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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Cyfarfod Cyhoeddus y Bwrdd/ Public Board Meeting

DYDDIAD Y CYFARFOD: DATE OF MEETING:	24 September 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Integrated Delivery Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Lee Davies, Executive Director of Strategy and Planning Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Shaun Ayres, Director of Delivery Andrew Spratt, Deputy Director of Finance Tracy Price, Head of Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA SBAR REPORT

Leadership Position Statement

Since July, the Health Board has made measurable progress in cancer performance (closer to the annual plan assumptions of mid 60% performance) and overdue follow-up appointments. Outpatient transformation is changing how patients receive ongoing care, additional diagnostic activity is supporting cancer recovery, and workforce programmes now share a reconciled staffing and financial baseline. These developments provide a firmer basis for delivery in the second half of the year.

The challenge is to extend this improvement across the plan and reduce the recurring cost of delivery to ensure the Health Board achieves financial sustainability. Urgent and Emergency Care remains under sustained pressure, the longest planned care waits have increased, and financial recovery requires a substantial improvement on the first five months. At the end of August (Month 5), the deficit was £26.3m. The £41m deficit plan remains dependent on £19.9m of further mitigation. Our current gross forecast is £60.9m, with insufficient assurance that the actions currently being progressed will close this gap. The response combines targeted service recovery with stronger executive oversight and practical support for Clinical Care Groups. This report explains what is changing, where that is making a difference and where further improvement remains essential.

Sefyllfa / Situation

This report updates the Board on delivery of the Annual Plan, bringing together performance, financial recovery and the action being taken in response to escalation. It focuses on progress since July and the priorities for the remainder of 2026/27. The detailed financial and performance positions are presented separately on the agenda.

Cefndir / Background

In July 2026, the Board asked for a clearer account of positive progress, the causes of underperformance and the actions needed to improve delivery. It also sought greater clarity on the sustainability of savings and the support available to services facing the greatest pressure.

This update develops that joint approach, connecting operational changes to their financial and patient-care consequences.

The Health Board remains subject to Level 4 escalation. The priorities remain sustainable improvement in urgent and emergency care, reduced fragility in clinical services and a credible route to financial stability. These priorities are closely connected. More reliable staffing, timely diagnostics and better patient flow can improve access while reducing reliance on premium staffing and externally purchased capacity (insourcing and outsourcing). Recovery therefore needs to be managed as one programme, with clear ownership of both the service benefit and the financial effect. Sustained delivery will be central to the 9 November 2026 escalation review.

The above and below is reinforced by national correspondence which sets out the expectations against which the Health Board's recovery will be assessed.

11 August 2026: Nick Wood, Deputy Chief Executive, NHS Wales, Welsh

Government. Following the August Escalation Board, the letter required accelerated recovery supported by credible improvement trajectories. For urgent and emergency care, the expectation is that no more than 7% of emergency department attendances exceed twelve hours in each of September and October, ahead of the November escalation review. For finance, the requirements are to close the savings identification gap and submit an agreed route to financial stability by the end of September, increase recurrent savings and explore opportunities to improve on the £41m forecast deficit. The recovery plan must also be discussed with Welsh Government before consideration by the September Board.

19 August 2026: Corrina Casey, Director of Performance and Delivery, NHS Wales

Performance and Improvement. The letter reinforced the requirement for an in-year financial recovery plan showing how the adverse variance would be recovered, with clear scheme ownership and less reliance on non-recurrent savings. It also required intensified action on ambulance handovers and twelve-hour waits, while protecting patient safety and avoiding the transfer of delays into other parts of the hospital.

25 August 2026: Nick Wood, Deputy Chief Executive, NHS Wales, Welsh

Government. The letter revised the ambulance handover de-escalation criterion. It now requires a 30% reduction in handovers exceeding 45 minutes, equivalent to no more than 789 per month across all receiving hospital sites, sustained for three months. This replaces the previous one-hour handover criterion.

8 September 2026: Dr Chris Clayton, Managing Director, NHS Wales Performance and

Improvement. The letter called for faster savings delivery, stronger expenditure control and explicit ownership of recovery actions and milestones. For urgent and emergency care, it required implementation of the operational review findings, including stronger daily management, discharge processes and executive oversight. It welcomed the Health Board's proposal for a dedicated Performance Recovery Group and additional leadership capacity.

The Health Board's response brings together operational improvement, financial recovery and strengthened executive oversight. The Assessment below sets out the action underway, the progress achieved and the remaining risks to meeting these expectations.

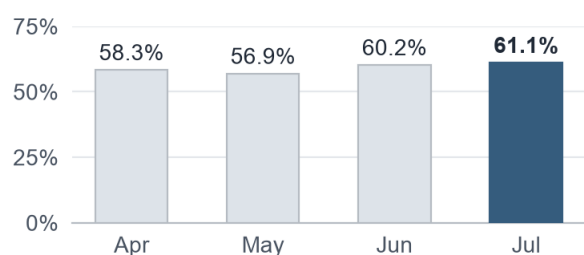
Asesiad / Assessment

Annual Plan Progress Summary

There is evidence of improvement that the Health Board can build on, although performance remains variable. The following charts recognise progress already made and identify where further sustained recovery is required. They show monthly actuals in the year to date, with the relevant escalation thresholds.

Cancer treatment within 62 days

More patients treated promptly



305 patients treated within 62 days in July.
Higher is better.

Overdue follow-up appointments

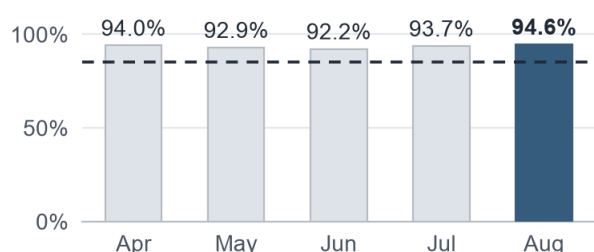
Lowest recorded number waiting



638 fewer patients waiting than in June.
Lower is better.

Diagnostic endoscopy waits

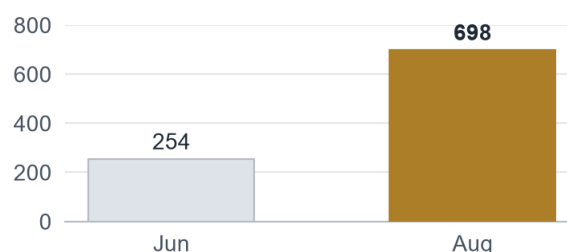
Above the escalation threshold



Dashed line = 85% escalation threshold:
at least 85 in 100 waiting under eight weeks.
Higher is better; all five months exceed it.

Planned care waits over 104 weeks

Long waits continue to increase



444 more pathways than in June.
Lower is better.

High-risk eye care (R1 Ophthalmology) has also improved, with 46.0% of waiting pathways within the clinical tolerance in July, compared with 43.6% in June. This remains below the 65% escalation threshold; however, there is evidence of positive movements. Children's mental health assessment and intervention standards were met in July, although adult psychological therapy access remains below standard. These gains are specific to the services and measures concerned.

IPAR performance trends

The Integrated Performance Assurance Report (IPAR) complements the in-month and year-to-date delivery position through statistical process control (SPC), which assesses variation in performance over time. Both perspectives inform assurance on recovery.

The IPAR Overview includes a summary, data, issues and mitigating actions for the Health Board's key performance improvement measures and the IPAR dashboard provides statistical process control (SPC) charts for each of our performance measures. Ahead of the Board meeting, the IPAR dashboard will also be made available via our [internet site](#).

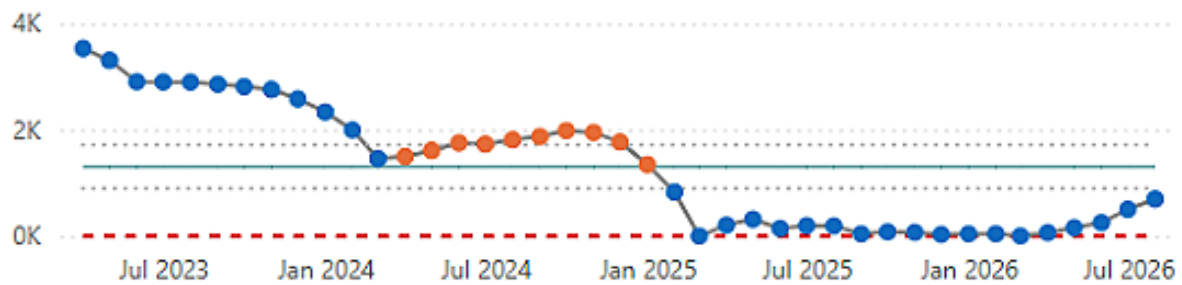
Improving variation in delayed follow-up appointments reinforces the progress set out above. Waits over 104 weeks also retain an improving SPC classification, reflecting the reduction over the longer period. However, the August position of 698 is the highest since February 2025. The recent increase therefore remains a delivery concern and requires the planned acceleration in treatment capacity and productivity.

Children and young people receiving a neurodevelopment assessment (ADHD and ASD) is showing improving variation. An outsourcing contract is in place for 2026/27 for 300 additional assessments to be completed by the end of November.

Adult psychological therapy access is a further area of concern. In July, 56.6% of patients were waiting less than 26 weeks to start therapy, against the 80% standard, and the IPAR shows concerning variation. Across the services contributing to this measure, recovery actions include group interventions and active waiting-list management, while staffing gaps and competing demands continue to constrain capacity.

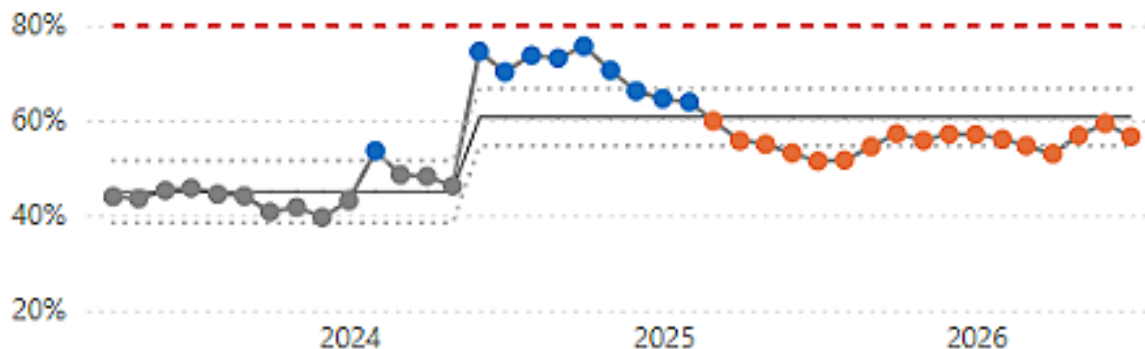
In the IPAR charts, blue points indicate improving variation, orange points concerning variation and grey points usual variation. The red dashed lines show the targets: zero waits over 104 weeks and 80% for psychological therapy access.

