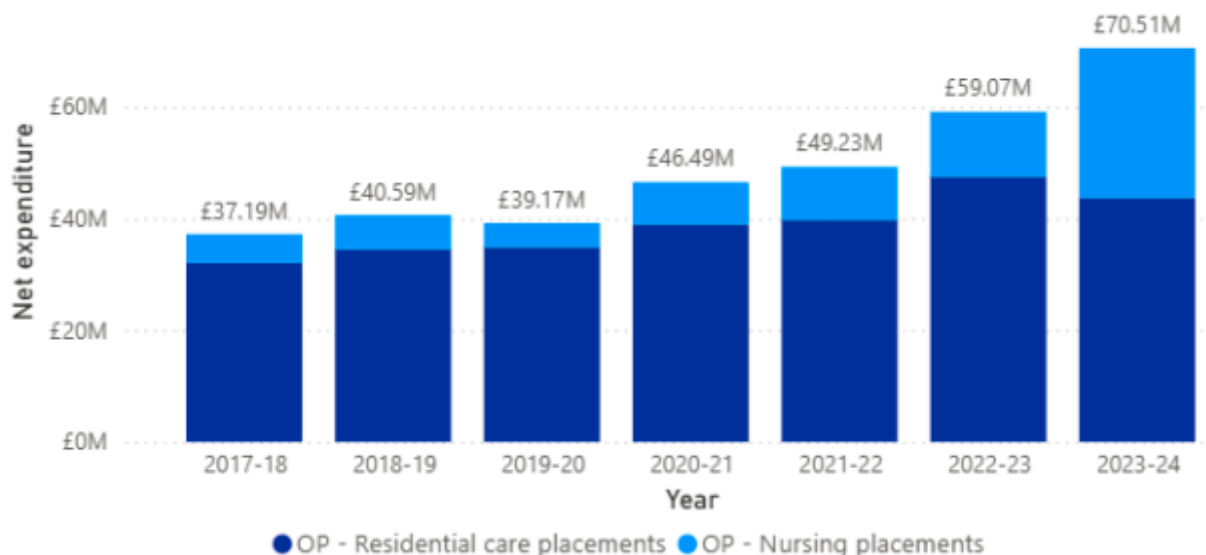
Population change estimates 2025 - 2035

Local authority	65 to 74	75 to 84	85 and over	All ages
Carmarthenshire	+18.1%	+8.2%	+41.0%	+17.2%
Ceredigion	+11.6%	+3.5%	+39.3%	+12.6%
Pembrokeshire	+18.9%	+8.1%	+46.3%	+18.7%
West Wales	+17.2%	+7.3%	+42.6%	+16.8%

The data sets show that the 85 and over age group is projected to increase by 5,738 (or 43%) from 13,482 to 19,220 by 2035. Dementia is closely associated with age, and the regional rate for advanced dementia is forecast to increase 36% by 2035.

Increasing complexity is also acknowledged in relation to each of the classes of care home Placement. Demand pressures are increasingly affecting Nursing and Nursing Dementia care home placements and whilst residential care expenditure grew year on year, except 2023, overall local authority spend on nursing care has increased significantly, increasing by 131% in 2023. Tabel below shows Local Authority (LA) spend only.

Net expenditure on placements for older people



Demographic trends indicate a projected increase in CHC demand, driven by:

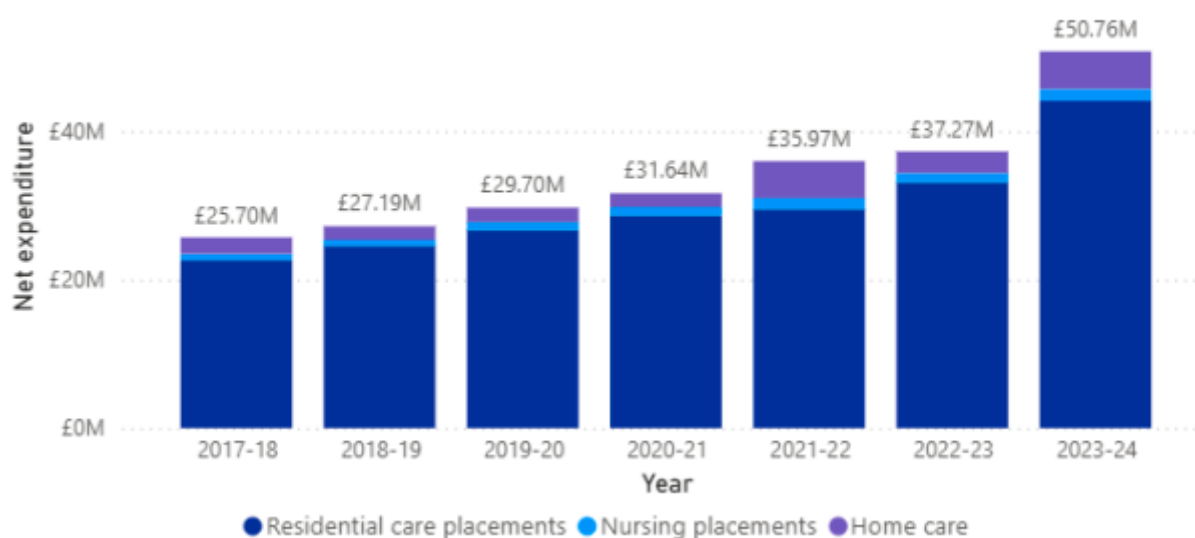
- An ageing population
- Increased prevalence of complex long-term conditions and frailty
- Improved survival rates for individuals with high acuity needs

This is expected to result in:

- Growth in CHC caseload and expenditure
- Increased complexity of care packages
- Greater demand on workforce and commissioning capacity

The working age adult population cohort includes MHLA and is projected to decline slightly. Whilst this could reduce the number of people who need care and support, this needs to be set against a trend of increasing complexity. The chart over indicates increased expenditure on domiciliary and care home placements for LAs only.

Total net expenditure on home care and residential placements for working age adults



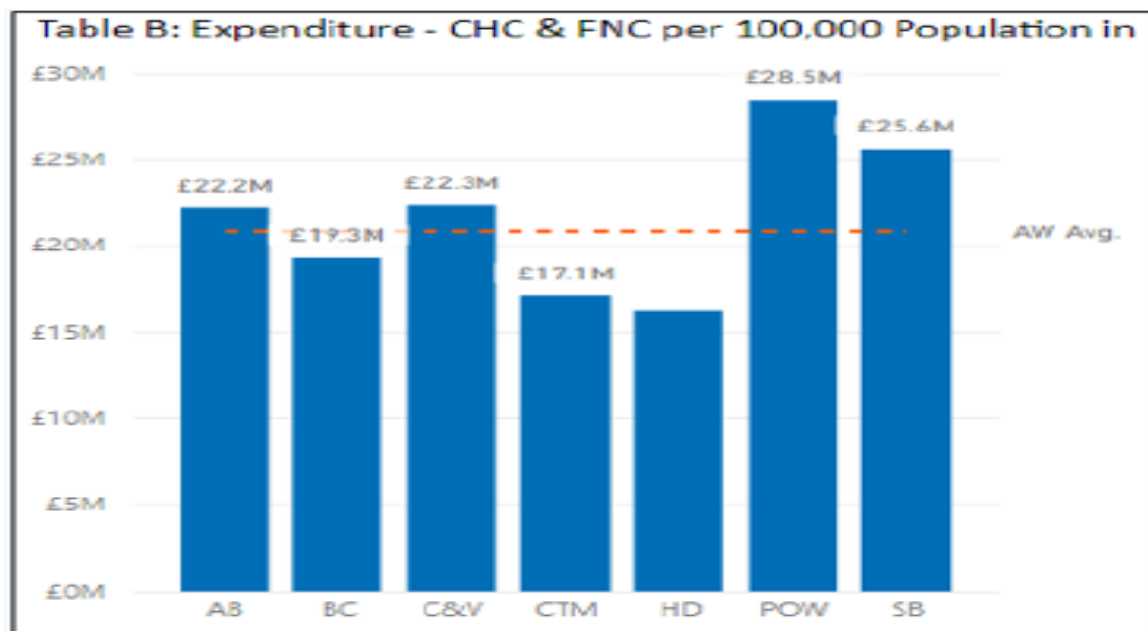
Comparison to other Health Boards in Wales

The most recent data comes from NHS Performance and Improvement Continuing Healthcare Q4 Update as of Month 12 2025/26.

Analysis of forecast CHC expenditure per 100,000 population for 2025/26 demonstrates notable variation across Health Boards, with an all-Wales average of £20.8 million.

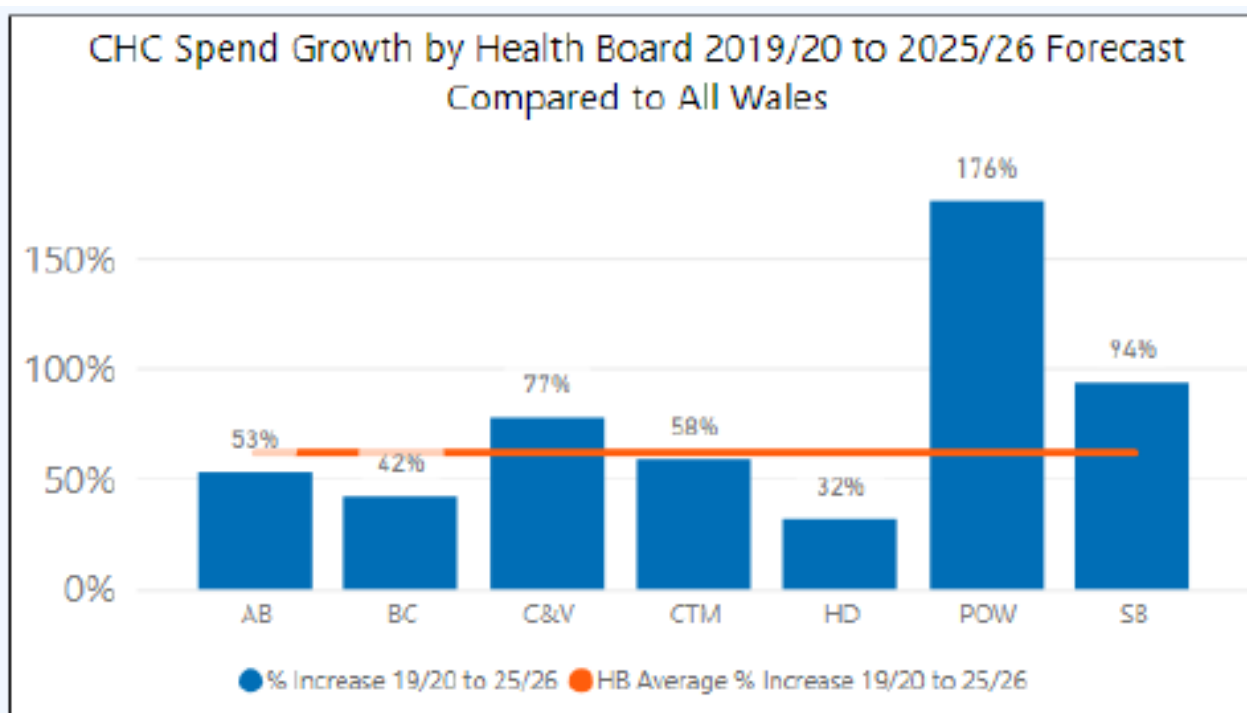
Aneurin Bevan University Health Board (£22.2 million), Cardiff and Vale University Health Board (£22.3 million), Powys Health Teaching Board (£28.5 million), and Swansea Bay University Health Board (£25.6 million) all report forecast expenditure above the all-Wales average on a population-adjusted basis.

In contrast, Betsi Cadwaladr University Health Board (£19.3 million), Cwm Taf Morgannwg University Health Board (£17.1 million), and Hywel Dda University Health Board (£16.2 million) are forecasting expenditure below the all-Wales average.

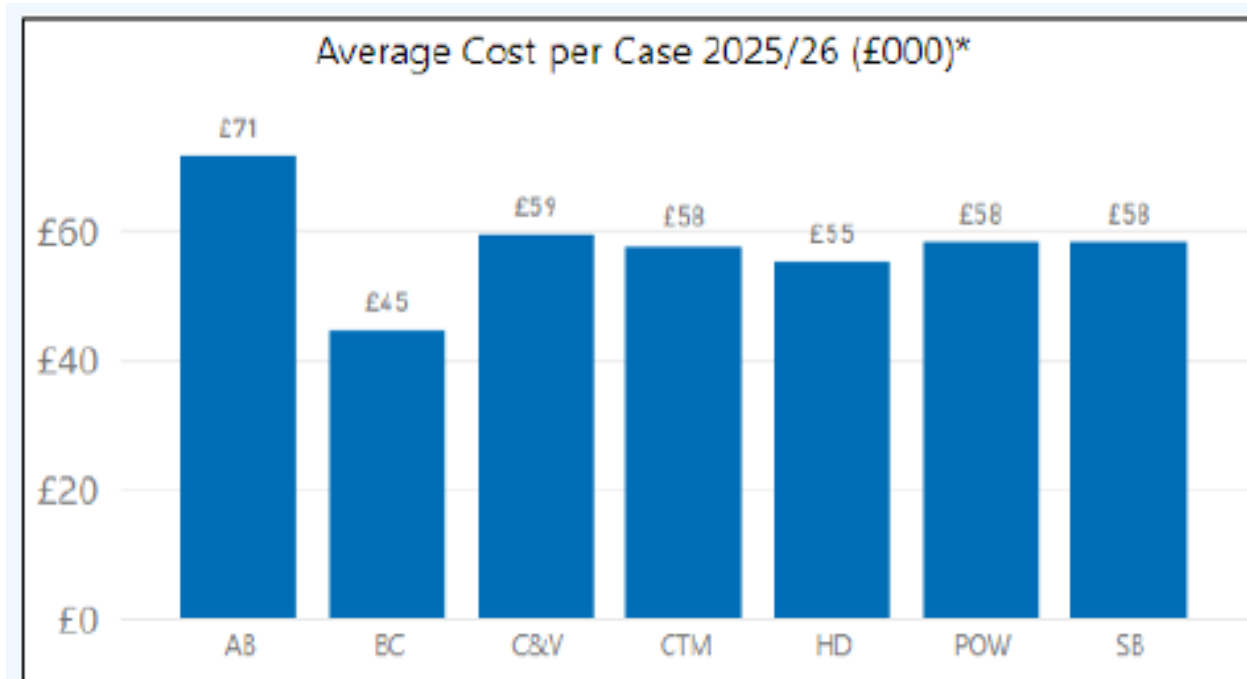


	19-20 Expenditure (£)	24-25 Expenditure (£)	25-26 Expenditure (£)	Change from 24-25	Change from 19-20
AB	91M	127M	140M	10%	53%
BC	97M	138M	138M	0%	42%
C&V	68M	109M	121M	11%	77%
CTM	51M	72M	80M	12%	58%
HD	49M	59M	65M	11%	32%
POW	15M	36M	40M	13%	176%
SB	53M	102M	103M	1%	94%
Total	425M	642M	688M	7%	62%

Hywel Dda University Health Board (HDdUB) CHC cost growth since 2019/20 is the lowest in Wales at 32%, with the all-Wales average growth since 2019/20 being 62%. The highest level of growth since 2019/20 was 176% at Powys Health Teaching Board (PHTB).



The average cost per case on an all-Wales basis is £56k, ranging from £45k at Betsi Cadwaladr University Health Board (BCUHB) to £71k at Aneurin Bevan University Health Board (ABUHB). HyDdUHB has an average cost per case in 2025/26 of £55k.



Asesiad / Assessment

CHC is a complex, high-cost area operating within a broad statutory framework, and as an entitlement, demand-led pressures cannot be fully controlled. Commissioned CHC services play a critical role in supporting patient flow and managing risk in the community. Placements are made based on assessed need, with demand fluctuating in response to system pressures, including facilitating timely hospital discharges and preventing admissions from the community.

Expenditure can be volatile due to both fluctuating demand and the high cost of individual packages. For example, private sector secure hospital placements can range from £4,000 to £10,000 per week, depending on complexity and observation requirements. This sits alongside sustained growth in demand driven by demographic change, including an ageing population, increasing acuity and complexity, and longer durations of care linked to improved life expectancy.

The net increase in packages totalling an additional 4745 commissioned days of care in 2025/6 which is the equivalent of an additional 13 FYE placements is consistent with these demographic trends. Despite this, HDUHB's CHC spend per population and the % increase in spend since 2019 is the lowest across Welsh Health Boards.

As CHC is an entitlement, demand is expected to continue to rise in line with demographic projections, despite the implementation of mitigation measures to manage cost and activity. CHC and commissioning teams are responsible for reviewing placements, negotiating costs, and ensuring quality assurance and performance management of commissioned services. They also contribute to market sustainability and service development to ensure sufficient capacity and appropriate provision for future demand.