Patients waiting over 104 weeks from referral to treatment



August 2026: 698 waits. Lower is better.

Adults waiting less than 26 weeks to start psychological therapy



July 2026: 56.6%, against an 80% standard. Higher is better.

The number of *C. difficile* cases increased in August to 22, the highest number in over 2 years; 11 of these infections were contracted in the community and 11 cases in a hospital setting.

Turning planned care improvement into sustained recovery

The Outpatient Transformation Programme, launched in July and led by the Executive Medical Director, is implementing specialty plans covering referral management, clinical triage and follow-up care. Where clinically appropriate, patients can initiate a follow-up when their condition changes, supported by arrangements to return when symptoms require review. This reduces unnecessary routine appointments and releases capacity for patients who need to be seen.

The number of patients waiting more than twice the clinically intended interval for a follow-up appointment has fallen to 14,009, the lowest recorded position. Conversion work for long-waiting follow-ups is complete across specialties other than ophthalmology, where a dedicated

programme continues. Ophthalmology has reduced delayed follow-ups by more than 1,000 during 2026. The programme is working towards 11,387 delayed follow-ups by March 2027, with clinical prioritisation maintained throughout.

Cancer recovery is also showing a tangible benefit. In July, 305 patients started treatment within 62 days, the highest number since May 2025. Additional activity in radiology, pathology and urology has supported this improvement. However, 497 pathways remained over 62 days in August. Sustaining the diagnostic capacity supporting recovery is therefore central to maintaining progress and reducing the backlog.

The Health Board has received £4.5m of planned care recovery funding, targeted at specialties with the greatest opportunity to reduce long waits. The Theatre Optimisation Workstream is implementing productivity standards and reviewing staffing, list loading and use of operating time. The delivery expectations include seven cataract procedures and four joint replacements per operating list. A separate programme to reduce missed appointments is improving booking, communication and reminders, helping services make better use of available clinic capacity.

These actions provide a clearer recovery response, although the increase to 698 pathways over 104 weeks and 457 first outpatient waits over 52 weeks shows that the pressure remains considerable. Administrative validation of patients at the diagnostic and post-diagnostic stages of their pathway is on track for completion by 30 September, followed by clinical review. Monthly specialty trajectories link additional activity to the reduction in long waits. Further acceleration depends on additional recovery funding and the staff needed to deliver it.

Diagnostics remain a constraint across several pathways. In August, 7,565 waits exceeded eight weeks, with radiology and imaging accounting for 5,998. Additional magnetic resonance imaging and ultrasound capacity form part of the recovery response, alongside work to resolve radiology reporting problems. Therapy waits over 14 weeks reached 4,165. Capacity planning in these services is particularly important because delays affect diagnosis, treatment and rehabilitation, and can prolong pressure elsewhere in the system.

Strengthening urgent care and patient flow

The urgent care response is becoming more coordinated across hospitals, ambulance services and community partners. The Wait 45 initiative has been implemented, with a senior management group meeting weekly to progress the operational improvement actions. Ambulance service managers participate in the daily patient flow call, supporting earlier decisions about handover, capacity and escalation.

Discharge arrangements are also being strengthened. A memorandum of understanding between health and local authority partners has been agreed, an electronic patient flow system has been introduced, and long-stay reviews are identifying barriers to discharge. Additional social work and reablement capacity is supporting this response. These measures address a central cause of emergency department congestion: patients who no longer need an acute bed but are waiting for assessment or onward care.

Longer-term changes will support resilience through winter. Seven-day clinical streaming is planned for November, with extended same-day emergency care at Withybush from January 2027. The immediate recovery programme must deliver improvement ahead of those developments. Its success will be judged through shorter waits, fewer discharge delays and safer care, alongside ambulance availability in the community.

Escalation and patient flow

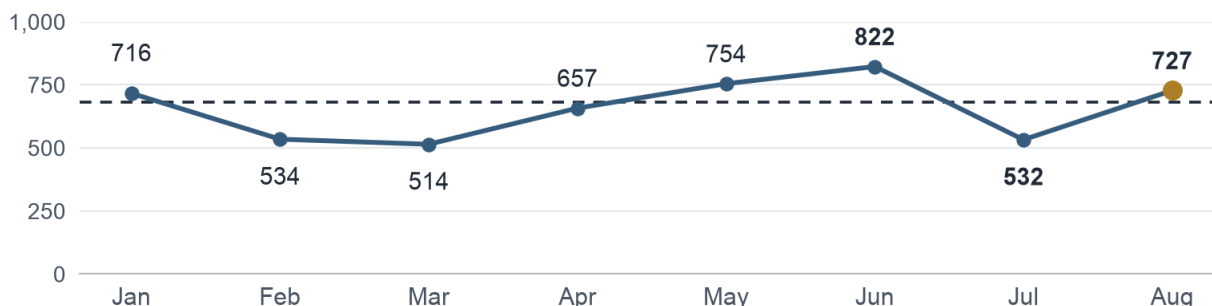
The August position shows why consistent implementation matters. Ambulance handovers over one hour rose from 532 in July to 727 in August. Delayed pathways of care increased from

204 to 250 patients. Meanwhile, 1,622 emergency department and minor injury attendances lasted over 12 hours, equivalent to 9.7%, compared with 9.2% in July. The gains achieved earlier in the summer therefore need to become sustained improvement.

Solid lines and dots show actual monthly results. Dashed lines mark the thresholds explained below. January to August 2026. Lower is better on all three charts.

Ambulance handovers over one hour

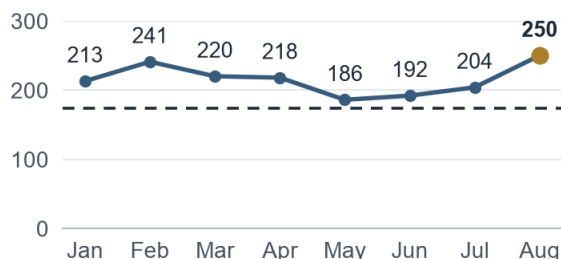
July's improvement was not sustained: 727 in August, 195 more than July.



Dashed line = the previous one-hour escalation threshold of 680 handovers per month. August was 47 above that level. The current 45-minute requirement is explained beneath the figure.

Patients delayed leaving hospital

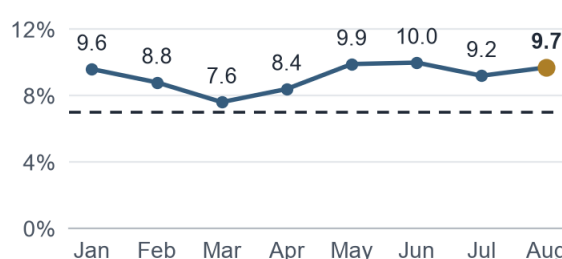
250 patients: 46 more than July



Dashed line = 174 patients, the escalation threshold after three successive 5% reductions from the agreed baseline of 203, then maintained. Monthly census; August count: 19 August.

Emergency stays over 12 hours

9.7%: above the 7% requirement



Dashed line = 7%: at most seven in every 100 attendances over 12 hours in September and October. Points above it exceed the requirement. Includes emergency departments and minor injury units.

Current ambulance de-escalation requires a 30% reduction in handovers exceeding 45 minutes, to no more than 789 per month, maintained for three months. It covers all receiving hospital sites. The national standard remains zero handovers over 45 minutes. The one-hour chart retains the previous 680 threshold to show the recovery since the July Board.

Delayed pathways of care include patients awaiting assessments, care packages and onward placements. Assessment issues remain the largest group of delays. This limits beds available for patients arriving through emergency departments and can lengthen ambulance waits. Daily clinical review, earlier discharge and joint resolution of complex cases remain the immediate priorities. The twelve-hour requirement applies at each hospital and across the Health Board.

Financial performance and deliverability

Savings identification has improved since July, reflecting further work by clinical care groups and corporate teams to develop schemes and clarify ownership. At Month 5, £30.5m is identified against the £42.8m annual requirement. The remaining identification gap is £9.5m lower than at Month 3. Actual savings of £14.5m compare with a year-to-date requirement of £17.8m.

Financial measure	Position at the end of August
Year-to-date deficit	£26.3m against £17.1m planned, a £9.2m adverse variance.
August deficit	£4.6m, compared with £5.1m in July. After adjusting for one-off effects, the August position is £5.0m.
Year-end forecast	£41.0m, dependent on £19.9m of further mitigating actions against a gross forecast of £60.9m.
Underlying deficit	£67.6m against a planned £40.8m.

The reduction in the reported monthly deficit is welcome, but the recurring expenditure position has changed little. To contain the year-end deficit at £41m, the remaining seven months would need to average approximately £2.1m per month, compared with £5.3m to date. The current gross forecast position is £60.9m, and delivering the planned deficit of £41m would require £19.9m of mitigating actions. While there are actions progressing, particularly through a focus on variable pay, these are insufficient in themselves to provide assurance that this gap can be closed.

The quality of savings remains central to sustainability. Of the £30.5m identified, £23.8m is non-recurrent and £6.7m recurrent. One-off benefits support the current year but do not reduce the cost carried into 2027/28. The £10.9m underspend discussed by the Board in July was being captured within non-recurrent savings; recognising an underspend does not itself create a further saving. The recovery programme therefore needs to convert opportunities into recurring changes in staffing, pathways and purchasing, with the effect on service activity made explicit.

Financial and operational pressures continue to be concentrated in Community and Integrated Medicine and Planned and Specialist Care, which remain at Level 4 of internal financial escalation. Their forecast gaps to plan are £15.2m and £6.9m respectively. Planned and Specialist Care has improved from £9.5m in June, although both portfolios continue to face material pressure from staffing and externally provided care. Externally commissioned care, comprising continuing healthcare and out of area placements, is a further significant source of expenditure pressure.

The recovery response connects these pressures to workforce stabilisation, theatre and outpatient productivity, and closer review of commissioned care and care packages. It also includes challenge to the cost of emergency activity purchased from Swansea Bay. Changes to dental funding arrangements create a further risk to the forecast, as the extent of any recovery of unused allocations remains uncertain. The September recovery work is focused on closing the savings gap and establishing a quantified route to financial stability for agreement with Welsh Government by the end of the month.

Delivery of the £41m position remains at risk until the required expenditure reduction is achieved.