The recent increase in expenditure reflects both higher demand during 2025/26 and the full-year impact of packages initiated during the previous year, as reflected in the Month 1 forecast. The revised Month 2 projection methodology, based on a rolling 12-month average, has reduced forecast volatility compared to the previous approach. However, there remains a degree of risk, as relatively low growth earlier in the prior year may suppress the current average, with the potential for increased projections as higher growth periods are incorporated, particularly if demand continues at current levels. CHC commissioning has implemented effective controls to manage and reduce expenditure where possible with several mitigation measures in place to address increasing demand:

MHLD

- Weekly Delayed Transfer of Care (DTC) meetings in place
- Monthly inpatient deep dive reviews undertaken to support flow
- Increased staffing establishment for 2025/26 to support higher acuity management
- Planned introduction of three additional short-term admission beds to facilitate timely discharge, reduce length of stay, and minimise reliance on private inpatient beds
- Realignment of medical staffing to strengthen community medical oversight on wards
- Regional Commissioning framework and costing model in development for residential care.

LTC

- Discharge to Assess model implemented in Carmarthenshire
- Feasibility of a public sector nursing home under exploration with Carmarthenshire Local Authority
- Fee rebasing exercise currently underway with Pembrokeshire Local Authority

CHC is however an entitlement, supported by a legislative framework and demand is driven by the wider system and demographic change.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to **TAKE ASSURANCE** that measures and controls are in place to ensure only essential Continuing Healthcare expenditure is incurred and aligned with agreed criteria.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.15 Seek assurance on the development and implementation of a comprehensive approach to performance delivery and quality management, to incorporate all performance requirements set by the Board, WG, regulators and inspectors, that enables all staff with managerial responsibility to strive for excellence whilst effectively delivering the basics. 3.1.16 Scrutinise the performance reports (including those related to external providers) prepared for submission to the Board, ensure exception reports are provided where performance is off track, and undertake deep dives into areas of performance as directed by the Board to seek assurance that appropriate action is being taken when performance against set targets deteriorates, and to support and promote continuous improvement in service delivery.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	4. Efficient 5. Equitable 6. Person-Centred
Galluogwyr Ansawdd: Enablers of Quality:	Not Applicable

Quality and Engagement Act (sharepoint.com)	
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	2 Financial recovery and route map 5 Mental health and CAHMS
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable

Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

5.4

11:45, 15 Mins

5.4 - FINANCE DEEP DIVE: ALERTS
(CLINICAL CARE GROUP SAVINGS PLANS):
Request to Defer

*Keith Jones (Hywel
Dda UHB - Director
of Operational
Planning &
Performance)*

| For assurance

5.5

12:00, 5 Mins

5.5 - INVESTMENT AND BENEFITS REALISATION REPORT

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

| For assurance

Attachments

[Investment and Benefits Realisation Report FPC 30 June 2026.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Investment and Benefits Realisation Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Siân Jenkins, Deputy Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide is to conclude the updates in respect of investment cases for 2025/26. The final outcome in respect of funding was reported at the Finance and Performance Committee meeting 30 April 2026. This final update provides insight into the benefits realised in respect of the strategic investments made.

Cefndir / Background

The Health Board approved an Annual Plan on 27 March 2025 which represented a planned deficit of £31.5m. This includes provision for investments totalling £11.9m, expected recurrent savings of £19.0m, plus a non-recurrent benefit of underspends and non-recurrent savings of £25.4m. Therefore, a total savings delivery for the year of £46.4m.

Recognising that appropriate scrutiny of investment plans is required ahead of final approval being granted, the Annual Plan earmarked funding to support a number of priority proposals which had been highlighted through the planning cycle, total value £11.9m. These cases were routed through an investment scrutiny process lead by representatives of the Finance, Operations, Planning, Workforce functions, with recommendations reported through to Formal Executive Team for decision.

Subsequent approvals totalled £10.2m on a recurrent basis, with a level of slippage identified in respect of in year spend for 2025/26 as a result of recruitment timescales and lead in times. The investment cases, their status and funding levels are summarised in the following table.

CCG / Function	Description	Approved Recurrent £k
2025/26 Strategic Investments:		
Planned and Specialist Care	Acute Oncology Service (AOS) provision improvement	398
Planned and Specialist Care	Ophthalmology IVT recovery plan - clinic staffing capacity	350
Planned and Specialist Care	Ophthalmology IVT recovery plan - drug consumption	1,300
Planned and Specialist Care	Endoscopy, two elements; surveillance backlog and	476
Operational Allied Health and	Radiology diagnostic improvement	1,500
Digital	Integrated Digital Care Programme (e-Flow, e-Obs and	1,800
Director of Nursing	Legal Service	325
2025/26 Statutory Compliance Investments:		
Estates and Facilities	RAAC revenue pressure	150
Estates and Facilities	Additional fire wardens required at WGH	178
Estates and Facilities	Additional fire wardens required at BGH	205
Estates and Facilities	Additional fire wardens required at GGH	205
Central Reserves	Nurse Staffing 25b Provisional Autumn 2024 Review	165
Central Reserves	Nurse Staffing 25a Provisional MH&LD	989
Community and Integrated	BGH EUCC Nursing	2,210
2025/26 Deferred Investments:		
Estates and Facilities	Maintenance Volume	0
Director of Workforce	International Recruitment (Medical)	0
Medical Director	VBHC - Heart Failure	0
Director of Public Health	Child Obesity PH	0
Director of Public Health	Health Coaches	0
Community and Integrated	GGH ED Nursing	0

Asesiad / Assessment

Approval of cases was staggered over the past 12 months as plans developed. The initial cases approved are reaching the 12-month mark in respect of confirmed approval. In respect of the strategic investments, service leads have been approached for feedback to ensure that the intended benefits have been realised.

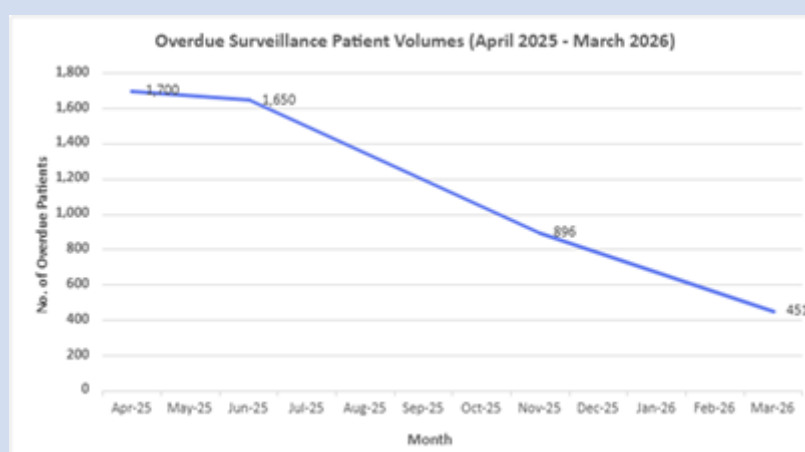
Feedback summary captured in table below. Implementation continues for certain schemes, particularly the Legal Service and Acute Oncology, therefore intended service change has not yet been realised and cannot be measured at this point. Overall, the intended benefits have been realised where plans are implemented. The intended improvement trajectory hasn't been reached withing Ophthalmology yet, but sustained progress has been achieved.

Case	Summary feedback
Acute Oncology Service 7 day service	Recruitment and training ongoing, alongside relevant organisational change process. 7-day service expected to be fully implemented during the summer to enable full service/patient impact.
Ophthalmology IVT recovery plan	Staff in post, though slightly different skill mix compared to original plan. Funding was used to afford outsourced activity whilst staff were recruited. Plan framed an improvement in overall R1 performance from 34% to 53% over 12 months; reaching 43% in March after 7 months of consecutive improvement since August 2025. (Follow up query raised, when will performance reach 53%, TBC).

R1 category	Total number of pathways without a target date allocated	Total number of pathways within target date	Total number of pathways beyond target date (end of month census snapshot)				Total	Total number of open pathways on the combined waiting list	Total within TD plus 25% beyond	Target %	Achieved %
			Up to 25% beyond target date	> 25% up to 50% beyond target date	>50% up to 100% beyond target date	>100% beyond target date					
Aug-25	0	5244	928	782	1259	9816	12785	18029	6172	95%	34%
Sep-25	0	5527	831	799	1301	9604	12535	18062	6358	95%	35%
Oct-25	0	5841	916	677	1327	9237	12157	17998	6757	95%	38%
Nov-25	0	6064	859	707	1185	9058	11809	17873	6923	95%	39%
Dec-25	0	6095	943	613	1176	9021	11753	17848	7038	95%	39%
Jan-26	0	6217	883	715	1118	8843	11559	17776	7100	95%	40%
Feb-26	0	6474	917	656	1107	8638	11318	17792	7391	95%	42%
Mar-26	0	6567	899	695	1130	8199	10923	17490	7466	95%	43%

Endoscopy surveillance backlog

Additional capacity was mobilised with immediate effect following approval of the case, June 2025. Intention to reduce the waiting list such that approximately 500 patients remaining on the surveillance backlog by March 2026. Figures, in fact, reduced to 450 and the backlog wait has reduced from 5 years (as of March 2025) to 2 years (as of March 2026). Aim to clear the backlog by September 2026, however associated workforce to enable Waiting List Initiatives (WLIs) is less consistent in the absence of Planned Additional Activity Rates (PAAR) rates, so alternative staffing model required which will be more costly and may compromise full delivery.



Endoscopy diagnostic improvement

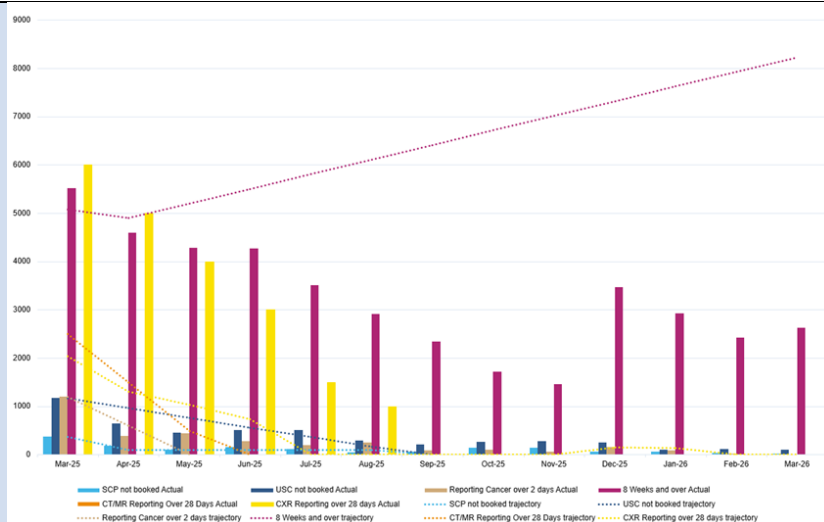
Successful recruitment to associated roles, all staff in post by October 2025, in line with planned timelines. Additional capacity sustained the 8-week ministerial standard throughout 2025/26, without the need for WLIs. Also supported Joint Accreditation Group (JAG) accreditation in Glangwili Hospital (GGH).

Radiology demand and capacity gap

Successful recruitment into Radiography posts including, CT, GGH and Withybush Hospital (WGH) and a Sonographer. Further capacity to be realised in 26/27 as competencies are achieved to support Band 6 roles. Funding was used effectively across staff and external capacity according to recruitment timelines.

This was supplemented with £1.6m Welsh Government (WG) non-recurrent monies. The investment aimed to shorten waiting times for USC patients and to prevent further decline in meeting the 8-week diagnostic waiting times, both were achieved. Additional capacity alongside improved governance and clinical working arrangements continue to enable improvements. As a result of WG funding ceasing the 8-week breach position is expected to deteriorate in 2026/27, though the USC performance is expected to remain stable.

The graph below demonstrates the overall Radiology position from March 2025 for USC, SCP and 8-week waits along with the trajectories provided within the initial investment proposal.



Integrated Digital Care Programme

Phase 1a of Patient Flow has been delivered broadly in line with the approved plan, with the core people, process and technology elements in place and operational. The Patient Flow solution (Miya) is live for acute adult wards, mental health and maternity, with full integration to WPAS for demographics, ADT and wait list/TCI data. There was no material delay against the approved delivery plan. Delivered within the agreed financial scope.

The early phases of eObservations deployment have delivered a safe, controlled foundation for digitised patient observations, aligned to the approved phased roadmap. The programme is proceeding at an appropriate pace for a clinically sensitive capability, prioritising patient safety, clinical confidence and long-term sustainability over rapid implementation.

The early phases of the ePMA programme have established a secure, clinically safe foundation for digitised prescribing and medicines administration. Delivery has progressed in line with the approved phased approach, balancing pace with patient safety, clinical engagement and long-term sustainability. Full benefits realisation is dependent on scale, integration and adoption maturity, as originally anticipated.

Legal Services

Part way through implementation. Staff recruitment complete, partial starts and training underway.

Assure (to note)

There is confidence that implementation has been progressed as intended following investment. Delivery of planned objectives have predominantly been met where timescales have been sufficient.

Argymhelliad / Recommendation

The Finance and Performance Committee is asked to:

- **ACKNOWLEDGE** that investment cases for 2025/26 were being progressed through a review and scrutiny process to inform a final approval decision at Formal Executive Team and all decision outcomes have been determined.
- **NOTE** that benefits realisation feedback for strategic investments as outlined.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Receive assurance on the development and realisation of opportunities. This will be achieved through scrutiny of the bi-monthly savings and opportunities report to the Committee. 3.1.13 Review any investment/disinvestment strategy, including Procurement and Contracting Strategy, maintaining oversight of the investments and disinvestments, ensuring compliance with policies by: 3.1.13.1 Establishing the overall methodology, processes and controls which govern investments and disinvestments, including the prioritisation of decisions; 3.1.13.2 Ensuring that robust processes are followed; and 3.1.13.3 Evaluating, scrutinising and monitoring subsequent investments/ disinvestments.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	2086 (score 20) Risk of the Health Board not being able to meet the statutory requirement of breaking even in 2025/26 due to significant deficit position.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Further Information:	
Ar sail tystiolaeth: Evidence Base:	Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termiau: Glossary of Terms:	BGH – Bronglais General Hospital CHC – Continuing Healthcare EOY – End of Year FNC – Funded Nursing Care FYE – Full Year Effect GGH – Glangwili General Hospital GMS – General Medical Services HSCEY – Health, Social Care and Early Years MHLD – Mental Health & Learning Disabilities NICE – National Institute for Health and Care Excellence OCP – Organisational Change Policy/Process OOH – Out of Hours PPH – Prince Philip Hospital PSPP – Public Sector Payment Policy RTT – Referral to Treatment Time T&O – Trauma & Orthopaedics TCT – Target Control Total WG – Welsh Government WGH – Withybush General Hospital WRP – Welsh Risk Pool WTE – Whole Time Equivalent YTD – Year to date
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad: Parties / Committees consulted prior to Finance and Performance Committee:	Finance Team Management Team Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	The impact on patient care is assessed within the savings schemes.

Gweithlu: Workforce:	The report considers the financial implications of our workforce.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

5.6 - PLAN FOR CLOSING THE RESIDUAL DELIVERY GAP TO £41M

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

- This has now been taken to In-Committee Board on 18 June 2026

| For assurance

5.7

12:05, 10 Mins

**5.7 - BAND 2 AND 3 HEALTHCARE
SUPPORT WORKER PAY RE-BANDING
UPDATE**

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

| For approval

Attachments

Band 2 and 3 HCWS Pay Re-Banding Update FPC 30 June 2026.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Band 2/3 Healthcare Support Worker Pay Re-Banding Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Siân Jenkins, Deputy Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides an update to the Finance and Performance Committee (FPC) on the Band 2/3 pay re-banding dispute affecting Healthcare Support Worker (HCSW) roles, and the related national Implementation Framework that has been adopted in Wales. The paper specifically highlights that calculations indicate the recurrent cost pressure is expected to exceed the £2.0m provision included in the 2026/27 financial plan, reflecting changes in volume and pay rate assumptions.

Cefndir / Background

In July 2021, the NHS Staff Council agreed minor wording clarifications to the national Job Profiles for Band 2 and Band 3 HCSW roles to better distinguish between Band 2 personal care duties and Band 3 duties involving a limited range of clinical tasks under supervision.

Guidance for employers and matching panels was issued in August 2021, and organisations were asked to review local roles against the clarified profiles and to ensure duties aligned to job descriptions. Following this, employers across the UK, including Hywel Dda University Health Board (HDdUHB), received increasing requests from individuals and groups to review banding where staff believed they were undertaking Band 3 duties while substantive Band 2.

Since 2021, Trade Unions have pursued re-banding and back-pay claims for affected staff in a number of organisations. Experience elsewhere in the UK has demonstrated the risk of protracted local disputes, including industrial action and significant financial exposure where claims have been backdated over multiple years. In Summer 2024, in anticipation of an escalation of claims in Wales, NHS Wales Employers was asked to support the development of a national approach, covering agreed job descriptions, a consistent assessment process and a timebound settlement position, to mitigate disruption and to support equitable treatment of staff across NHS Wales.

As part of this work, an Employers Reference Group supported the development of national job descriptions and an Implementation Framework. The NHS Wales job descriptions for the relevant roles were agreed through the Welsh Partnership Forum (WPF) by July 2025, and the Implementation Framework was finalised in November 2025, including arrangements for national oversight and a structured, person-by-person assessment process.

The framework sets out the requirement to make Recognition and Corrective payments to eligible staff for work already undertaken, alongside associated pay impacts where staff have moved within Band 3 pay points in line with the agreed framework. Going forward staff are re-banded to Band 3 payscales.

HDdUHB progressed preparatory work in parallel, enabling details for 1,074 staff to be submitted to Payroll in December 2025 for payment in February 2026. This captured the majority of staff, though further submissions have been made in subsequent months to align with latest guidance and resolution of queries. National discussions continued on aspects of framework interpretation and the application of the principles, this has identified further eligible staff, with a consequential impact on cost estimates and final outturn.

Whilst the majority of cases have been resolved, the payment process remains live as further staff queries are raised and validated through Workforce and NHS Wales Shared Services Partnership (NWSSP) Payroll, meaning that the final cost and eligible cohort are still subject to change.

Asesiad / Assessment

In light of progress through the national work stream and the status of the draft Implementation Framework, calculations of the associated costs for the Health Board were initially modelled in the build up to March 31 2025. This informed both the Annual Planning process ahead of 2025/26 in respect of the likely recurrent cost increase, plus the potential cost of recompensing staff for having worked at a Band 3 already through a Recognition Payment.

Concentrating on the recurrent cost, as that is the focus of this report, aggregate workforce data comprising staff in post was used as the basis to model cost estimates, alongside a generic level of enhanced pay across the HCSW staff cohort. This generated an indicative cost estimate of £2.3m for 973.54 whole-time equivalent (WTE) staff, on the premise that 100% of roles would migrate from Band 2 to Band 3. To be prudent, the assumption was made that staff would move to the top of scale at band 3.

As part of efforts to improve the Health Board's financial forecast following Quarter 1 2025/26, funds held in reserves for investment, of which the £2.3m was part of, were reviewed and consideration made as to the scale of funds required, or alternative decisions that could be taken. In light of the prudent assessment made to assume top of scale costs, the funding reserved for the recurrent impact of uplifting Band 2 HCSW to Band 3 was scaled back to £2.0m.

Through 2025/26 the national work stream progressed, and an updated draft framework was shared in September 2025, with the final version being confirmed in November 2025. The final framework had broadened to include both Recognition and Corrective Payments, plus the review of payscales for those staff already promoted to Band 3 during the period 1 January 2023 and 31 December 2024.

Locally, staff numbers had also increased, with acknowledgement of vacancies in the system, a result of having to pause recruitment to vacant roles pending conclusion of the pay banding dispute.

Given the shifting variables and framework developments the focus has been on ensuring the assessment of costs for 2025/26 was accurate and aligned to Welsh Government funding provision in time for 31 March 2026.

The funding provision for the recurrent cost impact of staff migrating to Band 3 paycales were maintained at £2.0m through the 2026/27 Annual Planning Cycle. On approval of the 2026/27 Annual Plan, work has progressed through late March and April to align budgets per the plan across a number of approved changes. In relation to the Band 2 to Band 3 re-banding, the detail of actual payments in February and March has been used to calculate the uplift required to budgets (payments at Band 3 having commenced in February). This has ensured the reality of paycales, and unsocial hours enhancements has been factored into recurrent budget changes on an appropriate and accurate basis. This detail has highlighted that the budget uplift required totals £2.8m, exceeding the £2.0m afforded by the Annual Plan.

In respect of variables impacting the recurrent cost against the £2.0m earmarked funding, the following changes have been identified which were not factored into original estimates:

- WTE has increased from 973.54 to 1047, additional 73.5 wte, £0.2m
- Already promoted staff being moved up the payscale to top of scale Band 3, 45 people £0.1m
- 2025/26 Pay award 3.6% and National Insurance Employers contribution has increased 13.8% to 15%, combined £0.1m.

In addition to these changes the reality of the specific detail of the payroll will have informed more accurate cost estimates to uplift the HCSW workforce establishment appropriately. This includes the specific pay points within both the Band 2 and Band 3 paycales that people have moved between, the detail in respect of hours worked, plus actual unsocial hours and associated enhancements.

To avoid a cost pressure across affected HCSW budgets, with the agreement of the Chief Executive and Director of Finance, budget was released to afford the £2.8m cost increase. As the increase of £0.8m was not included with the approved Annual Plan, there is no authority to issue budgets. Instead, a similar process has been followed to that of the nurse staffing levels (NSLs), where a negative reserve is created.

As such the following steps have been taken:

- Financial plan and accountability letter stated the Band 2/3 reserve was still pending and would be confirmed in due course once final.
- Imperative to ensure accurate establishment budgets are in place to control the financial decisions of budget holders therefore issued full £2.8m funding to budget holders, creating a negative central reserve to offset the £0.8m that isn't available.
- Signal an 'advise' to FPC in April to this ongoing piece of work/analysis, but the likely impact of an adverse impact against the assumed planned values.
- Finance to prepare a paper, together with Workforce, highlighting/explaining the moving parts that have been worked through since the plan was submitted, and split the changes between price, volume and or mix changes for each material change of the £0.8m (this paper).

- Report to be presented to Executive Team and then onto FPC in June 2026 to highlight the additional budget needed and seek retrospective approval for the negative reserve created.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to:

- **ACKNOWLEDGE** the approach taken and reasons for the difference between cost versus funding having arisen.
- **APPROVE** of the approach taken to enable the required £2.8m budget to be delegated, by creating a negative budget, recognising this will require further savings and mitigating actions to afford both within 2026/27 and as part of the Health Boards underlying position.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.7 Maintain oversight of, and obtain assurances on, key financial risks. This includes risks against the delivery of Health Board financial targets, the robustness of key income sources and contractual safeguards.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	2026/27 Annual Plan document and Monitoring returns to Welsh Government based on HDdUHB's financial reporting system.
Rhestr Termiau: Glossary of Terms:	HCSW – Healthcare Support Worker WTE – Whole Time Equivalent
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cyllid a Pherfformiad Parties / Committees consulted prior to Finance and Performance Committee:	Finance Team Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial implications are inherent within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	This paper and its recommendations seek to sustain existing service provision and the appropriate workforce model, as such there is no impact to patient care.
Gweithlu: Workforce:	The report considers the financial implications of our workforce.
Risg: Risk:	Financial risks are detailed in the report.
Cyfreithiol: Legal:	HDdUHB has a legal duty to deliver a breakeven financial position over a rolling three-year basis and an administrative requirement to operate within its budget within any given financial year.
Enw Da: Reputational:	Adverse variance against HDdUHB's financial plan will affect its reputation with Welsh Government, Audit Wales, and with external stakeholders.

Gyfrinachedd: Privacy:	Not applicable.
Cydraddoldeb: Equality:	Not applicable.

5.8

12:15, 5 Mins

5.8 - PROCUREMENT REPORT

*Lee Morgan (NWSSP
- Procurement)*

| For assurance

Attachments

[Finance and Performance Committee SBAR - Procurement V0.5.pdf](#)

[Appendix 1 - Value-Based Procurement in healthcare - What is it, why now an~.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 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:

1. 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.
2. Set out the proposed approval arrangements for procurement activity within HDdUHB, including delegated authority in the absence of the Deputy Head of Procurement.

Cefndir / Background

1. Procurement Outcomes:

Electronic Document and Records Management System (EDRMS) Renewal

Proposed outcome

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 September 2026 to 31 March 2032 with an option to extend to 31 March 2034	TBC - This will be confirmed post FPC and will be included within the Board paper.	£248,128.54	TBC	TBC

Minor Oral Surgery

Proposed Outcome

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 October 2026 to 30 September 2031 with an option to extend to 30 September 2036	TBC - This will be confirmed post FPC and will be included within the Board paper.	N/A	£506,000.00	Initial Contract Value £2,530,000.00 Total Inc Extensions £5,060,000.00

Outsourcing of Ophthalmology

Approval is sought to commence procurement activity for the Outsourcing Ophthalmology requirement:

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 August 2026 to 31 July 2028, with no option to extend	N/A	N/A	£6,000,000.00	£12,000,000.00

2. Procurement Plan for 26/27

The Health Board's Procurement Plan for FY26/27, detailing key strategic projects, regulatory changes, governance developments, and operational priorities.

3. Approval arrangements

In order to support effective and resilient procurement governance within Hywel Dda University Health Board, and recognising the importance of maintaining timely decision-making, it is necessary to establish clear and robust approval arrangements. This includes the ability to draw on regional expertise and capacity where required to ensure continuity of service

Asesiad / Assessment

1. Procurement Outcomes:

Proposed outcome for the tender exercise: Electronic Document and Records Management System (EDRMS) Renewal.

HDdUHB Digital Directorate are looking to award a contract to renew/replace their current EDRMS which expires in March 2027. The EDRMS is an essential system housing clinical patient records, some of which are exclusively stored within this system, and are not accessible through other platforms or physical records, which may have been destroyed as part of the digitisation process. As a result, continued access to this system is essential for safe, effective clinical care.

The system is used to store and manage patient records, whilst supporting a wider strategic programme of digitalisation of the Health Board's documentation and becoming a paper light organisation. This requirement is vital for ensuring that information and data follow the patient in their journey within NHS Wales as smoothly as possible, and that continuity of care is maintained. Any interruption or loss of access would present significant clinical, operational and legal risks.

This contract presents a key pillar to an integrated Digital Health Record (DHR), with long term intentions towards accessibility for both clinicians and patients and will be the foundation that all other clinical solutions will be built upon. It will allow clinicians to share patient information from multiple locations to both support and expedite decision making and provide better quality care.

Due to the scale of data held within the system, a significant handover/implementation period is essential. The new system will enable clinicians to access complete, accurate, searchable records at the point of care, from any location, and will support simultaneous access for multiple users. This will reduce operational inefficiencies, improve patient safety and support integration with national systems as part of the Health Boards digital transformation strategy.

A mini competition exercise was undertaken utilising the London Procurement Partnership (LPP) Framework for Digital Document Solutions under Lot 6 EDRMS Solutions. Following the deadline of the mini competition, three (3) bids were received, and an evaluation of technical, social value, and commercial bid responses was undertaken which was followed by subsequent demonstration sessions to confirm system functionality and provide confidence in delivery. The recommendation is to award the contract to the highest ranked provider and achieve a saving which will be reinvested by Digital Services within the EDRMS project to make sure it is successful and delivers maximum value for the Health Board as a learning taken from the previous contract.

The contract term will be from 01 September 2026 to 31 March 2032, with an option to extend until 31 March 2034.

Proposed outcome for the tender exercise: Oral Surgery

HDdUHB seek to establish a contract to satisfy the requirements for the delivery of Oral Surgery (OS) services within Primary Care and/or Community settings for patients aged 16 and over residing in the HDUHB area. The service aligns with Welsh Government policy to strengthen community-based care and reduce reliance on secondary care for appropriate OS needs.

The OS service will provide treatment for residents in Carmarthenshire, Ceredigion, and Pembrokeshire. A competitive procedure was undertaken under The Health Services (Provider Selection Regime) (Wales) Regulations 2025 on a lotted basis, with a lot per county. Providers were invited to submit bids for one or more lots.

Following the receipt of bids, Lot 1 (Carmarthenshire) received seven (7) bids, Lot 2 (Ceredigion) received six (6) bids, and Lot 3 (Pembrokeshire) received seven (7) bids. An

evaluation panel including clinical representation will evaluate the technical, social value and commercial criteria.

A recurring fixed budget of £506,000.00 ex VAT per annum has been allocated to deliver the service, with Carmarthenshire receiving £195,811.10 ex VAT per annum, Ceredigion receiving £83,057.31 ex VAT per annum, and Pembrokeshire receiving £227,131.59 ex VAT per annum.

Confirmation of awarded provider(s) will be included within the Board paper.

The initial contract term will be from 01 October 2026 to 30 September 2031, with an option to extend for a further five (5) years, by way of three (3) plus two (2) years.

Proposed Direct Award exercise: Outsourcing Ophthalmology

HDdUHB seeks approval to commission outsourced ophthalmology services to support delivery against the Welsh Government Eye Care Measures and to mitigate current capacity constraints within ophthalmology services. The requirement will cover a range of sub-specialties including, but not limited to, Cataracts, Intra-vitreous therapy, Vitreo-retinal (VR) surgery, and Ocular Plastics. An estimated volume of up to 6,000 referrals will be delivered on a up to two (2) year contract period, with an in-built break clause after year one (1) to manage performance, affordability, and service need.

The proposed Direct Award will be facilitated through the Countess of Chester Hospital (COCH) Framework Agreement for Insourced and Outsourced Clinical Services, Lot 2. The anticipated provider has submitted framework pricing below the NHS Payment Scheme (National Tariff), consistent with outcomes from previous ophthalmology procurements undertaken between 2023 and 2026, where market testing demonstrated that intended supplier is able to deliver ophthalmology services at or below tariff rates. This provides assurance that the proposed rates are commercially competitive, benchmarked, and sustainable.

The proposed award will rationalise outsourced ophthalmology activity into a single contractual arrangement, enabling:

- Improved clinical governance and oversight
- Stronger performance and quality management
- Greater consistency of clinical pathways and patient experience

It should be noted that this is a zero-commitment contract, permitting expenditure up to a maximum value of £12,000,000.00 over the contract term. This ensures the Health Board retains full control over activity volumes and spend, commissioning only what is required to meet patient need and performance priorities.

The proposed contract term will run from 01 August 2026 for up to 24 months with no further option to extend.

2. Approval arrangements

It is noted that approval for all procurement-related documentation within HDdUHB, covering approval to proceed, award decisions, and ongoing contract management will rest with the Deputy Head of Procurement (HDdUHB). In their absence, delegated authority to approve may be exercised by the Deputy Head of Regional Procurement (HDdUHB & Swansea Bay University Health Board (SBUHB)), the Head of Procurement (SBUHB) and/or the Assistant Head of Procurement (SBUHB).

This approach reflects a commitment to strengthening regional collaboration across Health Boards, utilising established relationships to enhance procurement resilience and capability. The arrangements are intended to provide reciprocal support, delivering benefits across all organisations involved.

Argymhelliad / Recommendation

Finance and Performance Committee (FPC) is asked to scrutinise and recommend for Board to:

- **APPROVE** the award of the Electronic Document and Records Management System (EDRMS) Renewal contract from the 01 September 2026 to the 31 March 2032 with an option to extend to 31 March 2034 at a total contract value of £1,244,903.00 ex VAT. This contract will have onwads submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the award for Oral Surgery contract for five (5) years from 01 October 2026 to 30 September 2031 with the option to extend for a further five (5) year, by way of three (3) plus two (2) years, with total contract value of £5,060,000.00 ex VAT. This contract will have onwads submission to HDdUHB Public Board, Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership) and Welsh Government for approval.
- **APPROVE** the commencement and subsequent award of the procurement process for Outsourcing Ophthalmology contract for up to two (2) years from 01 August 2026 to 31 July 2027 with no option to extend, with total contract value of up to £12,000,000.00 ex VAT. This contract will have onwads submission to HDdUHB Public Board, and Velindre NHS Trust (as hosts of NHS Wales Shared Services Partnership). This requirement does not require Welsh Government approval.
- **APPROVE** the approval and delegated authority arrangements for procurement activity within HDdUHB.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Not Applicable
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable

Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable



Value-Based Procurement in healthcare:

What is it, why now
and how?



Swansea
University
Prifysgol
Abertawe

School of Management
Yr Ysgol Reolaeth



Academiau Dysgu
Dwys Cymru

Intensive Learning
Academies Wales

Value-Based Procurement in healthcare:

What is it, why now and how?

Hamish Laing

Professor of Enhanced
Innovation, Engagement
and Outcomes
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EMAIL

WEB

Value-Based Procurement is no longer just an interesting idea: it is being used for healthcare procurement in many countries, including the UK. Value-Based Procurement is also a key enabler for Value-Based Healthcare. But what is it exactly, why is it important, and how is it done?

Most health systems are under significant pressure from ageing populations, rising complexity of care and comorbidity, constrained budgets and shortages of staff for the current models of care delivery. Whilst costs are rising steeply, population and individual health outcomes are not rising in step: for example, in the UK, Healthy Life Expectancy is falling for the first time in generations¹.

Value-Based healthcare

These challenges are leading Policymakers and Healthcare Providers to rethink how they get more from the healthcare resources they already have available to them. There is growing international adoption of the principles of Value-Based Health Care (VBHC), first described 20 years ago, with its focus on improving the outcomes of care at the lowest possible cost;² increasing the value of healthcare and, as a consequence, improving the economic sustainability of healthcare systems.

VBHC requires review of how resources are used and where they are allocated across the whole patient pathway. The value of each step or intervention can be maximised to create higher value for the patient and the system: this includes the use of medicines, medical devices, diagnostics and digital technologies, all of which must be procured.

Outcomes that matter

At its heart, Value-Based Healthcare is about establishing and measuring the outcomes that matter most to the person receiving care (“the patient” or “service user”) relative to the overall cost of achieving those outcomes; recognising that this may be as a result of a series of care activities (“a pathway”) rather than a one-off intervention.

Perhaps surprisingly, health systems historically have prioritised the measurement of activity volumes and inputs and not the measurement of outcomes, beyond patient survival and harm. There has been very limited attention paid to the health gain achieved at a personal or population level from the substantial human and financial resources invested. Clinicians have tried to compensate for this system-level information deficit with their own audits and registries of clinical outcome data: the National Joint Registry³ in the UK or the Swedish Quality registers, which collect outcomes captured by clinicians (Clinician Reported Outcome Measures – CROMs), are good examples of this⁴.