Finance Forecast Mid-Year Assessment

A mid-year assessment of the financial forecast is underway to test the latest organisational plans against the current run rate, the maturity of identified savings and the remaining opportunities to influence expenditure in the second half of the year. This work is intended to provide the Board, Welsh Government and the Executive Team with a more rounded view of deliverability, rather than to pre-empt a single fixed course of action before the assessment has concluded.

The review is examining the extent to which Clinical Care Group and executive function plans can realistically improve the forecast through the remaining variable elements of expenditure, including variable pay, premium staffing, commissioned and externally provided activity, non-pay controls, prescribing and care package expenditure. The focus is on identifying actions that are capable of being implemented safely within the remaining months of the year, with clear ownership, quantified benefit ranges and an assessment of operational, workforce and quality consequences.

At this stage, the likely recovery plan is expected to be framed around a small number of targeted expenditure controls and delivery programmes, rather than a broad reduction exercise. These will include tighter grip over discretionary and premium cost drivers, accelerated conversion of savings opportunities into deliverable schemes, further scrutiny of commissioned activity and care packages, and continued alignment between workforce improvement programmes, productivity gains and financial grip. The assessment will also distinguish between actions that improve the in-year forecast and those that materially reduce the underlying deficit into 2027/28.

The Board is therefore asked to note that the forecast assessment remains active and that the final balance of actions will need to be considered in advance of the Month 6 submission to Welsh Government.

Building the workforce and service capacity to deliver

Workforce recovery now has a stronger foundation. Staffing systems, roster information and financial assumptions have been reconciled, and a common baseline has been issued across the programmes. Ten workstreams have named leads and delivery trajectories, covering areas including recruitment, funded staffing levels, sickness absence and temporary staffing costs. Vacancy controls and reviews of staffing establishments are underway, and previously separate medical variable pay programmes are being brought together under one coordinated approach.

This responds directly to the need for clearer accountability between workforce decisions and financial consequences. Variable pay includes bank, agency, locum, overtime and additional duties. Reducing reliance on these arrangements must be accompanied by more reliable substantive staffing and safe service coverage. Long-term sickness case management has progressed, although rolling twelve-month absence remains at 6.83%, compared with 6.53% a year earlier. The benefits will therefore be measured through absence, staffing reliability and expenditure, rather than the existence of the workstreams alone.

The planning capacity approved in July is intended to strengthen support within Clinical Care Groups. Its contribution is to translate priorities into deliverable service plans, identify dependencies and support improvement where operational teams are under the greatest pressure. Workforce growth and reduction decisions need to be considered against that same test: the service benefit, affordability and effect on the wider recovery plan.

Implementation business cases are underway for several of the eight previously consulted fragile clinical services. This moves the programme into delivery, with service changes intended to improve resilience and reduce the operational consequences of persistent staffing

and capacity gaps. Stroke follows its separate consultation and Board decision process. Across these programmes, quality and equality impacts remain integral to decisions about service change.

Leadership support and assurance

The Performance Recovery Group is being established to bring financial recovery and operational delivery into a single executive discussion. Chaired by the Chief Executive, it will review progress fortnightly, challenge slippage and direct intervention where a programme is not delivering. Bringing workforce, commissioning, productivity and quality together will allow decisions to address the causes of pressure across services, rather than manage each consequence separately.

The Senior Leaders Group provides the complementary route for practical support. It brings senior colleagues across functions together to resolve barriers that an individual service cannot remove, coordinate improvement work and address shared corporate risks. For the escalated care groups, this means access to the planning, workforce, clinical and financial expertise needed to turn a recovery requirement into an executable change. Matters requiring investment or wider executive authority pass to the Formal Executive Team.

Both groups are accountable to the Formal Executive Team. Their work will use the existing Our Actions arrangements to connect ownership, milestones and evidence of benefit. Where a mitigation falls short, the recovery review will consider the cause, the support required and a replacement action or decision on the remaining gap. Committee scrutiny will continue to test the financial, workforce and quality consequences, with the Board receiving an integrated account of progress.

Quality oversight is developing alongside this approach. Overdue serious incident investigations have reduced, and work is underway to bring quality, operational, workforce and financial risks into a single organisational position. Infection prevention remains a priority. The emphasis is on learning and safer care, including the consequences of prolonged waits, so that faster access and financial recovery are assessed together with patient outcomes.

The Board can take assurance from the improvements already achieved in cancer and follow-up care, from the progress in savings identification and from the defined responsibilities across the workforce programme. Assurance on delivery of the full Annual Plan and wider Escalation expectations remains limited by urgent care performance, growing long waits and the scale of the financial reduction required. The next phase is to translate the strengthened response into sustained results, with September and October urgent care performance, monthly planned care recovery and the October financial run rate providing the immediate tests.

Argymhelliad / Recommendation

The Board is asked to:

- **NOTE** the progress since July, including improvements in cancer and follow-up care, the strengthened savings programme and the development of workforce improvement programmes.
- **SCRUTINISE** the overall financial deliverability of the Annual Plan, including the dependence of the £41m planned deficit on £19.9m of further mitigation and addressing remaining operational pressures, for which there is currently insufficient assurance
- **NOTE** that communication has been received from Welsh Government noting that any dental underspend reported as at Quarter 3 against the dental ringfence will be recovered by Welsh Government, placing further challenge to deliver on our forecast deficit.
- **SUPPORT** the Accountable Officer in reviewing the financial forecast following the conclusion of the mid-year assessment and in updating Welsh Government on a credible year end position, should this deviate from the Annual Plan deficit of £41.0m.
- **RECOGNISE** that further recovery actions will require revisiting the Health Board's opportunities framework and the alignment with our indicative financial routemap.
- **SUPPORT** the integrated recovery approach through the Performance Recovery Group and Senior Leaders Group, retaining clear executive accountability and committee oversight of financial, workforce and quality consequences.
- **REQUIRE** subsequent updates to demonstrate the effect of recovery actions on patient access, recurring expenditure and service sustainability, including the response where agreed milestones or benefits are not achieved.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	2326 (score 25): risk to delivery of the in-year financial plan. 1199 (score 25): financial sustainability risk. Both risks remain subject to executive and committee oversight.
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
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	7. All Apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Financial and operational performance, recovery delivery and the organisational risk position.
Rhestr Termau: Glossary of Terms:	Terms are explained within the report. Recurrent savings continue into future years; non-recurrent savings benefit the current year only. The underlying deficit describes the continuing financial position after adjusting for one-off effects.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Executive Team and clinical care groups through the Annual Plan and recovery programmes/Groups.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The £41m forecast depends on £19.9m of further mitigation. Financial recovery is linked to recurring savings, workforce affordability and improved use of service capacity.
Ansawdd / Gofal Claf: Quality / Patient Care:	Reducing long waits and improving patient flow support safer, more timely care. Recovery and service changes require clinical oversight and assessment of their quality consequences.
Gweithlu: Workforce:	The ten workforce workstreams connect safe staffing and productivity with affordability. Planning support will help care groups develop and implement recovery actions.
Tegwch Iechyd: Health Equity:	Service and pathway changes must consider unequal access associated with rurality, deprivation, disability and service location.
Risg: Risk:	Financial plan risk 2326 and sustainability risk 1199 are both rated 25. Delivery and quality risks remain subject to executive and committee oversight.
Cyfreithiol: Legal:	The Health Board's financial duties continue to apply. Recovery and service changes remain subject to the relevant statutory and governance requirements.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Enw Da: Reputational:	Sustained delivery against commitments is essential to public and regulatory confidence. This update sets out progress and the areas where further improvement is required.
Gyfrinachedd: Privacy:	The report contains aggregate organisational information. Patient and staff confidentiality is maintained in detailed recovery reviews.
Cydraddoldeb: Equality:	Equality impact assessment informs material service and workforce changes, including differential effects on access to care.



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2026/27 Financial Performance Report

Public Board

Month 05 August 2026/27

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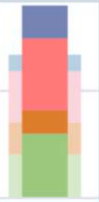
Key

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 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

Savings delivery remained limited in Month 5 for Planned and Specialist Care and Community Integrated Medicine (CIM), with CIM's run rate increasing. Level 4 remains in place for the COO for both Clinical Care Groups.

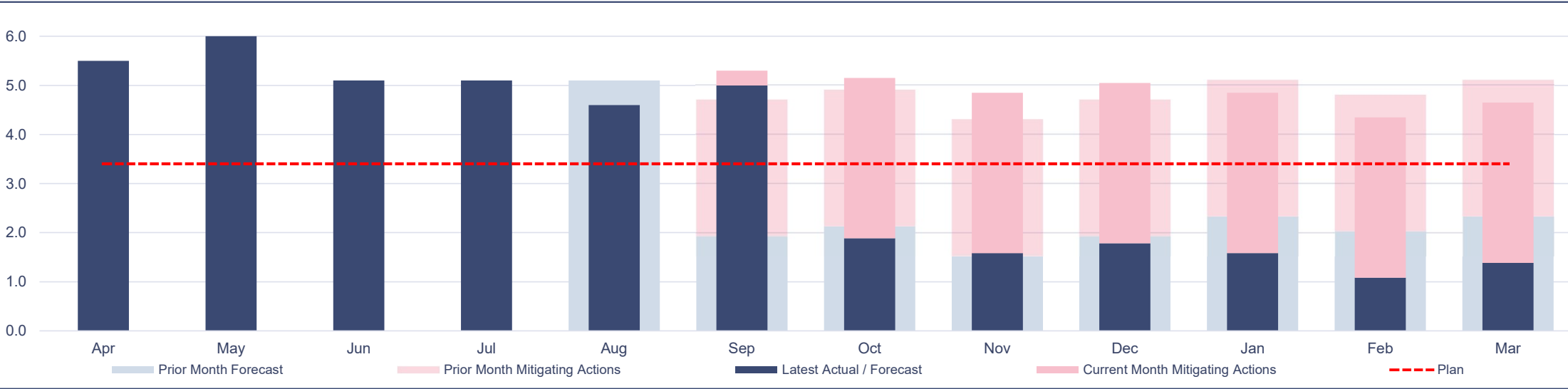
Executive Director Portfolio	Status	Explanation (Number of portfolios and their escalation levels)
Chief Executive	Assure	Delivering breakeven and savings
Chief Operating Officer	Alert (3 rd Month)	Continuation of 2 x Level 4 in Community and Integrated Medicine and Planned & Specialist Care (Savings and Breakeven gap), 1 x Level 3, 1 x Level 2, 1 x Level 1
Executive Medical Director	Advise	1 x Level 2 (Savings gap), 1 x Level 1
Executive Director of Nursing, Quality and Patient Experience	Assure	Delivering breakeven and savings
Executive Director of Workforce and Organisational Development	Assure	Delivering breakeven and savings
Executive Director of Finance	Assure	Delivering breakeven and savings
Executive Director of Strategy and Planning	Advise	1 x Level 3 (Savings and Breakeven gap), 1 x Level 1
Executive Director of Public Health	Assure	Delivering breakeven and savings
Executive Director of Allied Health Professions and Health Sciences	Advise	1 x Level 3 (Savings and Breakeven gap)

Mid-Year Financial Position Assessment

Key Update

Whilst the reported Month 5 position is influenced by one-off items, the normalised in-month deficit remains broadly consistent with the run-rate reported in previous months. A significant improvement trajectory is required to achieve the planned £41.0m deficit. The average monthly deficit of £5.3m reported in Months 1 to 4 would need to reduce to £2.1m across the remainder of the year. Achieving this will require accelerated delivery of expenditure reductions, recurrent savings and strengthened operational grip. Reflecting this challenge, the Corporate Risk relating to delivery of the in-year financial plan will remain at the highest rating of 25.