Patients care about clinical outcomes, of course: did their surgical wound heal as planned? Will their new hip last as long as promised? But they care about many other types of outcomes too. A patient with advanced cancer may prioritise quality of life and time with their family in their last few weeks over a short extension of life from further intensive oncology treatments. A person with an arthritic knee may choose to continue with weight loss, exercises and painkillers rather than undergo knee replacement, if having surgery means they could no longer pursue a particular sport or activity that they enjoy. Knowing about these person-centred outcomes is best achieved by asking the patient themselves; Patient Reported Outcome Measures (PROMs).

What else is important?

Health Resource Utilisation

Different interventions impact on the use of health resources differently, and this can be measured too. A procedure carried out as a day case (ambulatory care) uses fewer hospital resources than an in-patient stay: community-based breathing classes can reduce the number of inhalers a patient with chronic lung disease may have prescribed for them. Changing the way care is delivered can increase technical value (efficiency) and this too can be enabled by technologies such as remote monitoring and innovative diagnostics.

Value-Based Healthcare brings these different types of outcomes together to create person-centred, “holistic” outcome sets that can be measured and matched to the total cost of their care, allowing relative value for different steps in their care and different treatment options to be determined. The International Consortium of Health Outcomes Measurement (ICHOM) has supported the development of sets of Patient-Centred Outcome Measures (figure 1) for many major health conditions and for different general life course points⁵.



Figure 1: The set of Patient-Centred Outcomes Measures for people with Inflammatory Bowel Disease incorporating Clinical Outcomes, Patient-Reported Outcomes and measures of Health Resource utilisation. (Source ICHOM.org)

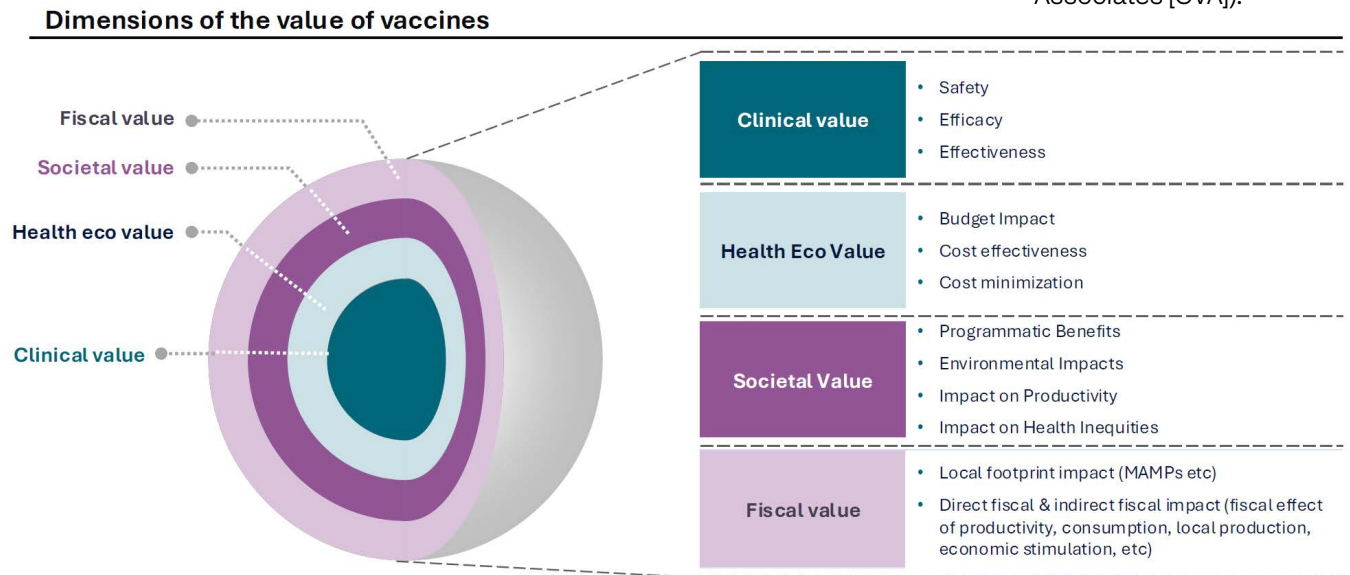
Environmental Outcomes

There are other outcomes of care that increasingly are being considered in the value equation. We know that healthcare globally contributes an estimated 4.4% of Global Greenhouse Gas emissions⁶: ironically causing significant illness and harm to some populations in the process of making others better. The majority of GHGs and other pollutants in health come from transport (patients, staff, goods), operating theatres (heating, anaesthetic gases, plastic waste) and medicines (manufacture, distribution and waste). Increasingly health systems are estimating or measuring environmental impact and making decisions about treatment that reduce adverse environmental damage.

Societal and Fiscal Value Impacts

In the context of constrained national resources there is increased interest in the wider societal impacts of healthcare such as national productivity and fiscal measures at a Governmental (macro) level. Sickness absence, retiring early due to ill health, disability or premature mortality have a direct impact on tax revenues, financial support and pension payments. Health interventions that mitigate these adverse outcomes can improve earning potential, defer retirement decisions and increase individual productivity at work⁷. If the impacts of illness on informal carers and family members, who may have to stop working themselves, receive carer benefits and reduce their personal expenditure, is considered, the fiscal value of improving someone's health is amplified. Fiscal value could be important when considering the merits of some very high-cost technologies such as Advanced Therapeutic Medical Products (ATMPs).

Figure 2: Value of medicines: The value dimensions of medicines are increasingly considered in a holistic approach, from clinical value to local footprint impacts (Source Corporate Value Associates [CVA]).



What has this got to do with Value-Based Procurement?

Healthcare is a complicated ecosystem with many actors, all of which need to be aligned if the healthcare system is to be Value-Based (figure 3).

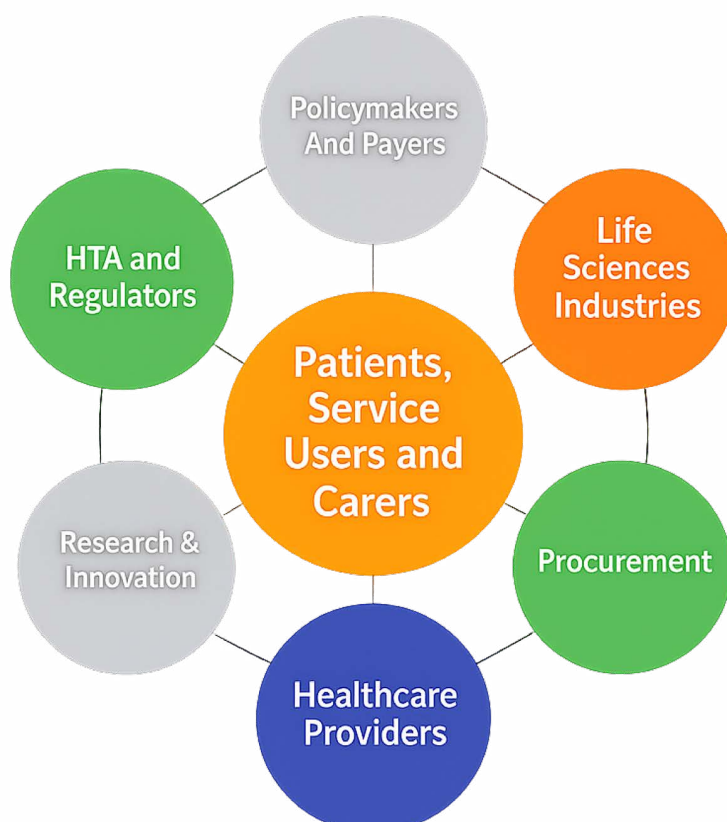


Figure 3: Actors in the Health Ecosystem. If the system is to be Value-Based, all need to share the objective of achieving better health outcomes from the resources invested.

Public procurement represents around 15% of total government expenditure in OECD-EU countries of which healthcare accounts for between 30-40%⁸. Procurement of medicines, medical technologies and digital healthcare is a significant proportion of overall health expenditure: typically the largest amount after salaries and wages of staff have been paid. Procurement in healthcare is therefore a powerful financial lever and can be a critical enabler of VBHC, because it determines which technologies enter the system and how key financial resources are allocated.

However, historically procurement has been the “go to” place for financial savings and the consolidation of purchasing power through Group Purchasing Organisations (GPOs) and Central Purchasing Bodies (CPB) has accelerated a price-reduction-led approach. Procurement has become a transactional and sometimes adversarial activity to purchase a product at the lowest price. In the EU over 60% of all Medtech tenders use only price as the evaluation criterion⁹. Whilst in the short term this may appear desirable, it devalues the impact of the purchased solution on the clinician, patient pathway and patient outcomes.

There is growing recognition that the cheapest does not always create the highest value for the patient or health system and is inadequate for delivering high-quality and financially and environmentally sustainable care. A cheaper technology or solution that fails to meet a patient’s needs or leads to more patient complications, longer hospital stays, or increased clinician workload and “rework” ultimately costs the system more. Conversely, a higher priced innovation that helps achieve the outcomes that matter to the patient, reduces readmissions or improves patient experience may deliver far greater value when the whole care pathway is considered. In addition, if tenders are evaluated only or mostly on price, then there is little incentive for industry to develop innovative solutions to address the real challenges facing healthcare today. A race to the bottom can reduce suppliers in the market and competition on functionality and improved outcomes.

Defining Value-Based Procurement

Value-Based Procurement (VBP) has emerged as a promising strategic alternative. Rather than awarding contracts solely on price or even the total cost of ownership (TCO), VBP evaluates the *total value* a product, service or solution delivers across the care pathway. This includes patient outcomes (CROMs and PROMs), patient and clinician experience (PREMs and CREMs), operational efficiency (technical value) and long term cost effectiveness and moves the conversation from TCO to Total Cost of Care (TCC).

The EU Alliance for Value in Health defines Value-Based Procurement as “involving making purchasing decisions that consider how a product or solution can best deliver the outcomes being measured and reduce the total cost of care – rather than focusing exclusively on purchasing a specific product at the lowest possible price”¹⁰.

Traditional Procurement	Value-Based Procurement	Table 1: Comparison of characteristics between traditional and Value-Based Procurement approaches
Focus on lowest price	Focus on outcomes + TCC	
Short term savings	Long term value	
Transactional	Strategic and collaborative	
Product centric	Pathway centric	
Limited supplier engagement	Early and ongoing engagement	
Risk borne by purchaser	Shared risk and reward	

Traditional procurement can unintentionally incentivise low quality products, fragmented care, and higher long term costs. VBP seeks to correct this by aligning incentives with outcomes.

In practice, VBP can consider:

- **Clinical outcomes** (e.g., reduced complications, faster recovery)
- **Patient reported outcomes and experiences (PROMs/PREMs)**
- **Technical Operational efficiency** (e.g., reduced theatre time, fewer readmissions, steps removed from a pathway)
- **Total cost of ownership** (TCO: maintenance, training, consumables, disposal)
- **Total cost of care** (TCC: across the whole patient pathway)
- **Environmental and social value** (Energy efficiency, decreased GHG emissions, reduced clinical waste, ethical supply chains, foundational economy)
- **Potential for Innovation and pathway transformation**

Policy Environment for VBP in the UK and Europe

Public Procurement is highly regulated. Following the UK's exit from the European Union ("Brexit") the legislative framework is now different in the UK and the EU, creating greater opportunities for Value-Based Procurement.

European Union

The current EU framework is collectively known as the 2014 EU Public Procurement Directives, implemented in 2016 comprising:

- **Directive 2014/24/EU** on public sector procurement
- **Directive 2014/25/EU** on procurement in utilities (water, energy, transport, postal services)
- **Directive 2014/23/EU** on the award of concession contracts

These directives form the backbone of EU procurement law and are implemented in national legislation across all Member States. They replaced the 2004 directives. Importantly, they introduced the concept of MEAT (Most Economically Advantageous Tender) as the default award mechanism, enabling non-price criteria such as quality, sustainability, and lifecycle costing to form part of procurement tenders. Where it is used, MEAT is mostly applied to Med Tech procurement, although there are examples from Norway and elsewhere of its application for medicines and vaccines and Advanced Therapeutic Medical Products (ATMPs) such as “gene therapies”.

The European Commission is undertaking a structured review of the 2014 framework¹¹, motivated by concerns that the current rules have not delivered expected improvements in competition, strategic procurement, or cross border participation and that price criteria continue to dominate public awards. The review aims to provide greater clarity and incentives for non-price criteria to be used in public procurement. It is expected to take until the end of the decade for this to have a full effect.

United Kingdom

The United Kingdom introduced the Procurement Act (2023)¹², which created four statutory objectives for contracting authorities:

- Value for money
- Maximising public benefit
- Sharing information for transparency
- Acting with integrity

These objectives move procurement away from a narrow price dominant model and towards multi dimensional value, which aligns well with Value-Based Procurement. In the Act, “Value for money” is explicitly defined in a way that allows quality, outcomes, and long term benefits to be considered, not just lowest price. There is a mandate for contracting authorities to consider broader definitions of value, including patient outcomes, lifecycle cost, sustainability, and innovation.

The Act replaces the EU’s rigid procedural options with a highly adaptable mechanism: the **Competitive Flexible Procedure (CFP)**, which allows procurement professionals to design a procurement process tailored to the market, including:

- Iterative dialogue
- Negotiation
- Staged evaluation
- Outcome based specifications
- Innovation friendly approaches

This change is a major enabler of VBP because it allows:

- Co-design with suppliers
- Testing of outcome metrics
- Negotiation of risk sharing or performance linked payment models
- Market shaping for innovative medtech or digital solutions

The Act also moves the UK away from the principle of **MEAT** (Most Economically Advantageous Tender) to **MAT** (Most Advantageous Tender) that both satisfies the contracting authority's requirements and is the best tender in respect of the award criteria when undertaking a competitive tendering procedure.

The explicit removal of 'economic' in the change from MEAT to MAT is to make it clear that the focus for awarding contracts does not have to be the lowest price or that price/cost must always be weighted higher than non-price factors. MAT does allow for assessment of the lowest price only, but contracts awarded on the basis of MAT would usually be determined on the basis of a wide range of factors – this may include price and quality criteria in addition to wider social and environmental issues, where that is decided to be relevant for the best solution or is mandated by Government or other authority as it is in many countries.

Digital Procurement

The UK Government also has positioned digital procurement in an outcome oriented, innovation enabling policy framework. With health policy direction in England and the devolved nations of “analogue to digital”, “digital front door” and “digital first” and the rapid expansion of AI use cases, this is very significant for healthcare. The UK Cabinet Office's *Transforming Public Procurement – Our Innovation Ambition* (2023)¹³ emphasises that contracting authorities should adopt innovative digital solutions “when those offer the best outcomes,” supported by the Procurement Act 2023's flexible procedures and statutory objectives of value for money, public benefit, and transparency.

The UK Government Digital Service (GDS) and HM Treasury's joint programme *Changing how we fund digital work to focus on outcomes*

(2025)¹⁴ proposes incremental, performance linked funding models for digital and data initiatives, explicitly piloted in HMRC. These reforms collectively reorient digital procurement away from upfront capital expenditure (Capex) and towards iterative delivery, measurable user outcomes, and long term public value. In doing so, they create a governance environment highly aligned with Value-Based Procurement, enabling contracting authorities to evaluate digital technologies based on lifecycle value, performance, outcomes and impact rather than lowest initial cost.

How to Implement Value-Based Procurement

For VBP to be successful requires a different approach, based on a more collaborative relationship between procurement professionals and suppliers, whilst retaining the appropriate safeguards for competition. VBP should be about procuring solutions that improve outcomes and solve problems rather than just “buying/selling products”. There is often a need to consider the wider pathway of care, not just the point of use of the technology, to ensure that the greatest value is achieved from it. Would it be better to deploy the solution earlier in the pathway? Exactly which patients will be likely to benefit and does the pathway ensure those patients get access to it? Are there patients who should not be offered the intervention?

An important change is the need to engage with stakeholders (figure 4), particularly clinicians, but potentially patient representatives, from the outset and at other stages throughout the procurement cycle. The implications of this are discussed later. A structured approach is required^{15,16}.

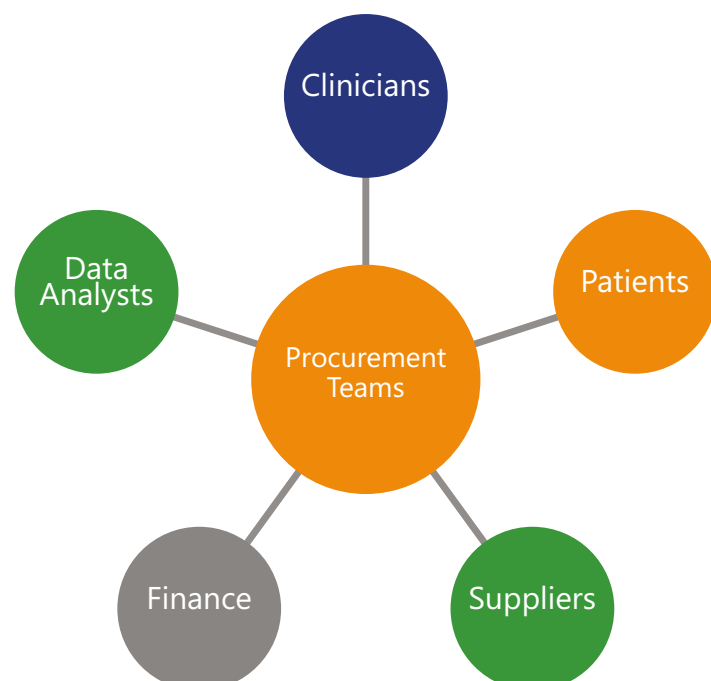


Figure 4: VBP requires engagement with a potentially wide range of stakeholders to be successful

A Structured Approach to Value-Based Procurement

A six-Step approach ensures that all requirements for a successful procurement have been addressed.