During September, the Finance Function will continue to review the likely year-end position, including the extent to which non-recurrent measures can be converted into sustainable recurrent improvements from Month 7. The outcome will be reported to Board on 24 September and will inform any necessary revision to the forecast submitted to Welsh Government in October 2026.



Actionable Insights – Top Priority Alerts



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Action / Decision	£m	Description	Owner	Status	Due Date
Mid Year Forecast Assessment	TBC	The reported deficit, which currently remains the same as the Annual Plan at £41.0m, is being reviewed throughout September. If there is no material improvement, or robust plans, the forecast will likely alter.	Andrew Spratt	In-progress	7 October
Dental Allocation Underspend Risk	TBC	Welsh Government has confirmed that forecast dental funding underspends at Q3 will be recovered. Immediate review of the dental financial position and delivery plans is required to maximise utilisation of the ring-fenced allocation and mitigate potential funding recovery.	Rhian Bond	Urgent action required	November
Identification and delivery of robust savings plans	12.3	Whilst there has been a significant shift in the identification and conversion of underspends, there remains an identification gap to achieve the plan. There is an inequity across services with some over-delivering against target, and others under-delivering.	All Executive Directors, exc. <i>Workforce, Finance and CEO</i>	Ongoing, urgent action to continue as part of de-risking the annual plan	Overdue
Medical pay and rostering Additional cover at premium costs	7.7	Continuing use of additional medical cover, including premium locum and agency in BGH, WGH, Planned Care and Mental Health. Month 5 deteriorating the end of year position further by £0.7m.	Mark Henwood	Update presented to the August Finance and Performance Committee, Committee to advise the Board on the challenges faced in delivering savings at the detriment of performance, the Committee asked for a further update be presented in December.	15 December (Finance & Performance Committee)

Position Overview – Executive Summary

The Health Board’s Annual Planned Deficit is £41.0m with an Annual Savings Target of £42.8m. Gross forecast position is £60.9m, with required mitigating actions of £19.9m to be finalised, to achieve the reported end of year forecast position of £41.0m. Total savings delivery are £30.5m, leaving a savings delivery gap of £12.3m against the savings target.

Financial Management	The in-month financial position is a deficit of £4.6m, which is an adverse variance against the £3.4m deficit plan. This is driven by a core operational overspend of £0.6m, and a £0.6m under identification of savings, with £3.0m savings identified against the savings target of £3.6m.				
	Key Driver (£'m)	Prior month variance to breakeven	Current month variance to breakeven	Year to Date variance to breakeven	Prior Month End of Year forecast to breakeven
	Planned Deficit	3.4	3.4	17.1	41.0
	Unidentified / (Identified) savings gap / (improvement)	2.5	0.6	3.3	13.0
	Under / (Over) delivery of savings schemes	0.0	0.0	0.0	0.0
	Core operational variation	(0.8)	0.6	5.9	6.4
	Gross Forecast	5.1	4.6	26.3	60.4
	Future Mitigating Actions	0.0	0.0	0.0	(19.4)
Key Measures BRAG based on Plan £30.0m (Risk rating = Impact x Likelihood)	Reported Position	5.1	4.6	26.3	41.0
	Core Operational Variation	Risk #2326 5 x 5 = 25	The in-month core operational overspend of £0.6m largely relates to drugs price and concessions increase in line with May Prescribing Audit Report £1.0m, Continuing Healthcare packages increase £0.5m, Theatres and Radiology outsourcing of activity and consumables expenditure £0.3m, Digital initiative programmes contract expenditure £0.2m, offset by General Medical Services supplementary services underspend £(0.9)m and Dental contracts handback £(0.5)m.		
	Cash		The Health Board will require strategic cash assistance in-year in line with the forecast deficit and working capital balances. Support will be required at the end of February or beginning of March 2027, and if it is not confirmed by December 2026, the cash management strategy would need to be implemented in the short term to support.		
	Savings		Of the annual savings target of £42.8m, £30.5m has been identified and forecast to fully deliver on an in-year basis resulting in a £12.3m under-identification gap. Of the schemes identified, £6.7m are recurrent savings and £23.8m are non-recurrent savings. There's a continued action to forecast savings into future periods as well as converting at pace the pipeline schemes into credible Green and Amber plans, alongside a commitment to convert non-recurrent savings to recurrent savings by Month 6.		
	Capital	N/A	Delivery against the capital programme is currently assessed as low risk. A number of individual capital schemes have medium risks flagged against them; however, these are not expected currently to present a risk to the overall delivery of the capital programme.		
	Underlying Deficit	Risk #1199 5 x 5 = 25	The planned underlying deficit is £40.8m, assuming delivery of £42.8m recurrent savings. £6.9m recurrent savings have been identified, leaving a recurrent savings gap of £35.9m. After recognising £10.3m recurrent mitigating actions and recurrent cost pressures relating to the Healthcare Support Workers re-banding dispute (£0.8m) and Resident Doctors contract (£0.4m), the underlying deficit is £67.6m. The organisation acknowledges the need to improve its financial trajectory to achieve breakeven by 2027/28, a requirement of the £26.0m conditionally recurrent funding, alongside a commitment to convert non-recurrent savings to recurrent savings by Month 6.		

Change from Prior Month Actual Position



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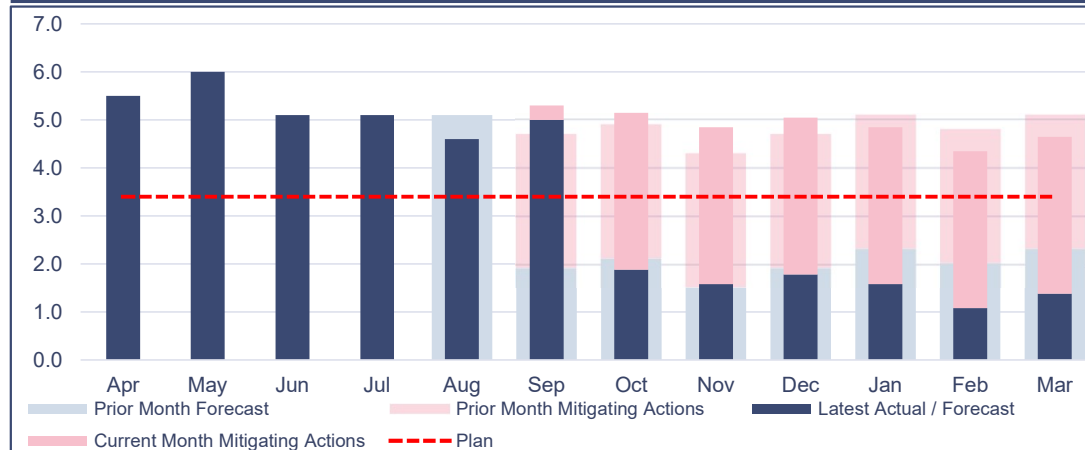
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Key Driver (£'m)	Prior Month Reported Position	Current Month Reported Position	Movement
Planned Deficit	3.4	3.4	0.0
Savings gap / (improvement)	2.5	0.6	(1.9)
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	(0.8)	0.6	1.4
Gross Forecast	5.1	4.6	(0.5)
Future Mitigating Actions	0.0	0.0	0.0
Reported Net Position	5.1	4.6	(0.5)

In-Month Revenue Deficit Trajectory (£'m)

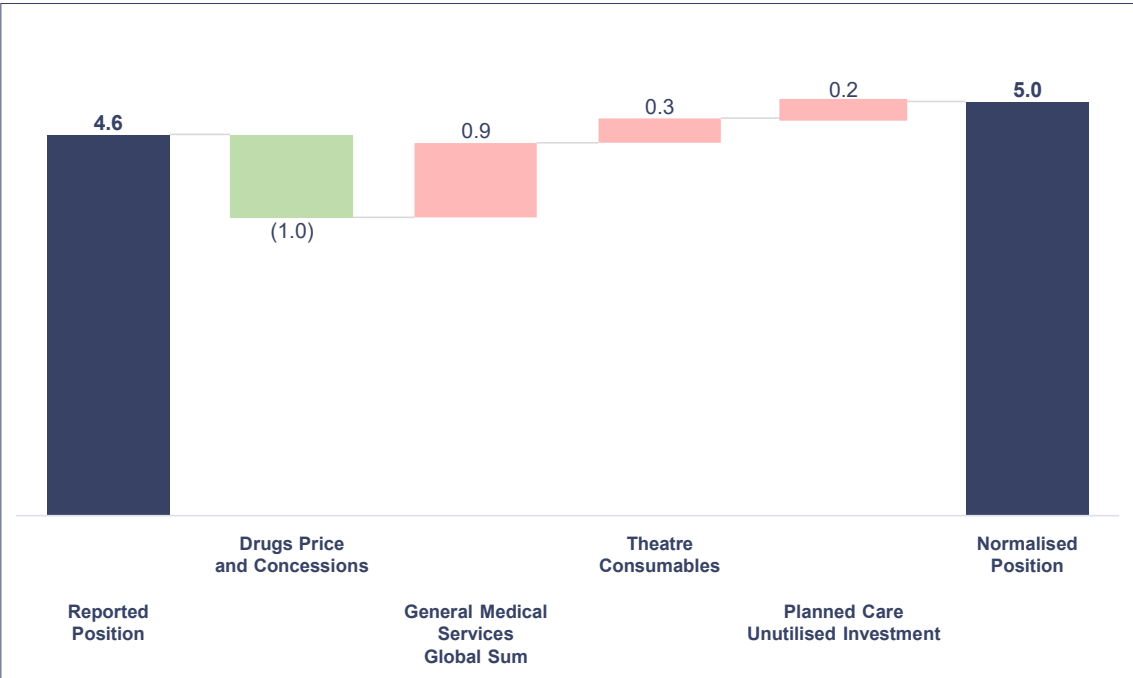


Unidentified Savings Gap (£'m)	Change
Primary Care Dental savings reclassified to core underspend in prior month	(1.9)
Movement in Unidentified Savings Gap	(1.9)