Step 1: Define the Problem and Desired Outcomes

Before engaging suppliers, organisations must clearly articulate:

- The clinical or operational problem
- The outcomes they want to achieve
- How those outcomes will be measured
- Which stakeholders need to be involved

Stakeholders might include:

- Clinicians
- Patients and carers
- Procurement professionals
- Finance teams
- Data analysts
- Suppliers (at the appropriate point)

Example: instead of just specifying “a wound dressing”, specify “a solution that reduces healing time, infection rates, pain and nursing workload/patient visits for community patients with venous ulcers”.

Step 2: Develop an Outcome Based Specification

Traditional specifications focus on technical features. VBP focuses on *functional* and *outcome based* requirements.

Example: Traditional: “Device must weigh < 2kg.” VBP: “Device must enable one handed operation and reduce procedure time by 20%.”

Outcome based specifications encourage innovation and avoid over prescribing technical details.

Step 3: Engage the Market Early

Early supplier/market engagement is essential for VBP.

Activities may include:

- Market sounding/Open Market Consultation

“
Outcome Based
Contracts (Outcome-
Based Agreements)
align incentives
between purchasers
and suppliers to
ensure the highest
value for patients.”

- Supplier days
- Innovation challenges
- Co-design workshops

Benefits:

- Suppliers understand the desired outcomes clearly and that these are important
- Purchasers understand what is technically feasible and what outcomes have been used elsewhere
- Builds trust and transparency

Step 4: Evaluate Value, Not Just Price/TCO

Evaluation criteria should reflect the full value proposition.

Common methods:

- Weighted scoring models
- Multi Criteria Decision Analysis (MCDA)
- Cost utility or cost effectiveness analysis
- Real world evidence review

Step 5: Contract for Outcomes

Outcome-Based Contracts (Outcome-Based Agreements) align incentives between purchasers and suppliers to ensure the highest value for patients. This is a Win-Win-Win approach.

Types of contracts:

- Risk sharing agreements
- Gain share models
- Pay for performance
- Innovation partnerships

Example: A supplier receives additional remuneration if their device reduces readmissions by 15% (bonus design) or a supplier pays a rebate if the outcomes agreed are not met fully (malus design). It is typical to cap the payment variance in either direction to reduce instability and risk to all parties and build trust.

Provision for significant unanticipated pathway changes in mid-contract (e.g., a change from a hospital to a community setting; a new technology is introduced in the pathway) or unforeseen events (e.g., COVID-19) should be included in the spirit of partnership to avoid unwarranted penalties for either party. This could include regular contract review points in the design.

Step 6: Monitor, Evaluate, and Improve

VBP requires ongoing performance monitoring.

Key elements:

- Clear KPIs
- Data collection, sharing and interoperability
- Regular review meetings
- Continuous improvement cycles

Digital tools (dashboards, analytics platforms) can support real time monitoring. It is important to establish ways of sharing outcome and contract performance data appropriately with the supplier. Some systems have used trusted third-party intermediaries for this, whilst others use pseudonymised and aggregated data sharing agreements. Blockchain-based data platforms can avoid the need to move data across boundaries and ensure auditable data flows.

This is a new way of working, and it requires suppliers, procurers and providers to capture and share learning with each other to improve processes and replicate successful approaches. There are also education and training needs to introduce VBP at scale.

The Approach for NHS England

The UK Department of Health and Social Care (DHSC) have co-created a VBP approach for Med Tech and Digital Tech procurement with industry, procurement professionals, providers, academia and other stakeholders (figure 5). This has been undergoing real-world testing and evaluation and is expected to be rolled out as “business as usual” in NHS England from Summer 2026.

It is designed to embrace the principles of VBP and MAT fully, whilst providing some degree of standardisation (to avoid suppliers having to respond to large numbers of entirely bespoke tenders), whilst retaining local flexibility for procurement teams to meet their specific needs and solution requirements.

Procurers select from up to five value domains and their weighting for the solution to be procured (always including at least 10% for social value and an overall weighting for value of *at least* 60%) and include the

appropriate questions to use from a standardised national question bank for each domain. Price or cost must be weighed at *no more than* 40% and uses a standardised Whole Life Cost measure.

Figure 5: Five Value Domains and Cost used to evaluate tenders. Minimum 60% for value (including the mandated minimum of 10% on social value) and a maximum 40% on cost (WLC). Source: UK Department of Health and Social Care, Medtech and Innovation Directorate.



Value Domains (60%+)

- Social Value (mandated 10%+). Generate wider social and environmental benefits
- Efficiency. Improves the patient pathway
- Patient and Staff. Supports better outcomes, experience and safety
- Supply chain. Has a resilient supply chain
- Purpose. Meets the specification

Cost (max 40%)

- Whole Life Cost

What does VBP mean for different stakeholders

Procurement Professionals

This is a very different approach to procurement, both technically and culturally. There is likely to be a need for training in outcomes measurement, tender design, economics, patient outcomes, data sharing and stakeholder engagement. Specifically working closely with clinical colleagues throughout the procurement process: from need identification, patient cohort specification, agreeing on appropriate outcomes to include, evaluating tenders, monitoring contract

performance and interpreting outcomes data. It may also be necessary to establish patient advocacy/representative groups and to understand how to engage with suppliers in a more collaborative way.

VBP allows procurement professionals to transition from “back-office” transactional teams focused on price saving to being part of the core value, sustainability and innovation functions of the health system.

Clinicians

Most clinicians will have little knowledge of procurement regulations, legislation or processes, let alone Value-Based Procurement and they may be very unfamiliar with collaborating with procurement teams. This is a knowledge gap that must be addressed as well as a cultural shift required towards partnership with procurement professionals, with each bringing their specialist expertise to the procurement. There is also a need for clinicians to prioritise and measure outcomes that matter to their patients and to ensure that these are captured, interpreted and shared to support effective contract management.

Patients

Patients may be asked to help identify needs to be met and outcomes that should be measured. They will need to be educated in procurement processes and where they can (and cannot) inform the procurement and decision-making. They may require specific support to participate in patient panels and learn how they can represent patient cohorts and not just their own lived experience. Appropriate compensation for their time and costs must be considered.

Data analysts, Informaticians and contract management

There may be little experience of Outcome-Based Agreements and the need to capture and analyse outcome measures to underpin the contract management and payments. Specific data flows from different sources may be required, and bespoke reports established. There will be a requirement to share data about contract performance with the industry supplier in a way that is compliant with GDPR or UK GDPR, and Information Governance expertise may also be required in the design of these data flows.

Long-term outcomes and other data monitoring will be required throughout the life of the contract, with the potential to vary reimbursement/payments as contract performance changes over time. Legal expertise in innovative procurement contracting will be helpful until core teams become familiar with this change in approach.

Industry Suppliers

Value-Based Procurement is a big change, technically and culturally, for suppliers as it is for procurement teams. Establishing trusted relationships and having the knowledge and expertise in suppliers will be critical to success. This applies not only to customer-facing teams (sales, market access, etc.) but across many other departments in the

“

Value Based Procurement represents a fundamental change in how health systems conduct purchasing and use the powerful financial lever of procurement.”

business, such as finance, legal, marketing, supply chain and executive teams, to ensure that the supplier is “internally ready” to flourish with this different approach and market environment. This readiness is described as Value-Based Supply¹⁷, and we have developed a self-assessment tool for companies to assess their own readiness against key domains and benchmark against industry norms.

Conclusion

Value-Based Procurement represents a fundamental change in how health systems conduct purchasing and use the powerful financial lever of procurement. By focusing on outcomes, total cost of care and long term value, VBP offers a route to more sustainable, patient centred, and innovative healthcare and can help accelerate Value-Based Healthcare more generally across health systems. VBP also places procurement professionals, working with clinical colleagues at the heart of service transformation and system sustainability. For industry it incentivises innovation and provides opportunities to contribute to solving the problems and challenges facing healthcare.

The transition requires cultural change, new skills, and better data – but the potential benefits are significant. As pressures on health systems intensify, VBP is not just a procurement strategy; it is a strategic imperative.

Acknowledgements

I am grateful to the International Consortium of Health Outcomes Measurement (ICHOM) for permission to use figure 1, to Corporate Value Associates (CVA) for use of figure 2 and the MedTech and innovation Directorate, UK Department of Health and Social Care (DHSC) for figure 5.

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5.9 - PROCUREMENT PLAN

***Lee Morgan (NWSSP
- Procurement)***

Attachments

Finance and Performance Committee SBAR - Procurement Plan V0.1.pdf



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Hywel Dda Procurement Plan 2026/27
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:

1. The Procurement Plan for Financial Year 2026/27 for Hywel Dda University Health Board.

Cefndir / Background

1. Procurement Plan for 26/27

The Health Board's Procurement Plan for 2026/27 sets out the strategic direction for procurement activity, including key projects, governance developments, and regulatory requirements. It reflects an increasingly complex landscape driven by the Procurement Act 2023, Welsh policy changes, and rising service demand.

The plan builds on work to strengthen regional collaboration, standardise approaches, and improve value for money, including the introduction of value-based procurement methodologies to support better patient outcomes and whole-life value. It aligns with wider organisational objectives on transformation, compliance, and the foundational economy.

Asesiad / Assessment

1. Procurement Plan

This paper outlines the Health Board's Procurement Plan for FY26/27, detailing key strategic projects, regulatory changes, governance developments, and operational priorities. The plan aligns with the Health Board's wider objectives on transformation, compliance and foundational economy.

Strategic Procurement Projects 26/27

A number of critical procurement projects are scheduled for FY26/27, supporting transformation, service sustainability, and statutory compliance:

- Regional Pest Control (HDdUHB/SBU collaboration)
- Regional Risk Management System (HDdUHB/SBU collaboration)
- Patient Service Centre
- WCCIS (Connecting Care)
- Insourcing and Outsourcing Initiatives
- Third Sector Recommissioning Projects
- GMS and Dental Projects

These projects are being delivered in collaboration with clinical, commissioning, digital, and operational leads to ensure alignment with the Health Board's overarching strategic aims, with an increasing focus on regional delivery where appropriate.

The Procurement Team has been working collaboratively with Swansea University, supported by the Department of Health and Social Care (DHSC), to establish a pilot programme exploring the application of a Value-Based Procurement (VBP) approach to Medical Technology and Digital Technology procurement. This work draws on recently published DHSC guidance, with further detail on Value-Based Healthcare (VBHC) principles and proposed methodology provided in Appendix 1.

A programme of targeted workshops is being developed to build capability within the procurement function and to foster a shared understanding of value-based methodologies across stakeholders. These sessions will support a transition from traditional price-focused procurement towards approaches that assess total value across the care pathway, including patient outcomes, experience, operational efficiency and long-term system impact. In line with VBP principles, procurement decisions will increasingly consider whole-life value and total cost of care, rather than lowest upfront cost, ensuring that outcomes for patients and wider system benefits are consistently prioritised

Efficiency & Savings Delivery

Work continues at both a regional and national level to drive savings and efficiencies through standardisation and rationalisation:

- Rationalisation of frameworks across medical and clinical categories (e.g. urology, orthotics, women's health consumables)
- National sourcing initiatives for provisions, catering disposals and patient hydration snacks and hydration.
- Commissioning - Radiology reporting contract extensions delivering significant savings through national negotiation
- Digital (All-Wales) focus on tail-end spend reduction, catalogue leakage and standardisation of hardware (e.g. laptops).

Current Savings Target – National

National Sourcing Category	Savings Target May 2026
National – Clinical	£266,000
National – Hotel Services and Textiles	£97,000
National – Maintenance	£10,000
National – Medical	£108,000
National – Provisions	£40,000
Total	£749,000

The Procurement Team will continue to support and actively drive the identification and delivery of additional All-Wales savings opportunities throughout the financial year, working in collaboration with Health Boards and Trusts to maximise collective impact. Delivery against these targets by the National Sourcing Teams will be subject to monthly monitoring and tracking

Locally, there is increased collaboration with operational teams to deliver efficiencies through:

- Review and standardisation of carriage charges
- Aged debt negotiation
- Loan kit utilisation reviews
- Maintenance contract rationalisation

These initiatives support financial sustainability while reducing variation and improving value for money.

Hywel Dda Procurement Team Savings –

	Apr-26	May-26
Forecast	£ 134,739.95	£ 269,479.89
Actual	£ 227,126.90	£ 64,703.63

The figures presented above reflect all local savings achieved to May 2026, including cost avoidance, income generation, and cash-releasing savings. The figures below represent locally delivered cash-releasing savings and income only, along with the forecast for the financial year.

Full Year	Forecast	Actual
Total Savings	£ 350,720.15	£ 130,004.84

Regional Working

Strengthening regional collaboration remains a key priority for FY26/27. The introduction of a Deputy Head of Regional Procurement role will now provide dedicated oversight across Hywel Dda and Swansea Bay procurement teams.

This role will:

- Drive the regional procurement agenda
- Encourage collaboration and consistency of approach
- Promote sharing of best practice and market intelligence
- Support teams in managing workload and resource pressures

These benefits are further strengthened by the future appointment of a Regional Clinical Procurement Nurse, supported by a Regional Data Analyst, providing dedicated clinical insight and data-led intelligence to inform procurement decisions, contract management, and service evaluation and efficiencies.

A continued focus on regional tendering activity, including areas such as pest control, risk management systems, and WCCIS, will further support this agenda and drive consistent, value-for-money outcomes across the region.

Legislative & Governance Changes

The ongoing implementation of the Procurement Act 2023 continues to have a significant operational impact. Key implications include:

- Increased transparency requirements, including publication of additional notices
- Greater emphasis on planning, documentation, and route-to-market justification
- Increased administrative burden across procurement teams

The service is continuing to develop and refine internal guidance to support Health Board stakeholders in navigating the new regime.

Procurement teams are working more proactively with Clinical Care Groups and corporate services to:

- Ensure awareness of governance requirements
- Provide earlier input into procurement planning
- Strengthen compliance and mitigate risks

Additional policy developments include:

- Welsh Procurement Policy Notes (WPPNs) – including enhanced transparency requirements such as publication of contract award notices and ongoing reporting requirements (including payment and performance data)
- Social Partnership and Public Procurement (Wales) Act – introducing strengthened duties relating to social value, fair work, and collaborative working together with an annual Socially Responsible Reports to be reported by September 2027 for the financial year 25/26.

These requirements, while increasing complexity, support improved governance, transparency, and alignment with Welsh Government priorities.

Compliance & Risk Management

There continues to be pressure on the procurement function arising from urgent and unplanned procurement requests, which can:

- Impact delivery timelines
- Increase risk of non-compliance with procurement regulations and Standing Financial Instructions
- Limit opportunities for strategic procurement input

A continued focus on early engagement, strengthened governance processes, and clearer accountability for procurement planning is being reinforced across all directorates. The procurement team is also increasing its visibility and support to service areas where historically engagement has been more limited.

Contract Management and Operational Focus

Contract management is a key area of focus for FY26/27, with an increased emphasis on ensuring that all Health Board contracts deliver the requirements as set out in the contract and demonstrates value for money throughout the lifecycle.

This programme is being progressed jointly across Procurement, Finance, and service areas, with the aim of strengthening assurance, accountability, and performance management across all contracted activity, enabled through the use of technology to improve data visibility, performance monitoring, and reporting.

Key priorities of the programme include:

- Targeted focus on the top 100 contracts within the Health Board, based on value and strategic importance, ensuring proportionate oversight and consistent application of contract management principles.
- Full adoption of the All-Wales Contract Management Framework and supporting toolkits, embedding standardised processes and expectations across all contracts.
- Ensuring that every contract has a clearly identified contract manager, with defined responsibilities and accountability for contract delivery.
- For strategically important or high-value contracts, formal contract management groups will be established, comprising service representatives, Finance, Procurement, key stakeholders, contract managers, and service users as appropriate, to provide robust oversight throughout the contract lifecycle.
- For lower-value or less complex contracts, ensuring as a minimum that an identified contract owner is in place, with responsibility for overseeing performance, compliance, and delivery of contractual requirements on a regular basis.

The programme is focused on reinforcing a clear and consistent message: that the Health Board is achieving value for money, receiving the service it is paying for, and holding suppliers to account for delivery.

In addition, there is a renewed focus on supplier engagement and innovation, particularly within the medical and clinical existing supply base. As part of the programme Suppliers are being actively encouraged to:

- Work in partnership with the Health Board to bring forward innovative and value-based solutions and service improvements
- Identify opportunities to deliver additional value, improved outcomes, or more efficient ways of working

To support this, Procurement is working in partnership with Digital Services to better utilise available data and intelligence, bringing together multiple data streams and progressing the development of a new AI-enabled contract management tool to support real-time oversight. This will provide:

- Timely, robust performance information
- Improved visibility of contract utilisation, demand, and outcomes
- Enhanced evidence to support informed decision-making and appropriate challenge where required
- Effective contract monitoring.

This data led and technology enabled approach will strengthen assurance, enable more proactive contract management, and support the Health Board in demanding consistently high-quality performance from its suppliers. Overall, the programme will ensure that contract management is not solely focused on compliance, but acts as a key enabler of value, performance, and continuous improvement, ensuring the Health Board not only gets what it pays for, but secures the maximum possible benefit from its commercial arrangements.

Procurement continues to operate within an increasingly complex and evolving environment, with rising regulatory requirements and service demand. Despite these challenges, the function is continuing to:

- Deliver key strategic and transformation projects
- Strengthen regional collaboration and leadership
- Embed new legislative requirements

- Drive efficiencies through standardisation and national alignment
- Continue to support the Welsh foundational economy through procurement activity and Welsh Government Net Zero ambitions.

The focus for financial year 26/27 will remain on supporting the Health Board to deliver safe, effective, and sustainable services, while maximising value and ensuring full regulatory compliance.

Argymhelliad / Recommendation

Finance and Performance Committee (FPC) is asked to scrutinise and recommend for Board to:

- **NOTE FOR INFORMATION** the Procurement Plan Financial Year 2026/27.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Not Applicable
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau:	Not Applicable

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable

**Cydraddoldeb:
Equality:**

Not Applicable

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5.10 - PLANNING GOALS UPDATE REPORT
Q1 2026/27

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

| For assurance

Attachments

[Planning Goals Update Report Q1 2026-27 FPC 30 June 2026.pdf](#)



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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Planning Goals Update Report Q1 2026/27
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 so 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 will remain a key element of the Annual Plan for 2026/27. Where there are outstanding actions as part of the 2025/26 plans, these are expected to be carried over into 2026/27 for completion.

Planning Goals

The current status of the Planning Goal aligned to this Committee are:

Planning Goal	Executive Lead	Q1 Status and Key Outcomes
Planning Goal 6: Safe, timely, high-quality care	Chief Operating Officer	Planning Objective 3 On Track: Since April 2026, the Six Goals Programme has: • 2026/27 UEC Three Pillars Programme Plan developed and signed off • Transitioned from planning to active delivery of 7-Day business case for Clinical Streaming and SDEC services. Local Implementation groups established with robust governance and reporting arrangements • Frailty lead appointed and plan developed • Community Sprint launched and has strengthened collaboration across: Primary care, community services, acute care, and WAST, particularly through initiatives such as: Call Before Convey • Csylltu 72 events held and communities of practices formed to develop project plans • Delivered measurable outputs in falls prevention and community response programme • Embedded hospital flow improvements and front door models • DEWI tool launched across acute sites and evaluation being currently undertaken • Strengthened system-wide integration and data-driven decision-making through remodelling of CSH dashboard and Community Sprint However, delivery continues to be constrained by workforce, financial, and system pressures, requiring sustained programme oversight. The programme is on track but slightly delayed in some areas

		Planning Objective 4 (Diagnostics) Behind: Radiology • NOUS contract extended, with additional capacity being sought. Internal staffing (Insourcing) ongoing funded by vacancy. • MRI van extended from Apr– Aug 2026 using core funding (vacancy lag). WG funding for second van ended 31 March, reducing capacity by 540 patients per month. • CT van extended to end Q1 with additional funding (Planned Care). Capacity for 250 additional urgent suspected cancer patients per month. • Demand management pathway work underway with physiotherapy, podiatry and maternity to increase capacity via workforce diversification. Endoscopy • Insourcing agreed for May-June 2026 in gastrointestinal endoscopy to bridge baseline capacity deficit in-order-to-maintain the 8-week performance standard. Maintenance of zero breaches reliant on funding to bridge D&C gap of 3 lists/week, as noted in the Endoscopy annual plan submission. • Cystoscopy waits beyond 8 weeks reducing monthly. Galeas Bladder trial for urgent suspected cancer continuing, with funding for 2 additional sessions in June. Maintenance of zero breaches relies on continuation of the programme and ability to resource lists appropriately. Cardiology • Plans are in place to procure insourcing activity during June and July to support a reduction in the current breach position, however additional funding will be required	
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		to achieve full recovery and deliver a sustained breach-free position.	
		Planning Objective 5 On Track: • Open Access Demonstrator Projects – Status On Track Completed three-day Leadership Exchange Programme with the national strategic programme. Local Demonstrator Project Implementation Group, project governance structure & performance tracking arrangements established. Nominated support provided by Performance & Improvement and HEIW • 111 Option 2 – Status On Track Completed three-day Leadership Exchange Programme with the national strategic programme. Local Demonstrator Project Implementation Group, project governance structure & performance tracking arrangements established. Nominated support provided by Performance & Improvement and HEIW • Psychological Therapies – Status In progress Expanding group and trauma-focused DBT to improve trajectory Risk: Backlog up to 2 years without further intervention Challenges: Recruitment delays reducing capacity; digital transition issues (Attend Anywhere stopped, MEDIO not live) impacting group delivery • Patient Flow – Improving MH Inpatient Flow & Reducing Out of Area Beds – Status In progress 72 Hour crisis admission pathway working group starting July Aim to establish a consistent, clinically robust pathway and clear standards Focus on improving assessment, treatment, discharge planning, and patient flow	

		Emphasis on multi-disciplinary, multi-agency working and continuity across services Vanguard work supporting improvements in patient flow and reducing out of area placements Neurodevelopmental (ND) – Status On Track School cluster pilot underway which has shown initial outcomes to be positive. Working with education providers to move to a needs-led response rather than reliance on diagnosis. Contract for AI scribe in place for further year. Trajectory for Q1 of 16% of CYP ASD assessments completed within 26 weeks. Performance data as of 30/04/2026 is 22.5% due to the impact of outsourced assessments. Additional WG funding received of £567,000. Further outsourcing contract being agreed. Risks / Challenges – Demand continues to outstrip capacity. Additional funding received in 26/27 will not bring about the eradication of over 3 year waits without further system change Learning Disabilities (LD) – Status On Track Finalise OCP for LD Service Redesign and begin recruitment – OCP briefing paper awaiting Workforce sign-off; on approval, implement with affected staff, supported by Workforce, and commence recruitment to vacant posts. Start HEF digitisation rollout planning. – HEF digitisation implemented across CLDTs, with initial data capture underway and monthly performance reporting established with Performance & Improvement. Confirm GP register validation and AHC support arrangements. – Ongoing work to strengthen GP register validation and improve Annual Health Check (AHC) uptake, Targeted support to practices, alongside coordinated education, and awareness for people with learning disabilities, families, carers, and PHC teams. Paul Ridd Learning Disability Awareness ESR Training – as of 11th June 2026	
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		Health Board Compliance rate 94.79% MH & LD rate 98.4% against Q1 trajectory of 95% Health Board Wide. Suicide & Self Harm – Safe Discharge, Ligature Safety, Multi Agency Prevention - Status On Track Continued monitoring of compliance with 72 hour follow up Increased focus on quality and effectiveness of follow up, not just compliance Clear trajectory in place to sustain compliance in the next quarter Contribution to development of national standards to align with best practice In April 2026, 120/197 (61%) inpatient staff had undertaken the Ligature awareness training. Ahead of the planned compliance expectation. Established Hywel Dda Suicide and Self Harm Strategic Group (first meeting 15th June 2026) Recommendation to establish a Health Board Ligature Reduction Group, supported by the Health and Safety Compliance Group (June 2026)	
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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)

Objectives: (must be completed)

Committee ToR Reference:
Cyfeirnod Cylch Gorchwyl y Pwyllgor:

3.1.17 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.

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care 6. Sustainable use of resources
Amcanion Cynllunio Planning Goals	Planning Goals – Planning Goal 6 Safe, timely, high-quality care
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Annual Plan 2026/27
Rhestr Termiau: Glossary of Terms:	Explanation of terms is included within the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board	Public Board - March 2026 (acceptance of 2026/27 Planning Goals being developed through Quarter 1 26-27 as part of the Annual Plan)

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

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

6 - FOR INFORMATION

6.1

0 Mins

6.1 - ALL-WALES CAPITAL PROGRAMME
2026/27, CAPITAL RESOURCE LIMIT AND
CAPITAL FINANCIAL MANAGEMENT
UPDATE

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

| For information

Attachments

[Capital Update FPC 30 June 2026.pdf](#)



PWYLLGOR CYLLID A PHERFFORMIAD
FINANCE AND PERFORMANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 June 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	All-Wales Capital Programme 2026/27, Capital Resources Limit and Capital Financial Management Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Sarah Welsby, Head of Capital and Special Projects

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This update report is presented to the Finance and Performance Committee to:

- Note the 2026/27 Capital Resource Limit (CRL)
- Note the project updates

Cefndir / Background

This report provides and update on the CRL for 2026/27

Asesiad / Assessment

Capital Resource Limit 2026/27

The CRL for 2026/27 has been issued with the following allocations:

Allocation	£'m
All Wales Capital Programme (AWCP)	26.502
Discretionary Programme* (DCP)	8.087
Total	34.589

*The Health Board received DCP of £11.228m in 2026/27. A contribution of £2.011m has been made towards the Targeted Estates Fund schemes within AWCP and a contribution of £0.11m towards the refurbishment costs of Picton Terrace. A further £1.02m has been paid back to the AWCP to account for capital scheme slippages in 2025/26.

Capital Expenditure Plan

The following table shows the capital expenditure plan for 2026/27 with expenditure incurred to date:

Scheme	Planned Spend 2026/27 £m	Cumulative Spend Apr-May £m	Spend May £m	Remaining balance £m
AWCP				
Withybush - Fire Enforcement and Associated Works - Phase 2	4.034	0.352	-0.032*	3.682
Bronglais - Fire Precaution Upgrade Works - Fees	0.741	0.183	0.175	0.558
Year End Funding – October 2024 – Pentre Awel	0.250	0.002	0.002	0.248
Aseptic Unit, Withybush Hospital	2.364	0.427	0.204	1.937
TEF - Fire	0.644	0.015	0.015	0.629
TEF - Infrastructure	5.214	0.490	0.063	4.724
TEF - Decarbonisation	1.699	0.000	0.000	1.699
TEF - Mental Health	0.759	0.005	0.000	0.754
TEF - Decontamination	0.157	0.014	0.007	0.143
Decarbonisation Project	5.416	2.161	2.161	3.255
Diagnostics equipment - DEXA scanner	0.628	0.020	0.020	0.608
Major Infrastructure Investment Plan, Phase 1 BJC Fees	0.834	0.035	-0.008*	0.799
Commercial Research Delivery Equipment Call Funding	0.024	0.009	0.000	0.015
Mental Health Quality and Safety Schemes 2026-27	0.515	0.007	0.007	0.508
Carmarthen Hwb - Equipment and Fit-out costs	1.385	0.083	0.014	1.302
Fishguard Health and Wellbeing Centre	1.513	0.008	0.004	1.505
Bandi Children Centre	0.325	0.001	0.000	0.324
Sub-total AWCP	26.502	3.812	2.632	22.690
Discretionary				
I.T.	0.650	0.215	0.208	0.435
Equipment	2.630	0.007	0.007	2.623

Statutory Compliance	0.450	0.005	0.003	0.445
Estates	3.257	0.082	0.054	3.175
Other	1.100	0.044	0.002	1.056
Sub-total Discretionary	8.087	0.353	0.274	7.734
TOTAL	34.589	4.165	2.906	30.424

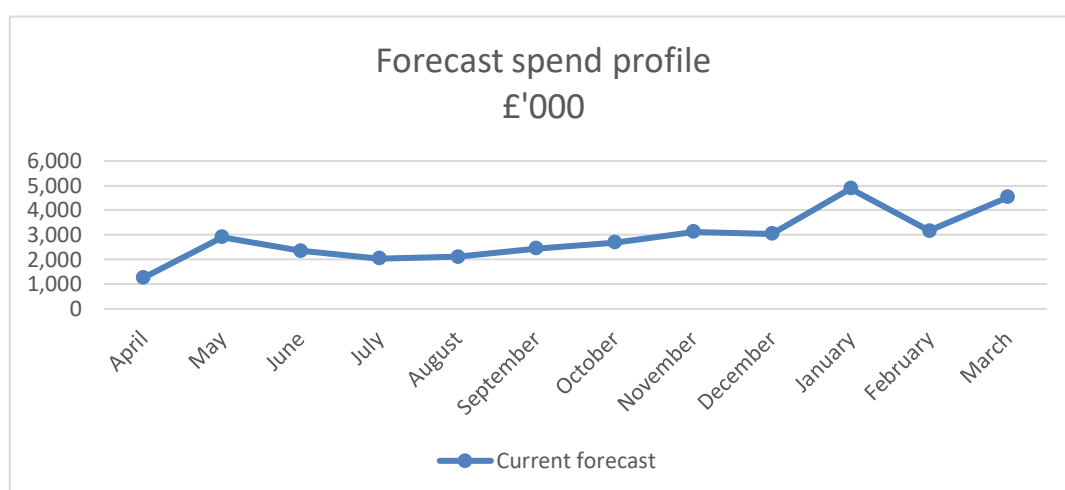
- Negative in month spend is due to the recovery of VAT.

Further details on the revenue consequences of these schemes are noted in **Appendix 1**.

Expenditure Profile Forecast

The below graph indicates that capital spend is expected to remain fairly consistent until December with an increase in spend between January and March 2026.

Progress will be monitored on a monthly basis with corrective actions taken where material slippages are identified.



CAPITAL SCHEME UPDATES (SCHEMES GREATER THAN £1M)

Withybush Hospital Fire Enforcement and Associated Works – Phase 2

Phase 2 of the major Fire Precaution Upgrade works started on site in January 2026, with programme completion expected October 2027. Current indications are that the scheme is forecast to remain within the current year allocation

Bronglais Hospital Fire Precautions Upgrade Works – Fees

A business case is in development for fire precaution upgrade works to the main hospital building at Bronglais Hospital (BGH) and core blocks. This is due to be submitted to Welsh Government (WG) at the end of 2026.

Aseptic Unit – Withybush Hospital

A sustainable compliant Aseptic Unit will be built at WGH in advance of the development of a South-West Wales Regional Aseptic Unit. This will ensure that the facilities and delivery of aseptic services within Hywel Dda University Health Board (HDdUHB) will meet the required regulatory standards. Whilst there has been a slight delay to the original completion date, the scheme is progressing well with commissioning and occupation of the new unit due to occur towards the end of 2026.

Decarbonisation Project

Funding has been provided towards several energy performance improvements across Health Board sites. The scheme is progressing well with an expected completion date of February 2027.

Carmarthen Hwb

This project is led by Carmarthenshire County Council, in partnership with the Health Board and University of Wales Trinity St David. A number of services will be co-located within the building which are currently being delivered across a number of different locations.

Funding has been provided to the Health Board for equipment, furniture and digital items. Occupation of the building is forecast to occur in February 2027.

Fishguard Health and Wellbeing Centre

Fees have been received to develop a business case for an Integrated Health and Wellbeing Centre in Fishguard working in partnership with Pembrokeshire County Council and other Public Service Board partners. This will include a longer-term solution for the existing Fishguard Healthcare Centre and support local delivery of services for the North Coastal Integrated Community Network.

Bandi Childrens Centre

A business case is being produced to redevelop a Childrens Centre in the Carmarthen area in partnership with Carmarthenshire County Council and the Bandi Charity Trustees. This would create a multipurpose facility to develop outpatients and day care services for children with medical and disabling conditions.