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

Core Operational Variation (£'m)	Change
Primary Care Dental savings reclassified to core underspend in prior month	1.9
Drugs price and concessions increase within May Prescribing Audit Report	1.0
Mental Health Continuing Healthcare reduction in packages	(0.1)
Planned Care delay to phased implementation of nursing investment	(0.2)
Theatre consumables reduction in line with reduced activity across services	(0.3)
Primary Care delay in General Medical Services contracts expenditure	(0.9)
Movement in Core Operational Variation	1.4

In-Month Position Normalised



Normalisation Adjustments	£'m
Reported In-Month Position	4.6
Pharmacy and Medicines Management year to date increase in expenditure relating to drugs price and concessions increase in line with May Prescribing Audit Report	(1.0)
Primary Care General Medical Services Global Sum reduction in year to date expenditure due to delay in project plans	0.9
Reduction in theatre consumables reflects lower elective activity due to Anaesthetist shortages and the prioritisation of cancer pathway patients.	0.3
Unutilised nursing investment funding within Planned and Specialist Care, reflecting delays to phased implementation of approved investments.	0.2
Total Normalised Adjustments	0.4
Normalised In-Month Position	5.0

Key Information

The reported in-month deficit of £4.6m includes a net £0.4m favourable impact from one-off items that are not expected to recur at the same level in future months. Excluding these items results in a normalised in-month deficit of £5.0m, broadly consistent with the Month 3 and Month 4 run-rate deficit of £5.1m, indicating limited underlying improvement in the Health Board's financial position.

The in-month position reflects lower than anticipated expenditure within General Medical Services £(0.9)m due to expenditure phasing into later months, together with reduced activity related costs within Planned and Specialist Care £(0.3)m, including lower theatre consumables arising from Anaesthetist shortages and the prioritisation of cancer pathway patients, alongside unutilised nursing investment funding. These favourable variances are partially offset by increased prescribing drug prices and concessionary expenditure £1.0m, in line with the latest Prescribing Audit Report for May.

Change from Prior Gross Forecast



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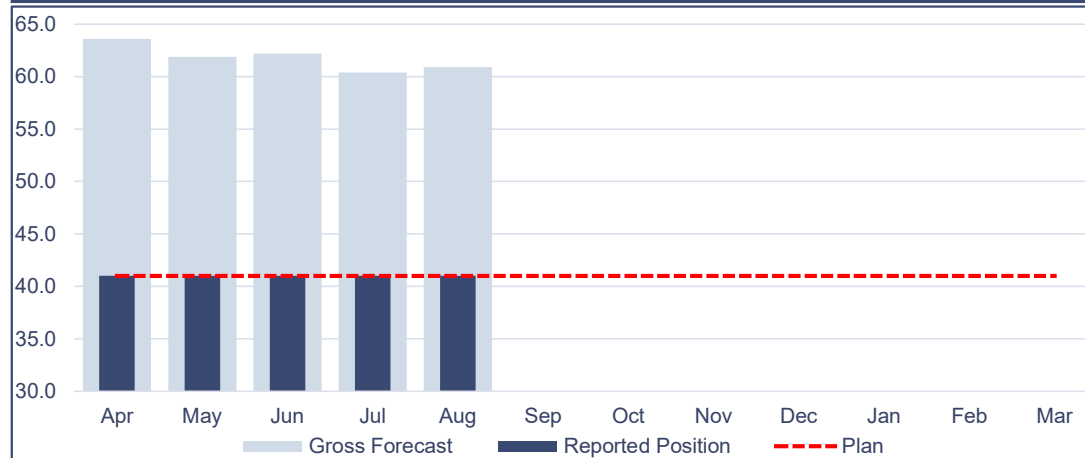
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Key Driver (£'m)	Prior Month End of Year Forecast	End of Year Forecast	Movement
Planned Deficit	41.0	41.0	0.0
Savings gap / (improvement)	13.0	12.3	(0.7)
Under / (Over) delivery of savings schemes	0.0	0.0	0.0
Core Operational Variation	6.4	7.6	1.2
Gross Forecast	60.4	60.9	0.5
Future Mitigating Actions	(19.4)	(19.9)	(0.5)
Reported Net Position	41.0	41.0	0.0

End of Year Revenue Deficit Trajectory (£'m)



Unidentified Savings Gap (£'m)	Change
Full year conversion of core operational underspends to savings	(0.5)
Central Income Injury Cost Recovery underspend converted to saving	(0.2)
Movement in Unidentified Savings Gap	(0.7)

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
Drugs price and concessions increase within June Prescribing Audit Report	1.1
Community and Integrated Medicine Medical fill rate cover increase	0.9
Full year conversion of core operational underspends to savings	0.5
Central Income Injury Cost Recovery underspend converted to saving	0.2
Public Health reduction in vaccination programmes uptake	(0.3)
Operational Allied Health reduction in Pathology drugs expenditure	(0.4)
Workforce Improvement Programme 3 (Admin Recruitment Restrictions)	(0.8)
Movement in Core Operational Variation	1.2

Financial Summary – Key Drivers vs Plan



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In-Month

Reported Position

£4.6m



Planned Deficit **£3.4m**
Prior Month Forecast **£5.1m**

Savings Identification Gap

£0.6m



Savings Target **£3.6m**
Total Identified **£3.0m**

Savings Delivery Gap

£0.0m



Savings Delivery **£3.0m**
Prior Month Delivery **£1.1m**

Core Operational Variation

£0.6m



Prior Month Variation **£(0.8)m**

Year to Date

Reported Position

£26.3m



Planned Deficit **£17.1m**

Savings Identification Gap

£3.3m



Savings Target **£17.8m**
Total Identified **£14.5m**

Savings Delivery Gap

£0.0m



Savings Delivery **£14.5m**
Prior Month Delivery **£11.5m**

Core Operational Variation

£5.9m



Prior Month Variation **£5.1m**

End of Year

Reported Position

£41.0m



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

Savings Identification Gap

£12.3m



Savings Target **£42.8m**
Total Identified **£30.5m**

Savings Delivery Gap

£0.0m



Savings Delivery **£30.5m**
Prior Month Delivery **£29.8m**

Core Operational Variation

£7.6m



Prior Month Variation **£6.4m**

Gross Forecast

£60.9m



Prior Gross Forecast **£60.4m**
Mitigating Actions **£19.9m**

Net Risks / (Opportunities)

£9.0m



Prior Month **£3.7m**

Capital Position

£38.0m



Annual Plan **£38.0m**
Prior Annual Forecast **£34.6m**

Underlying Deficit

£67.6m



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

Financial Summary

In-Month Actual

£116.5m

Variance to Plan £1.2m

YTD Actual

£579.8m

Variance to Plan £9.2m

EOY Forecast

£1,417.7m

Variance to Plan £19.9m

3-Year Growth

8.0%

2023-24 Outturn £1,313m*

In-Year Growth

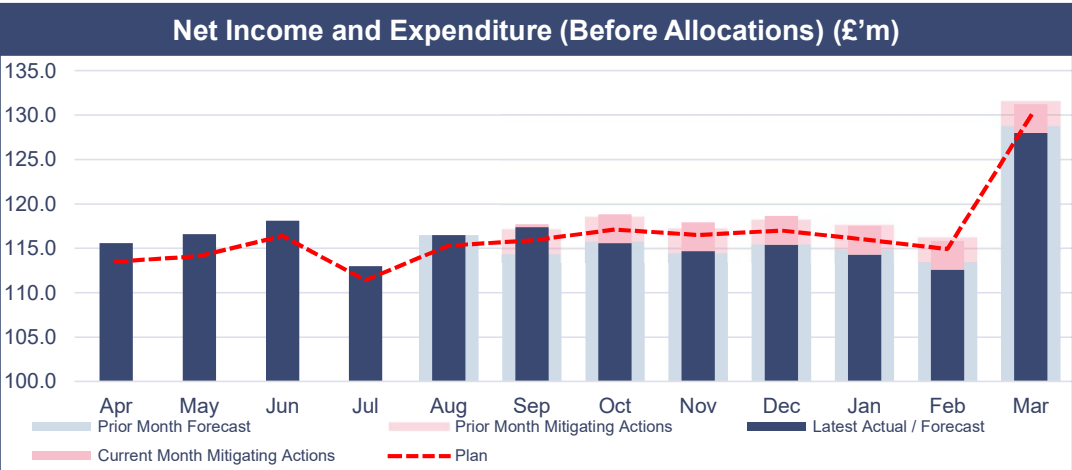
(0.3)%

2025-26 Outturn £1,422m*

YTD Extrapolation

£1,391.6m

Risk / (Opp) £(26.1m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay	61.0	59.5	59.9	299.2	718.2	720.8		(2.6)
Administration and Estates	12.4	12.2	12.3	61.4	147.4	147.6		(0.2)
Allied Health, Scientists and Other	7.5	7.5	7.5	37.2	89.2	89.6		(0.3)
Medical and Dental	14.7	13.9	14.2	69.7	167.4	167.9		(0.5)
Nursing, Midwifery and Clinical Support	26.4	25.8	26.0	130.9	314.2	315.8		(1.5)
Non Pay	64.1	61.3	63.9	316.4	759.3	781.4		(22.1)
Clinical Services and Supplies	4.7	4.6	4.1	21.6	51.9	52.2		(0.3)
Commissioned Healthcare Services	37.1	37.0	36.6	185.5	445.1	447.4		(2.3)
Drugs and Prescribing	13.2	14.2	13.8	66.8	160.3	160.9		(0.6)
Other Non-Pay	9.1	5.5	9.4	42.5	102.0	120.9		(18.9)
Income	(7.0)	(7.8)	(7.3)	(35.8)	(85.9)	(84.5)		(1.4)
Net Income and Expenditure	118.1	113.0	116.5	579.8	1,391.6	1,417.7		(26.1)
Allocations	112.9	108.0	111.9	553.6	1,328.6	1,356.9		
Gross Position	5.1	5.1	4.6	26.3	63.0	60.9		
Reported Position *	5.1	5.1	4.6	26.3	63.0	41.0		

Key Information

Month 4, July, reduction in expenditure relating to a decrease in Capital Charges due to reduced impairments adjustment £4.0m, with a corresponding reduction in Revenue Resource Limit.

Month 7, October, onwards includes a reduction in expenditure due to planned mitigating actions of £19.9m anticipated within Pay £10.8m and Non Pay £9.1m, resulting in a corresponding risk for Non Pay and Pay due to the future months forecast being lower than year to date expenditure levels.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £14.3m, with a corresponding increase in Revenue Resource Limit, resulting in an opportunity within Non Pay due to future months forecast expenditure being higher than year to date expenditure levels.