Argymhelliad / Recommendation

The Finance and Performance Committee is requested to **NOTE** the contents of the All-Wales Capital Programme 2026/27, Capital Resource Limit and Capital Financial Management Update report and **TAKE ASSURANCE** on the delivery of the capital programme within 2026/27.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.5 Receive assurance on the delivery of the financial plan. This will be achieved through scrutiny of the monthly finance report. This report shall ensure clarity in: 3.5.3 Performance against other financial metrics, such as cash management, capital management and Public Sector Payment Policy.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 1196 - not be able to provide safe, sustainable, accessible and kind services. This is caused by insufficient investment to ensure we have appropriate facilities, medical equipment and digital infrastructure of an appropriate standard. Score 16
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	3. Striving to deliver and develop excellent services 6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	7 Primary and community strategic plan 8 Estates plans 9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Capital Allocation and prioritisation process. Capital Investment procedure and all relevant Welsh Government guidance.
Rhestr Termiau: Glossary of Terms:	Explanation of terms is included in the main body of the report.
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy:	Capital Monitoring Forum Capital Planning Group Individual Project Boards of Capital Schemes Welsh Government Capital Review Meeting Capital Sub-Committee

Parties / Committees consulted prior to Sustainable Resources Committee:	
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Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Capital values noted within the report. Included within individual business cases and Capital prioritisation process.
Ansawdd / Gofal Claf: Quality / Patient Care:	Included within individual business cases and Capital prioritisation process
Gweithlu: Workforce:	Included within individual business cases and Capital prioritisation process
Risg: Risk:	Risk assessment process is integral to the capital prioritisation process and the management of capital planning within HDdUHB
Cyfreithiol: Legal:	Included within individual business cases and Capital prioritisation process
Enw Da: Reputational:	Included within individual business cases and Capital prioritisation process
Gyfrinachedd: Privacy:	Included within individual business cases and Capital prioritisation process
Cydraddoldeb: Equality:	Included within individual business cases and Capital prioritisation process

APPENDIX 1

REVENUE CONSEQUENCES OF CAPITAL SCHEMES

The below table summarises the revenue consequences of capital schemes of which funding has been received in 2026/27:

Scheme	Total £'m	Additional £'m	Costs included in current budgets (replacements) £'m
AWCP			
Withybush - Fire Enforcement and Associated Works - Phase 2	0.00	0.00	0.00
Bronglais - Fire Precaution Upgrade Works - Fees	0.00	0.00	0.00
Year End Funding – October 2024 (Pentre Awel)	0.48	0.48	0.00
Aseptic Unit, Withybush Hospital	Efficiencies of at least £0.033m will be generated		
TEF - Fire	0.00	0.00	0.00
TEF - Infrastructure	0.00	0.00	0.00
TEF - Decarbonisation	0.00	0.00	0.00
TEF - Mental Health	0.00	0.00	0.00
TEF - Infection Prevention Control	0.00	0.00	0.00
TEF - Decontamination	0.00	0.00	0.00
Decarbonisation Project	Spend to save project. Revenue savings will be utilised to repay capital costs.		
Diagnostics equipment - DEXA scanner	0.00	0.00	0.00
Major Infrastructure Investment Plan, Phase 1 BJC Fees	0.00	0.00	0.00
Commercial Research Delivery Equipment Call Funding	0.00	0.00	0.00
Mental Health Quality and Safety Schemes 2026-27	0.00	0.00	0.00
Carmarthen Hwb - Equipment and Fit-out costs	0.45	0.45	0.00
Fishguard Health and Wellbeing Centre	Business case under development – revenue consequences of project not yet known		
Bandi Children Centre	Business case under development – revenue consequences of project not yet known		
Sub-total AWCP	0.93	0.93	0.00
Discretionary			
IT	0.00	0.00	0.00
Equipment	0.00	0.00	0.26
Estates – Statutory	0.00	0.00	0.00
Estates Infrastructure	0.00	0.00	0.00
Other	0.00	0.00	0.00
Sub-total Discretionary	0.26	0.00	0.26
TOTAL	1.19	0.93	0.26

The above table shows the total revenue costs as a consequence of capital expenditure in 2026-27 as £1.19m. Total additional costs are estimated at £0.93m and costs assumed to be included in current revenue budgets, as they are equipment replacements, totals £0.26m.

The following assumptions were made: -

- Medical Equipment replacement assumed at 10% of capital cost.
- Any Estates work to existing buildings are assumed to be revenue neutral unless the building footprint increases or changes significantly.
- Some capital investments will lead to longer term revenue savings (such as decarbonisation initiatives and digital investment); however, it has been assumed that these will be included as a part of directorate savings plans.

6.2

0 Mins

6.2 - JCC PLANNING, PERFORMANCE AND FINANCE SUB-COMMITTEE REPORTS

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

| For information

Attachments

JCC PPF Highlight Report 28 April 2026.pdf

Joint Commissioning Committee

Highlight Report from the Planning, Performance and Finance Sub-Committee

Dyddiad y Cyfarfod / Date of Meeting	26/05/2026
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Maxine Evans, Assurance & Risk Officer
Cyflwynydd yr Adroddiad / Report Presenter	Paul Worthington, PPF Chair and Lay Member, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Huw George, Chief Commissioner, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Assurance
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Health Boards		Noted

1. SITUATION/BACKGROUND

This report has been prepared to provide Health Board Chief Executive Officer Members of the Joint Commissioning Committee (JC) with a summary of the key issues considered by the NHS Wales Planning, Performance and Finance (PPF) Sub-Committee at its public meeting on 28 April 2026.

Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

(Links to reports highlighted - [April 2026 - NHS Wales Joint Commissioning Committee](#))

Status	Update
Alert / Escalate	The NWJCC Finance Report - Month 12 2025/26 was received. A year-end overspend of £6.3 million was reported, which represented an improvement on earlier forecasts. This was more favourable than anticipated due to lower activity through the winter period, delays in the opening of the Neath Port Talbot Welsh Kidney Network (WKN) Unit and underspends on other non-committed expenditure. The importance of prospective financial monitoring with early identification and reporting of emerging service and financial pressures for 2026-27 was noted.
Advise	The NWJCC Combined Operational Performance Report at Month 11 was received. Highlights included improvements in dialysis, particularly within North Wales, and PET scan turnaround times. Reductions in inpatient and outpatient stays in specific specialties were highlighted whilst the Sub-Committee noted ongoing escalations in services such as the Caswell Clinic and medium secure units. The need for clear de-escalation criteria and timelines for the Caswell Clinic were discussed. The outcome of the upcoming meeting with Swansea Bay University Health Board (SBUHB), including clarity on outstanding actions and the route out of escalation would be shared outside the meeting. The performance stats for Ambulance Services were discussed in detail. Ongoing discussions with the Welsh Ambulance Service Trust (WAST) to set meaningful performance goals and improvement trajectories was noted. Performance around high rates of late arrivals and aborted journeys for the Non-Emergency Transport Service (NEPTS) were also highlighted as areas for improvement. Any future commissioning decisions on the WAST service model would form part of the planned strategic review.
Assure	The PPF Organisational Risk Register (ORR) was received for the assigned risks from the NWJCC Operational Risk Register as of 31 March 2026. After PPF scrutiny and review, the NWJCC Joint Committee will receive the March 2026 risk register at its May 2026 meeting. The following were highlighted: • Four commissioning risks and two corporate risks, with a score of fifteen or above had been assigned to the PPF sub-committee.

Status	Update
	• Escalated (Risk 68 - Specialist Auditory Implant Device Service' CVUHB) and de-escalated risks (Risk 61 - Obesity surgery for the population of North Wales) • The continued efforts to improve the risk register were highlighted. The ongoing review and oversight of risk will continue to contribute to the JCC's risk maturity and support the final development and approval of a robust Joint Assurance Framework (JAF), alongside the consideration and implementation of a risk appetite statement for the JC. • The need to capture emerging financial and strategic risks was highlighted, particularly around financial break-even for 2026-27 and the impact of the planned strategic reviews as reflected in the Annual Plan 2026-27, as these would likely identify further risks for the JCC. • Members were pleased with the progress made to date. The NWJCC Foundation Plan Quarterly Delivery Update was received providing updates on Quarter 1, 2, 3 and 4 deliverables. The report was noted, acknowledging the level of detail included and the areas reporting as red and amber as a result of the decisions made within the Foundation Plan discussions to not invest in legacy areas which had been agreed previously. Areas of successful delivery and projects rolling over into the 2026-27 Annual Plan delivery were highlighted. Members discussed the critical need for improved assurance on delivery against the 2026-27 Plan, reflecting on lessons learnt and early identification of delivery issues, highlighting that rigor, drive and delivery will need to improve. An update was provided on the NWJCC Annual Plan 2026-27 which is set within a 3-year context and had been approved by the JC on 30th March 2026. It was noted that a full project support function had been put in place to support delivery. Members discussed the significant capacity challenges of managing a risk based annual plan on a day-to-day basis, in addition to the programme of strategic reviews and deep dives reflected within it. The role of NHS Wales Performance and Improvement (P&I) was raised as a potential source of support with which to engage. The urgent need for delivering change at pace was highlighted, recognising that this would involve a number of difficult decisions needing to be made.
Inform	A report on Referral Management and Pathway Optimisation provided members with an update on the continued work to manage the financial pressures of activity growth in NHS England

Status	Update
	through a number of opportunities that might be exploited, and the ongoing review of the current NWJCC Referral Management Framework. The Annual Governance Statement 2024-25 was presented and members were invited to provide comments, queries, and suggestions for accuracy or completeness before the statement is submitted to the CTM Audit and Risk Committee (ARAC) on 19 May, and to the JC in May for approval. Members noted the thoroughness of the report. A verbal update was provided on the Annual Effectiveness Survey for 2025-26, noting the low response rate to date. Members were advised that although the deadline had passed, they should submit their responses as soon as possible as the feedback will inform the JC strategy day in June and help develop a plan to improve committee effectiveness. A brief update on the status of the Consultation and Engagement Framework was provided, noting that the document is still awaited. This item would remain on the committee's forward plan and be brought back for consideration once the framework is available following the May Senedd elections.
Appendices	None.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC Link to JCC Strategic Objectives(s)	Maximise Value
	Ensure Quality; Reduce Duplication; Improve Equity & Population Health; Facilitate Integration
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Resilient Wales
	A Healthier Wales
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality	Leadership
	Culture and Valuing People; Learning, Improvement and Research; Whole-systems Perspective

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	Efficient; Equitable; Person-centred; Timely; Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: ☒	No: ☒
	Outcome for Equality (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE Outcome for Welsh Language (delete as appropriate): POSITIVE/NEUTRAL/NEGATIVE	If no, please include rationale below: This is a summary of the latest meeting of the JCC
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.	
Effaith Adnoddau (<i>Pobl /Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	Yes (Include further detail below) The performance of the services will be used to develop the IMTP and identify the areas where resources may be required.	

4. RECOMMENDATIONS

The Health Board is asked to:

- **Note** the highlights outlined in Section 2 of this report.
- Receive the report as **assurance**

6.3

0 Mins

6.3 - NWSSP PROCUREMENT SERVICES 2025-26 SUMMARY REVIEW

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

| For information

Attachments

[NWSSP Procurement Services 2025-26 Summary Review FPC 30 June 2026.pdf](#)

NWSSP Procurement Services

Hywel Dda Frontline Team Meeting April 2026



GIG
CYMRU
NHS
WALES

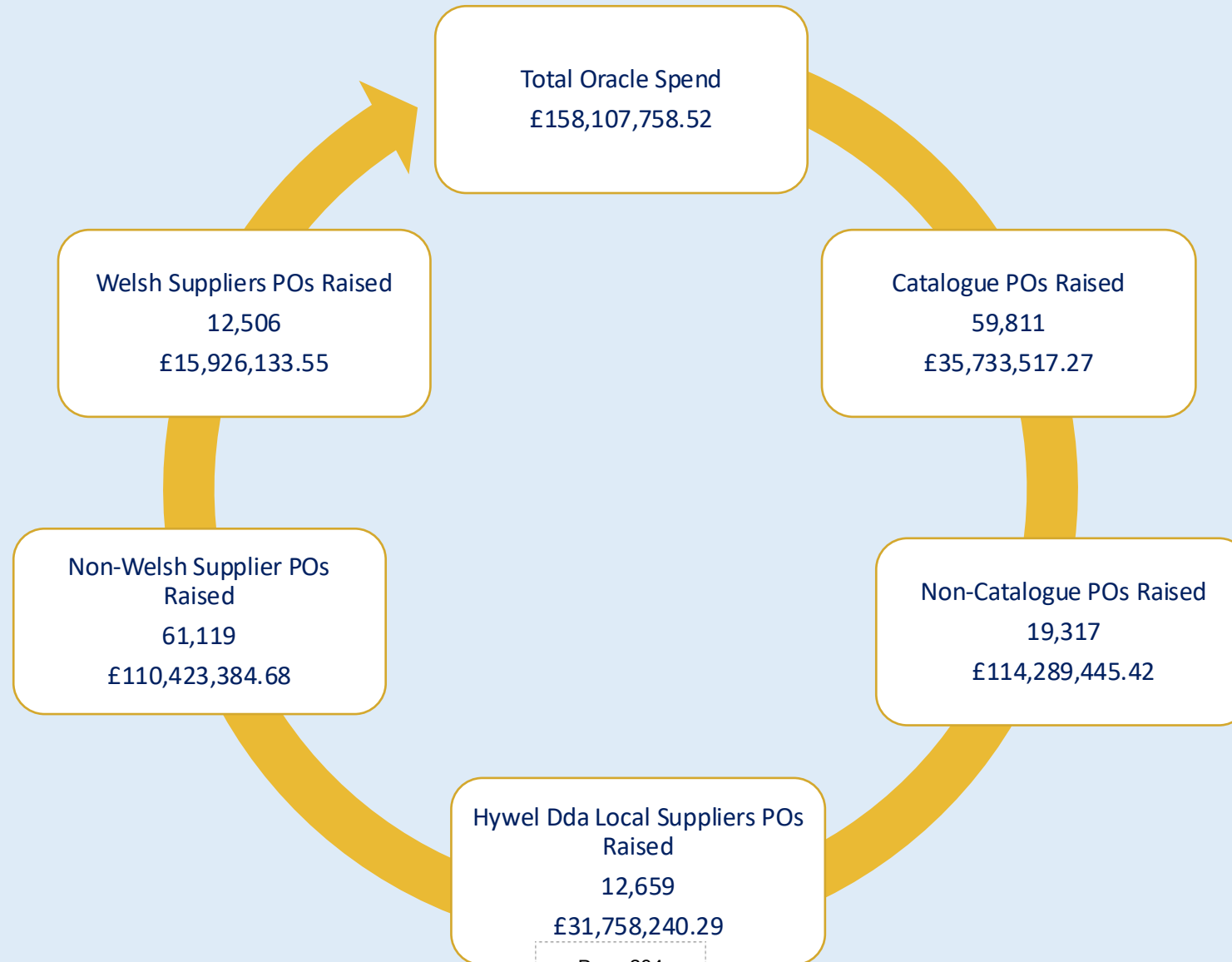
Partneriaeth
Cydwasaethau
Gwasanaethau Caffael

Shared Services
Partnership
Procurement Services

*Adding Value
Through Partnership,
Innovation and Excellence*

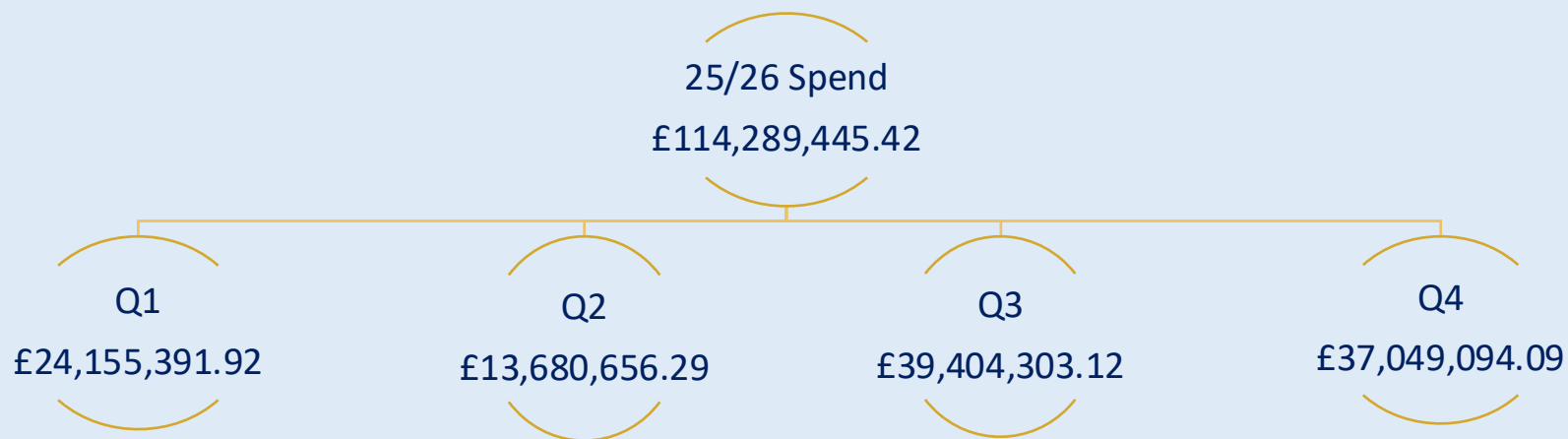


Total Hywel Dda Spend FY 25/26





Total Local Buyer Spend FY 25/26



2025/ 2026	Number of POs raised
Quarter 1	4,279
Quarter 2	4,756
Quarter 3	4,907
Quarter 4	5,375
Grand Total	19,317

TOP 10 SUPPLIERS BY NUMBER OF POs PROCESSED (Local Buyers Only)

Supplier	Number of POs Raised
NHS SUPPLY CHAIN	853
LYRECO UK LTD (2 WAY MATCH ONLY)	688
CASTELL HOWELL FOODS LTD	547
ADVANIA UK CCS LTD	541
DACEY LTD	427
STRYKER UK LTD	193
F&T REFRIGERATION LTD	143
WOLSELEY UK LTD	141
TJ ELECTRICAL WHOLESALE LTD	130
D & G OFFICE INTERIORS LTD	121

25/26 Requisition Turnaround

KPI (%)

90.8%

Average days from Requisition approval to PO approval

3.4 days

Charitable Funds Spend

£1,450,158.136

Charitable Funds

£1.45m
Total
Spend



Key
projects



Memory
boxes for
bereaved
families



Cancer Hair
Care-
Specially
Trained Hair-
dressers



Items for
older adult
mental
health
services



'Hospice in
Hospital'
Care
Packages

Local Hywel Dda Spend FY 25/26



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Caffael
Shared Services
Partnership
Procurement Services

20% of
total
spend
is local
£31.7m

Top 10 Local SMEs by spend value

SMEs via Charitable Funds



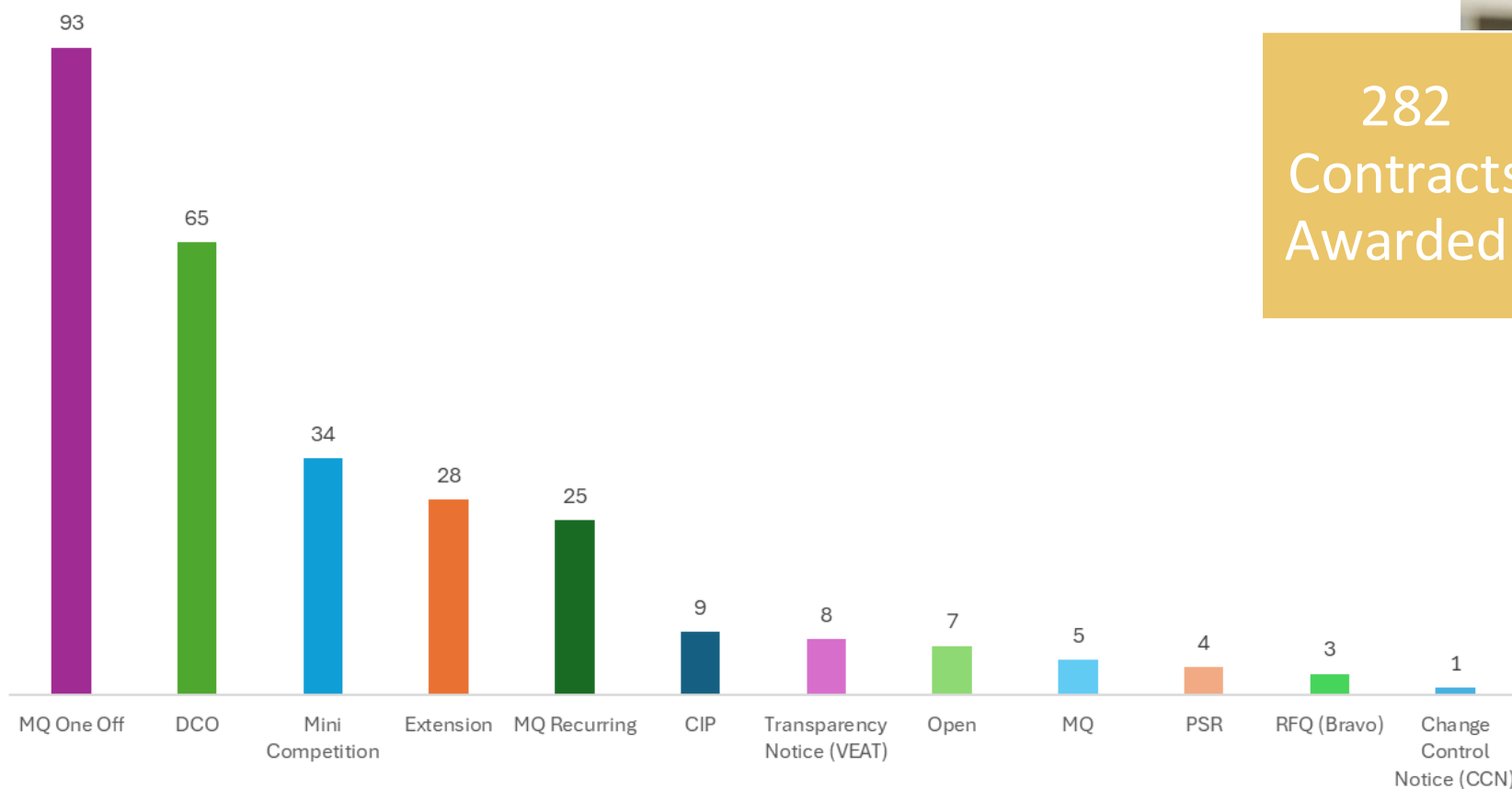
Split
between:
Capital
£18.3m
Revenue
£12.9m

32.5% of
Charitable
funds spent
locally
£472k



It's Been a Productive Year

Awards by Route to Market



282
Contracts
Awarded!





Breakdown By Value

Below £25k

146

Contracts Awarded

£1,547,654.42

Total Contract Value

25k – 500k

115

Contracts Awarded

£15,404,566.02

Total Contract Value

Over 500k

21

Contracts Awarded

£28,208,480.44

Total Contract Value

282 Contracts Awarded

£45,160,700.88 Total Contract Value



In & Outsourcing

13 In and Outsourcing Contracts Awarded

In Sourcing

- ✓ Theatre Staff (2)
- ✓ Obstetric & Non-Obstetric Ultrasound Examinations
- ✓ Outpatients Appointments

Outsourcing

- ✓ Ophthalmology (4)
 - ✓ T&O (2)
- ✓ MRI Prostate Pathway
 - ✓ Vasectomies
- ✓ Computed Tomography Coronary Angiography (CTCA)

Insourcing
Value
£4.5M



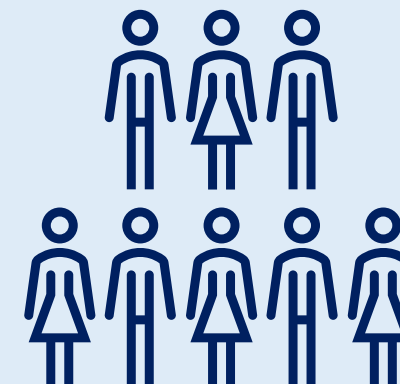
Outsourcing
Value
£8.5M



Total Value
£13M

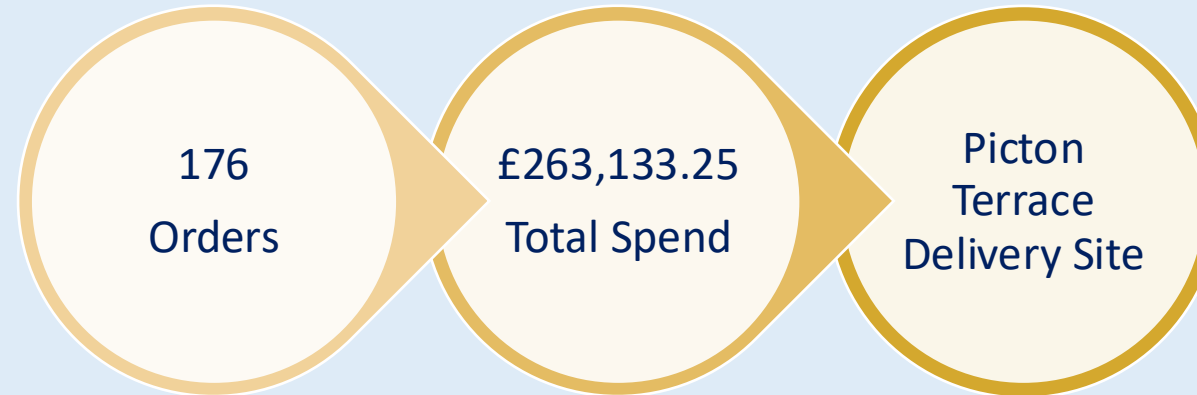
Impact

Across all activities,
this has allowed the
health board to help
15,215 patients





Picton Terrace Programme



Key
projects



Door Systems
£20,116.57



Furniture
£24,354.04



Hardware
Licensing and
support
£33,441.86



Monitors and
Peripherals
£75,670
(£3,760 Saving)

Savings

Local



Cash Releasing(Inc Income)

£1,974,936

Cost Avoidance

£3,509,684

Cost Pressures

-£1,611

Carry Forward

£43,628

Total

£5,526,637



Sourcing



Cash Releasing (Inc Income)

£5,049,508

Cost Avoidance

£131,809

Cost Pressures

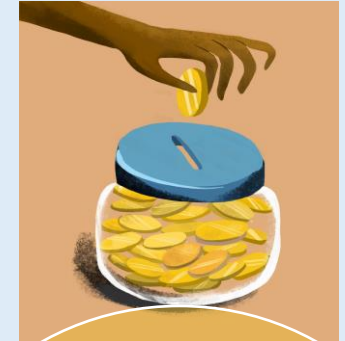
-£1,134,753

Total

£4,046,564



Total



Local

£5,526,637

Sourcing

£4,046,564

Total

£9,526,637

Key Deliveries

Cash Releasing

B BRAUN

B Braun Route Switch

61% above forecast
savings



Lone Working
Devices

£16,848.00



Medical and Theatre
Consumables

£121,849.90



Buyer One-Off

£85,849.78

Cost Avoidance



Ad Hoc VAT
Savings

£147,355.93



Scan 4 Safety

£138,165.79



Warp It

£42,468.00

Income



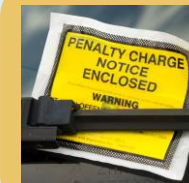
VAT Re-Review

£418,561.10



A&E Vending
Machine

£38,861.85



Car Park Fines

£24,796.40

The Year ahead



GIG
CYMRU
NHS
WALES

Partneriaeth
Cydwasaethau
Gwasanaethau Caffael
Shared Services
Partnership
Procurement Services



£2m
Target

Local Projects

Arts Partners Framework
Training Providers Framework
Oral Surgery & GA's
Food Provision at Picton Terrace
Substance Misuse
Connecting Care/WCCIS
Patient Service Centre – CGI
MHLD Services Renewals

Regional Projects

Pest Control
Estates Consumables
Risk Management
Debt Collection Services
Maintenance Contracts

Sourcing Projects

IT Peripherals
Software Licences
Fuel Cards
Radiology Reporting

6.4

0 Mins

6.4 - FINANCE AND PERFORMANCE COMMITTEE WORK PLAN 2026/27

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

| For information

Attachments

FPC Work Programme 2026-27 Draft.pdf

FINANCE AND PERFORMANCE COMMITTEE WORK PLAN APRIL 2026 – MARCH 2027

Currently, Finance and Performance Committee (FPC) meets bi-monthly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2026 – March 2027.

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
GOVERNANCE									
Welcome and Apologies	Chair	All		✓	✓	✓	✓	✓	✓
Declarations of Interests	Chair	CSO		✓	✓	✓	✓	✓	✓
Minutes from previous meeting	Chair	CSO	Approval	✓	✓	✓	✓	✓	✓
Table of Actions (ToAs)	Chair	CSO	Approval	✓	✓	✓	✓	✓	✓
FPC Terms of Reference (TORs) Review (12.1)	Chair	JW	Approval					✓	
FPC Annual Report 2025/26 (10.4.1)	Chair	HT	Approval	✓					
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW	Assurance						✓
Self-Assessment of Committee Effectiveness: Six-Month Review (10.5)	Chair	JW	Assurance			✓			
Assurance and Risk Report (3.1.18 & 3.1.19)	CW	RW	Assurance	✓	✓	✓	✓	✓	✓
ESCALATION OVERVIEW									
Escalation Oversight and Highlight Report (3.1.8)	SA	SA	Assurance	✓	✓	✓	✓	✓	✓
ESCALATION RESPONSE – RECOVERY ACTIONS AND IMPROVEMENT TRAJECTORIES (Areas to be agreed at Agenda Setting)									
Hospital Flow Processes	AC	AC	Assurance	✓			✓		
Q1 2026/27 Planned Care Trajectories	AC	AC	Assurance	✓					
Enabling Actions: Value and Opportunities	HT	HT	Assurance	✓					

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Q1 2026/27 Financial Trajectory	HT	HT	Assurance	✓					
De-risking the Annual Plan – Board Choices and Savings Considerations	SA	SA	Assurance		✓				
FINANCE									
Financial Performance Assurance Report (3.1.5) to include: - Deficit Drivers Annual Refresh (3.1.2) - Financial Outlook 2025/26 (3.1.5) - Financial Recovery/In-Year Savings Programme (3.1.5) - Risks on delivery of key financial targets key income sources & contractual safeguards (3.1.7)	HT	AS	Assurance	✓	✓	✓	✓	✓	✓
Financial Plan and Strategy (3.1.4)	HT	AS	Assurance	✓					
(Investments and) Benefits Realisation Report (3.1.13)	HT	SJ	Assurance	✓	✓	✓	✓	✓	✓
Planning for 2027/28 (3.1.4)	HT	HT	Assurance					✓	
Financial Systems Assurance Report (3.1.6)	HT	AS	Assurance						
Finance Targeted Intervention Actions (3.1.8)	HT	SA	Assurance	Incorporated within Escalation Oversight and Highlight Report					
Value and Enabling Actions	HT	HT	Assurance		✓				
Plan for Closing the Residual Delivery Gap to £41m	LD/AC/JS	LD/AC/JS	Assurance		✓				
Resident Doctor Contract Implementation	LG/AC/MH	LG/AC/MH	Assurance		✓				
Band 2/3 Healthcare Support Worker Pay Re-banding Update	SJ	SJ	Assurance		✓				
Financial Grip and Control Assessment	HT	HT	Assurance		✓				
Procurement Plan (3.1.10)	HT	GD	Assurance		✓				

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Contract Management	HT	GD	Assurance	✓					
Procurement Scrutiny (3.1.10 & 3.1.13) • Review any investment/disinvestment	HT	GD	Assurance	✓	✓	✓	✓	✓	✓
Planning Objective Update Report (3.1.17)	HT	ALP	Assurance	✓ Q4/Closure	✓ Q1		✓ Q2		✓ Q3
Contracts Assurance Report (3.1.11 & 12)	HT		Assurance						
Balance Sheet Report (3.1.5)	HT	AS	Assurance		✓				✓
Deep Dive: Risk Landscape of Health Board Financial Position	HT	HT	Assurance	✓					
Deep Dive: Financial Alerts (Medical, Continuing Healthcare, Clinical Care Group Savings Plans)	MH/AC	MH/AC	Assurance		✓				
PERFORMANCE									
Integrated Performance Assurance Report (IPAR) (3.1.14)	HT	SH	Assurance	✓	✓	✓	✓	✓	✓
Performance Deep Dive: Alert Areas	AC	AC	Assurance		✓				
Performance Management Framework (3.1.14)	HT	HT	Assurance						
NHS Wales Shared Services Partnership (NWSSP) Performance Report 2025/26 (quarterly) (3.1.16)	HT	RD	Assurance		✓ (Q4)	✓ (Q1)		✓ (Q2)	
Public Sector Emissions Reporting	HT	DW	Assurance				✓		
FOR APPROVAL									
Financial Procedures (3.1.21)	HT	TJ	Approval	✓	✓	✓	✓	✓	✓
Policies (as required) (3.1.22)	All	All	Approval	✓	✓	✓	✓		✓

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.9)	HT	HT	Approval	✓	✓	✓	✓	✓	✓
• UEC Business Case: Implementation and Evaluation	AC	AC	Approval		✓				
FOR INFORMATION									
All-Wales Capital Programme 2026/27, CRL and Capital Financial Management Update (3.5.3)	HT	RD	Information	✓	✓	✓	✓	✓	✓
JCC Planning, Performance and Finance Sub-Committee Reports (3.1.20)	HT	JM	Information	✓	✓	✓	✓	✓	✓
NWSSP Procurement Services 2025-26 Summary Review	HT	HT	Information		✓				
Finance and Performance Committee Work Plan 2025/26	Chair	Chair	Information	✓	✓	✓	✓	✓	✓
COMMITTEE ADMINISTRATION									
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓
Draft agenda to go to Executive Team	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting)	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓
Issue a draft TOA within two days of the meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	Lead	Responsible Officer	Purpose	30 Apr 2026	30 Jun 2026	27 Aug 2026	27 Oct 2026	15 Dec 2026	23 Feb 2027
Circulate minutes and TOA to the Lead Director within 7 days of meeting	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	N/A	✓	✓	✓	✓	✓	✓

Chair: Michael Imperato **Vice Chair:** Anna Lewis **Lead Executive:** Huw Thomas

HT	Huw Thomas	MH	Mark Henwood	LD	Lee Davies	JW	Joanne Wilson
LG	Lisa Gostling	SA	Shaun Ayres	AS	Andrew Spratt	SJ	Sian Jenkins
DW	Daniel Warm	RD	Rhian Davies	GD	Gemma Deverill	KJ	Keith Jones
AJ	Amorelle Jones	SHi	Steph Hire	DB	Debra Bennett	LC	Liz Carroll
AL	Angela Lodwick	HTy	Helen Tyler (JCC)	SH	Sally Havard	VC	Vicky Coppack
TJ	Timothy John	JM	Jacqueline Maunder (JCC)	RW	Rachel Williams	CSO	Committee Services Officer
D	Deferred						

7 - ANY OTHER BUSINESS

8 - DATE OF NEXT MEETING

- Thursday 27 August 2026; 09:30 - 12:30

9 - IN COMMITTEE SESSION

In accordance with the Committee's Terms of Reference, which permit the Committee to operate an in-committee function for the consideration of sensitive and/or confidential information, the next part of the meeting will be held in private session. Attendance will be restricted to Committee Members and those individuals (or their nominated deputies) identified in the Terms of Reference.

This session will consider the following items:

- **NHS Wales Pay Growth Review**

A summary of matters considered will be reported to the next appropriate Committee meeting.