Note an opportunity within Commissioned Healthcare Services due to Primary Care delay in General Medical Services and Cluster project plans expenditure anticipated in future months.

*Reported Position for end of year includes £19.9m of assumed mitigating actions to deliver the £41.0m Planned Deficit.
*Outturn adjusted for Notional Pension costs 2025-26 c£42.8m, 2024-25 c£40.3m

Total Pay Insights



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In-Month Actual

£59.9m



Variance to Plan **£0.0m**

YTD Actual

£299.2m



Variance to Plan **£2.8m**

EOY Forecast

£720.8m



Variance to Plan **£0.0m**

3-Year Growth

20.0%

2023-24 Outturn **£600.9m***

In-Year Growth

8.7%

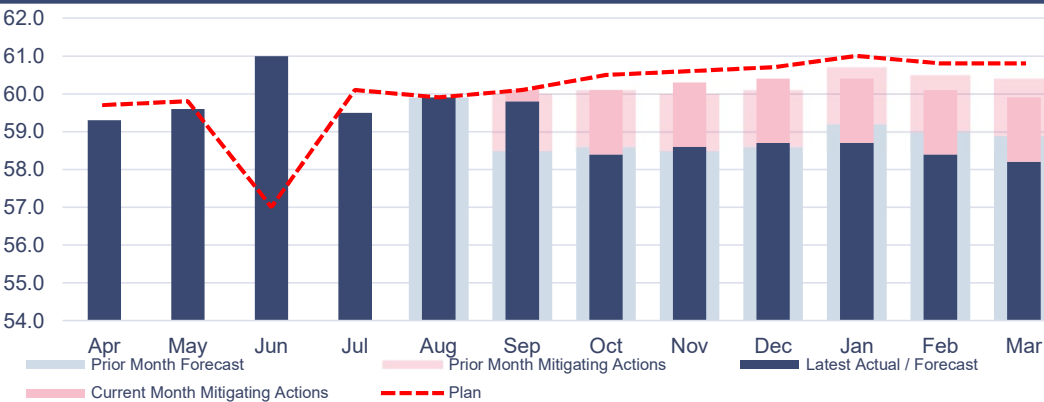
2025-26 Outturn **£662.9m***

YTD Extrapolation

£718.2m

Risk / (Opp) **£(2.6)m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Substantive	55.9	54.5	54.6	273.9	657.3	663.0	●	(5.7)
Administration and Estates	12.0	11.9	11.9	59.7	143.4	143.8	●	(0.5)
Allied Health, Scientists and Other	7.3	7.2	7.2	36.0	86.4	86.6	●	(0.2)
Medical and Dental	12.2	11.5	11.5	57.5	138.0	139.2	●	(1.2)
Nursing, Midwifery and Clinical Support	24.4	23.8	24.0	120.6	289.5	293.4	●	(3.8)
Variable	4.2	4.0	4.2	20.5	49.2	46.6	●	2.7
Administration and Estates	0.3	0.3	0.3	1.7	4.0	3.8	●	0.2
Allied Health, Scientists and Other	0.2	0.2	0.2	0.9	2.2	2.2	●	0.0
Medical and Dental	1.9	1.8	2.0	9.3	22.3	21.4	●	0.9
Nursing, Midwifery and Clinical Support	1.7	1.6	1.7	8.6	20.7	19.2	●	1.5
Agency (Premium)	0.9	1.0	1.1	4.9	11.7	11.2	●	0.4
Administration and Estates	-	-	-	-	-	-	●	-
Allied Health, Scientists and Other	-	0.1	0.1	0.3	0.7	0.8	●	(0.1)
Medical and Dental	0.5	0.6	0.7	2.9	7.1	7.3	●	(0.2)
Nursing, Midwifery and Clinical Support	0.3	0.3	0.3	1.6	3.9	3.2	●	0.8
Total Expenditure	60.9	59.5	59.9	299.2	718.2	720.8	●	(2.6)
Plan	57.0	60.1	59.9	296.5	711.5	720.8		
Gross Variance to Plan	3.9	(0.6)	0.0	2.8	6.6	(0.0)		
Reported Variance to Plan *	3.9	(0.6)	0.0	2.8	6.6	(10.8)		

Key Information

- Month 3, June, increase in expenditure due to year to date payment of the FY26-27 Medical and Dental 3.5% pay award £1.4m, offset by a reduction in the plan relating to the exercise to convert year to date core operational underspends to savings, with £4.8m savings being identified for pay vacancies.
- Month 5, August, increase from prior month expenditure largely relating to Community and Integrated Medicine and Planned and Specialist Care increase in Medical fill rate cover.
- Month 6, September, deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.
- Month 7, October, onwards includes a reduction in expenditure due to planned mitigating actions of £10.8m anticipated within Substantive £8.8m and Variable £1.9m to deliver from Month 7 to 12, with the reduction in Variable anticipated within Medical. Mitigating actions result in a risk for Pay due to the future months forecast being lower than year to date levels.

*Reported Variance to Plan for end of year includes £10.8m of assumed mitigating actions to deliver the £41.0m Planned Deficit.

*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

£54.6m



Variance to Plan £(3.6)m

YTD Actual

£273.9m



Variance to Plan £(14.5)m

EOY Forecast

£663.0m



Variance to Plan £(38.3)m

In-Year Growth

8.4%

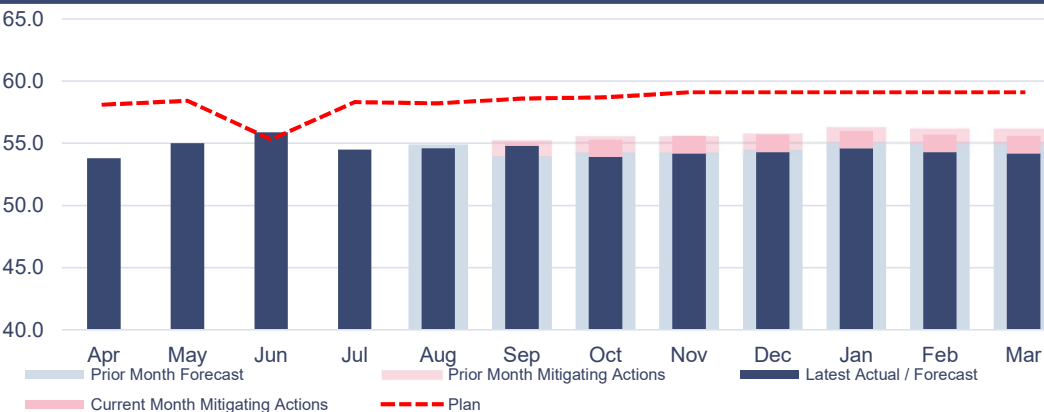
2025-26 Outturn £611.7m

YTD Extrapolation

£657.3m

Risk / (Opp) £(5.7)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	55.9	54.5	54.6	273.9	657.3	663.0		(5.7)
Administration and Estates	12.0	11.9	11.9	59.7	143.4	143.8		(0.5)
Allied Health, Scientists and Other	7.3	7.2	7.2	36.0	86.4	86.6		(0.2)
Medical and Dental	12.2	11.5	11.5	57.5	138.0	139.2		(1.2)
Nursing, Midwifery and Clinical Support	24.4	23.8	24.0	120.6	289.5	293.4		(3.8)
Functions	55.9	54.5	54.6	273.9	657.3	663.0		(5.7)
Chief Operating Officer Management	0.7	0.7	0.7	4.2	10.0	9.4		0.6
Community and Integrated Medicine	17.2	16.8	16.7	84.2	202.1	206.9		(4.8)
Mental Health and Learning Disabilities	6.2	6.1	6.1	30.6	73.5	73.6		(0.1)
Operational Allied Health and Health Sciences	5.9	5.8	5.8	29.0	69.6	69.4		0.2
Planned and Specialist Care	14.4	13.9	13.9	69.6	166.9	167.4		(0.5)
Primary Care	1.4	1.4	1.3	6.7	16.0	16.0		0.1
Executive Functions	10.1	9.7	10.0	49.6	119.1	120.3		(1.2)
Total Expenditure	55.9	54.5	54.6	273.9	657.3	663.0		(5.7)
Plan	55.3	58.3	58.2	288.3	692.0	701.3		
Gross Variance to Plan	0.6	(3.9)	(3.6)	(14.5)	(34.7)	(38.3)		
Reported Variance to Plan *	0.6	(3.9)	(3.6)	(14.5)	(34.7)	(47.2)		

Key Information

Month 3, June, increase in expenditure due to year to date payment of the FY26-27 Medical and Dental 3.5% pay award £1.4m, with a corresponding increase in Revenue Resource Limit. Note a reduction in the plan relating to the conversion of year to date core operational underspends to savings, with £4.8m savings identified for pay vacancies.

Month 6, September, deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 7, October, onwards includes a reduction in expenditure due to planned mitigating actions of £8.8m to deliver from Month 7 to 12. Mitigating actions result in a risk for Pay within Executive Functions due to the future months forecast being lower than year to date expenditure levels.

Note an opportunity within Community and Integrated Medicine due recruitment plans in relation to Urgent and Emergency Care and Clinical Streaming Hubs investments and International Educated Nurses intake anticipated later in the year, with future months forecast expenditure therefore being higher than year to date levels.

*Reported Variance to Plan for end of year includes £8.8m of assumed mitigating actions to deliver the £41.0m Planned Deficit.

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In-Month Actual
£4.2m ●
Variance to Plan **£3.0m**

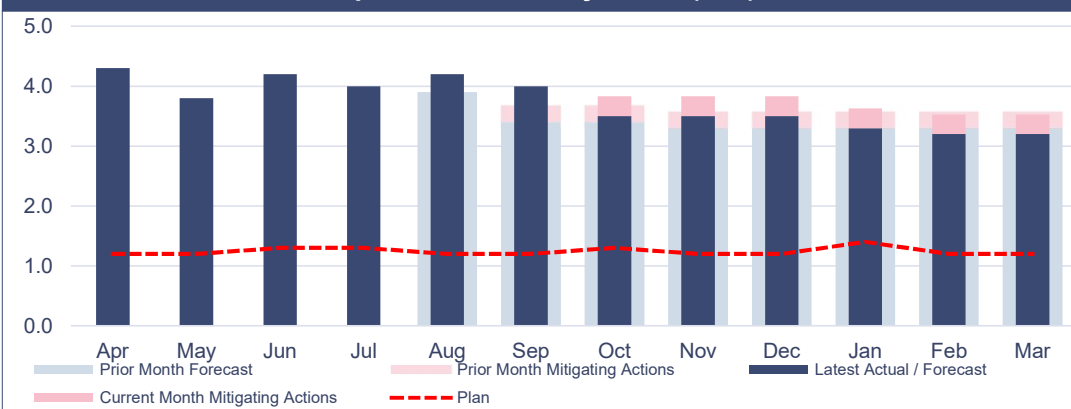
YTD Actual
£20.5m ●
Variance to Plan **£14.2m**

EOY Forecast
£46.6m ●
Variance to Plan **£31.6m**

In-Year Growth
(12.4)%
2025-26 Outturn **£53.2m**

YTD Extrapolation
£49.2m
Risk / (Opp) **£2.7m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	4.2	4.0	4.2	20.5	49.2	46.6	●	2.7
Administration and Estates	0.3	0.3	0.3	1.7	4.0	3.8	●	0.2
Allied Health, Scientists and Other	0.2	0.2	0.2	0.9	2.2	2.2	●	0.0
Medical and Dental	1.9	1.8	2.0	9.3	22.3	21.4	●	0.9
Nursing, Midwifery and Clinical Support	1.7	1.6	1.7	8.6	20.7	19.2	●	1.5
Functions	4.1	4.0	4.2	20.5	49.2	46.6	●	2.7
Chief Operating Officer Management	-	-	-	-	0.1	0.1	●	(0.0)
Community and Integrated Medicine	1.7	1.5	1.9	8.2	19.8	19.2	●	0.5
Mental Health and Learning Disabilities	0.2	0.2	0.2	1.1	2.6	2.6	●	(0.0)
Operational Allied Health and Health Sciences	0.3	0.3	0.2	1.3	3.1	3.0	●	0.1
Planned and Specialist Care	1.3	1.2	1.3	6.3	15.1	13.2	●	1.9
Primary Care	0.4	0.4	0.3	1.9	4.6	4.8	●	(0.2)
Executive Functions	0.3	0.5	0.3	1.7	4.1	3.6	●	0.5
Total Expenditure	4.1	4.0	4.2	20.5	49.2	46.6	●	2.7
Plan	1.3	1.3	1.2	6.3	15.2	15.0		
Gross Variance to Plan	2.8	2.7	3.0	14.2	34.0	31.6		
Reported Variance to Plan *	2.8	2.7	3.0	14.2	34.0	29.7		

Key Information

Month 2, May, reduction in Bank expenditure due to inability to fill shifts within Community and Integrated Medicine and Primary Care, and reduction in patient acuity within Mental Health, alongside reduction in Waiting List Initiative activity within Planned and Specialist Care Nursing.

Month 6, September, deviation from prior month forecast as mitigating actions previously assumed to deliver are unlikely to deliver within the required timeframe.

Month 7, October, onwards includes a reduction in expenditure due to planned mitigating actions of £1.9m required to deliver from Month 7 to 12, largely anticipated within Medical and Dental. Mitigating actions result in a risk for Medical Pay within Executive Functions due to the future months forecast being lower than year to date expenditure levels.

Note a risk within Planned and Specialist Care Nursing due to future months forecast expenditure being lower than year to date expenditure levels.

*Reported Variance to Plan for end of year includes £1.9m of assumed mitigating actions to deliver the £41.0m Planned Deficit.

Agency Insights



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In-Month Actual
£1.0m ●
Variance to Plan **£0.6m**

YTD Actual
£4.9m ●
Variance to Plan **£3.0m**

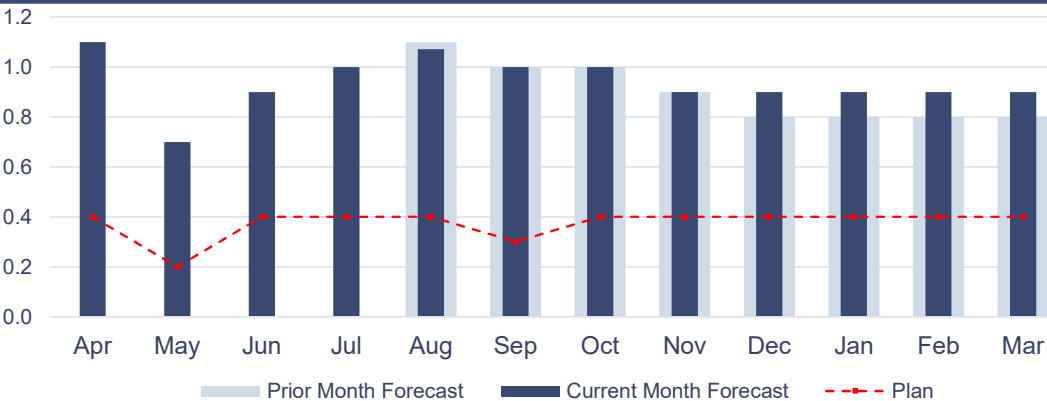
EOY Forecast
£11.2m ●
Variance to Plan **£6.7m**

3-Year Growth
(66.2)%
2023-24 Outturn **£33.1m**

In-Year Growth
7.7%
2025-26 Outturn **£10.4m**

YTD Extrapolation
£11.7m
Risk / (Opp) **£0.4m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Pay Groups	0.9	1.0	1.1	4.9	11.7	11.2	●	0.4
Administration and Estates	-	-	-	-	-	-	●	-
Allied Health, Scientists and Other	-	0.1	0.1	0.3	0.7	0.8	●	(0.1)
Medical and Dental	0.5	0.6	0.7	2.9	7.1	7.3	●	(0.2)
Nursing, Midwifery and Clinical Support	0.3	0.3	0.3	1.6	3.9	3.2	●	0.8
Functions	0.9	1.0	1.0	4.9	11.7	11.2	●	0.4
Chief Operating Officer Management	-	-	-	-	-	-	●	-
Community and Integrated Medicine	0.7	0.6	0.7	3.3	7.9	6.8	●	1.1
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.3	0.8	0.8	●	0.0
Operational Allied Health and Health Sciences	0.1	0.2	0.2	0.8	2.0	2.0	●	0.0
Planned and Specialist Care	0.1	0.1	0.1	0.6	1.5	1.9	●	(0.3)
Primary Care	-	-	-	-	-	-	●	-
Executive Functions	-	-	-	(0.2)	(0.6)	(0.2)	●	(0.3)
Total Expenditure	0.9	1.0	1.0	4.9	11.7	11.2	●	0.4
Plan	0.4	0.4	0.4	1.8	4.4	4.6		
Gross Variance to Plan	0.5	0.6	0.6	3.0	7.3	6.7		

Key Information

- Month 2, May, reduction in Agency expenditure from prior month within Medical and Nursing across various areas, with a reduction in plan following recognition as saving, alongside a further reduction in expenditure within Operational Allied Health.
- Month 4, July, increase in Medical and Nursing Agency expenditure from prior month within Planned and Specialist Care and Operational Allied Health.
- Month 8, November, recognises a reduction in Agency expenditure due to the substantive recruitment of International Educated Nurses within Community and Integrated Medicine. This results in a risk within Community and Integrated Medicine Nursing due to future expenditure anticipated being lower than year to date expenditure levels.
- Increase compared to the prior month forecast from December onwards within Community and Integrated Medicine due to higher agency costs, as substantive recruitment is now anticipated to be lower than previously forecast.

Clinical Services and Supplies Insights

In-Month Actual

£4.1m



Variance to Plan £0.2m

YTD Actual

£21.6m



Variance to Plan £2.3m

EOY Forecast

£52.2m



Variance to Plan £5.7m

3-Year Growth

16.0%

2023-24 Outturn £45.0m

In-Year Growth

1.0%

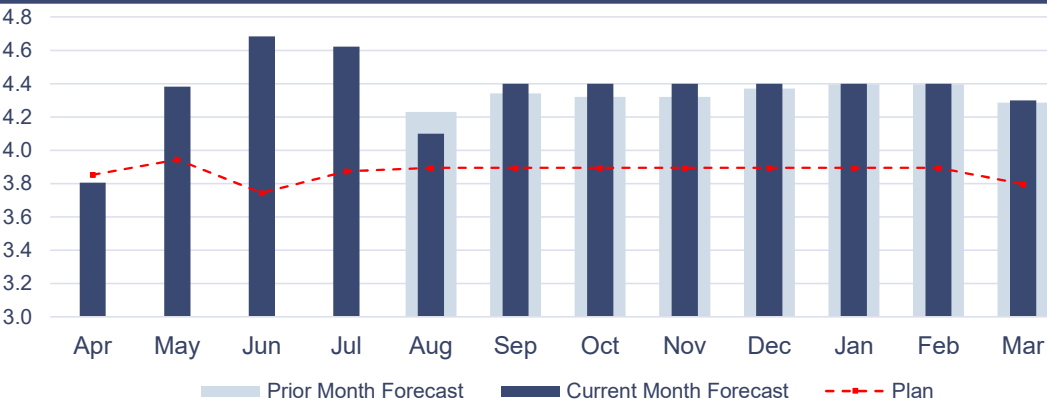
2025-26 Outturn £51.7m

YTD Extrapolation

£51.9m

Risk / (Opp) £(0.3)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	4.6	4.6	4.1	21.6	51.9	52.2		(0.3)
Chief Operating Officer Management	0.1	-	-	0.1	0.3	0.4		(0.2)
Community and Integrated Medicine	1.2	1.2	1.2	5.9	14.3	14.2		-
Mental Health and Learning Disabilities	-	-	-	0.1	0.2	0.2		-
Operational Allied Health and Health Sciences	1.2	1.1	1.1	5.6	13.6	13.8		(0.2)
Planned and Specialist Care	2.1	2.3	1.8	9.7	23.4	23.1		0.3
Primary Care	-	-	-	0.1	0.4	0.4		-
Executive Functions	0.1	(0.1)	-	(0.1)	(0.1)	0.1		(0.2)
Total Expenditure	4.6	4.6	4.1	21.6	51.9	52.2		(0.3)
Plan	3.7	3.9	3.9	19.3	46.3	46.5		
Gross Variance to Plan	0.9	0.7	0.2	2.3	5.6	5.7		

Key Information

Month 2, May, and Month 3, June, reflects an increase driven by Planned and Specialist Care Theatres and Dermatology outsourcing and insourcing of activity and consumables purchases including loan kits and implants alongside an increase within Operational Allied Health relating to Radiology outsourcing of services.

Month 5, August, reduction in expenditure within Theatre consumables reflects lower elective activity due to Anaesthetist shortages and the prioritisation of cancer pathway patients.

Note a risk within Planned and Specialist Care due to the increase seen in May to July of outsourcing of Theatres and other services activity not anticipated to continue at the same level in future months. Note an opportunity within Operational Allied Health due to the increase in Radiology outsourcing from Month 3 onwards anticipated to continue for future months.

Forecast overspend relating to Theatres, Dermatology, Anaesthetics, Urology and Ophthalmology outsourcing within Planned and Specialist Care offset by Ophthalmology drugs underspend £2.3m, Radiology outsourcing and dual running of services offset by vacancies £2.2m and Community and Integrated Medicine insulin pumps, sleeping machines and other consumables spend £1.2m.

Commissioned Healthcare Services Insights



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In-Month Actual

£36.6m



Variance to Plan £(0.8)m

YTD Actual

£185.5m



Variance to Plan £(1.3)m

EOY Forecast

£447.4m



Variance to Plan £(1.1)m

3-Year Growth

15.9%

2023-24 Outturn £385.9m

In-Year Growth

3.0%

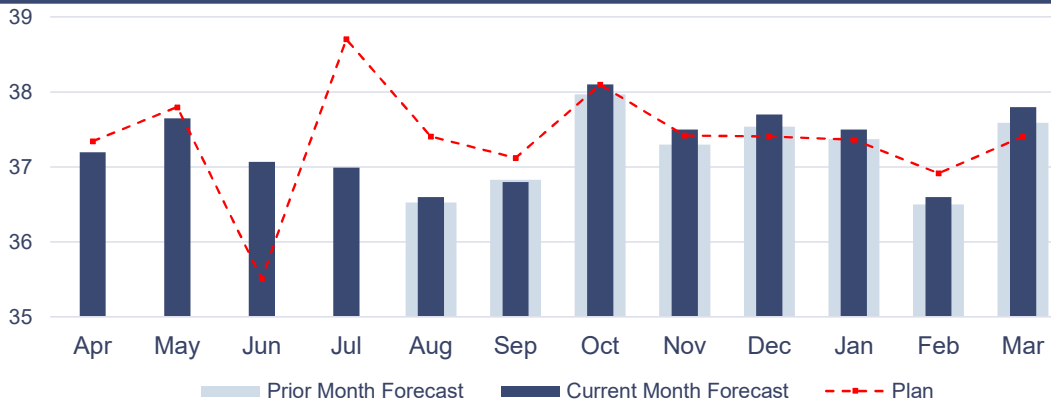
2025-26 Outturn £434.2m

YTD Extrapolation

£445.1m

Risk / (Opp) £(2.3)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	37.1	37.0	36.6	185.5	445.1	447.4		(2.3)
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	2.9	2.9	3.0	14.6	35.0	35.0		-
Mental Health and Learning Disabilities	3.7	4.1	3.9	19.6	47.1	47.0		0.1
Operational Allied Health and Health Sciences	0.5	0.4	0.5	2.3	5.6	5.5		-
Planned and Specialist Care	0.7	0.4	0.5	2.9	6.9	6.3		0.5
Primary Care	10.2	10.5	9.7	51.4	123.3	127.2		(3.9)
Executive Functions	19.0	18.6	19.0	94.7	227.2	226.3		0.9
Total Expenditure	37.1	37.0	36.6	185.5	445.1	447.4		(2.3)
Plan	35.5	38.7	37.4	186.8	448.2	448.5		
Gross Variance to Plan	1.6	(1.7)	(0.8)	(1.3)	(3.1)	(1.1)		

Key Information

- Month 2, May, increase from prior month due to year to date recognition of Pharmaceuticals Company expenditure in line with pass through Joint Commissioning Committee funding.
- Month 3, June, reduction in plan due to year to date Primary Care Dental underspends being recognised as savings, resulting in a worsening to the core operational position in Month 3.
- Month 4, July, increase in plan due to reversal of prior month Primary Care Dental saving to core operational underspends, resulting in an improvement to the core operational position in Month 4.
- Month 5, August, reduction in expenditure from prior month relating to Primary Care General Medical Services Global Sum reduction in year to date expenditure due to delay in project plans.
- Month 7, October, increase in expenditure relating to commencement of Primary Care vaccination programmes.
- 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.
- Note an opportunity within Primary Care due to the delay in General Medical Services and Cluster project plans expenditure anticipated in future months.

Drugs and Prescribing Insights

In-Month Actual

£13.8m

Variance to Plan £0.8m

YTD Actual

£66.8m

Variance to Plan £0.1m

EOY Forecast

£160.9m

Variance to Plan £(0.7)m

3-Year Growth

8.2%

2023-24 Outturn £148.7m

In-Year Growth

8.1%

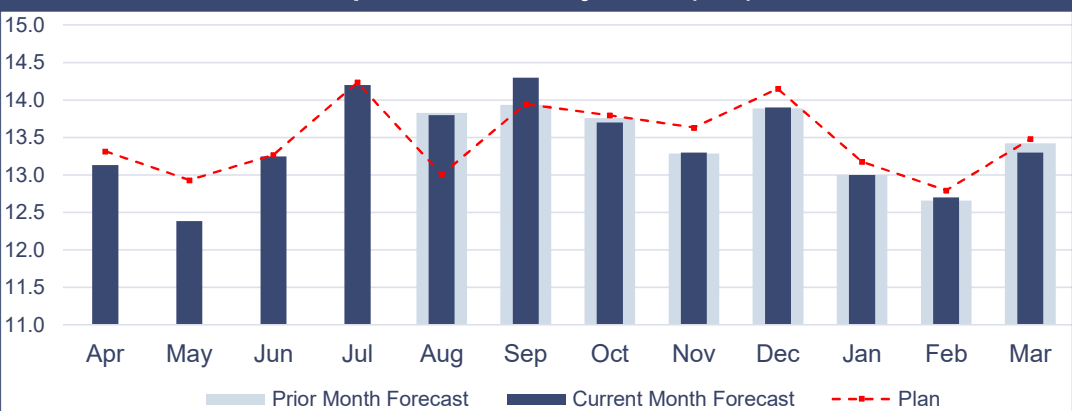
2025-26 Outturn £148.8m

YTD Extrapolation

£160.3m

Risk / (Opp) £(0.6)m

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	13.2	14.2	13.8	66.8	160.3	160.9		(0.6)
Chief Operating Officer Management	-	-	-	-	-	-		-
Community and Integrated Medicine	1.7	1.8	1.6	8.2	19.8	19.3		0.5
Mental Health and Learning Disabilities	0.1	0.1	0.1	0.5	1.3	1.4		(0.1)
Operational Allied Health and Health Sciences	0.5	0.5	0.4	2.3	5.5	5.6		(0.1)
Planned and Specialist Care	3.5	3.4	3.2	16.2	38.8	38.2		0.6
Primary Care	-	-	-	0.1	0.2	0.1		-
Executive Functions	7.5	8.4	8.5	39.5	94.8	96.3		(1.5)
Total Expenditure	13.2	14.2	13.8	66.8	160.3	160.9		(0.6)
Plan	13.3	14.2	13.0	66.7	160.2	161.6		
Gross Variance to Plan	(0.0)	(0.0)	0.8	0.1	0.1	(0.7)		

Key Information

Monthly fluctuations in expenditure largely relating to the number of prescribing days in the month and therefore the corresponding expenditure on drugs based on activity.

Month 4, July, increase in prescribing days resulting in increased activity and expenditure, alongside increase in drugs price and concessions in line with Prescribing Audit Report.

Month 5, August, increase in expenditure compared to the first quarter due to Pharmacy increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with May Prescribing Audit Report.

Month 6, September, increase from prior month forecast largely relating to Pharmacy increase in drugs price in line with June Prescribing Audit Report from £8.67 to £8.74 per item, resulting in an opportunity within Executive Functions due to forecast Pharmacy expenditure in future periods being higher than year-to-date expenditure levels.

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 £(1.7)m, drugs system process improvement review £(0.6)m, Pathology changes in prescribing patterns of drugs £(0.4)m and Public Health lower vaccination uptake £(0.4)m, offset by Pharmacy drugs price and concessions in line with latest Prescribing Audit Report £2.0m and increased Homecare drug costs within Community and Integrated Medicine £0.6m.

Other Non-Pay Insights



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In-Month Actual
£9.4m



Variance to Plan **£1.0m**

YTD Actual
£42.5m



Variance to Plan **£5.9m**

EOY Forecast
£120.9m



Variance to Plan **£16.6m**

3-Year Growth
11.1%

2023-24 Outturn **£108.8m**

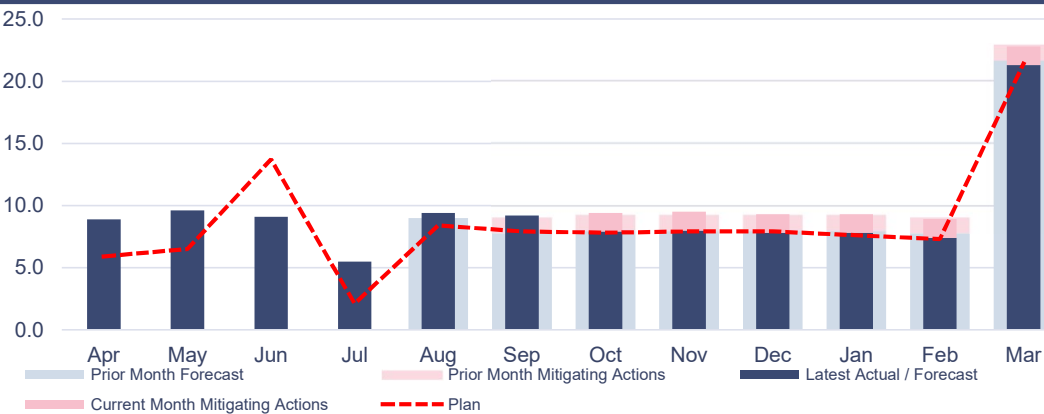
In-Year Growth
22.0%

2025-26 Outturn **£99.1m**

YTD Extrapolation
£102.0m

Risk / (Opp) **£(19.0)m**

Expenditure Monthly Trend (£'m)



Expenditure Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	9.1	5.5	9.4	42.5	102.0	120.9		(19.0)
Chief Operating Officer Management	0.2	0.2	0.1	0.8	1.9	1.9		-
Community and Integrated Medicine	0.7	0.9	0.9	4.2	10.2	10.0		0.2
Mental Health and Learning Disabilities	0.2	0.2	0.2	1.1	2.6	2.6		-
Operational Allied Health and Health Sciences	0.2	0.2	0.2	1.0	2.3	2.4		(0.1)
Planned and Specialist Care	0.4	0.3	0.3	1.6	3.9	3.9		-
Primary Care	0.2	0.1	0.1	0.7	1.6	1.4		0.2
Executive Functions	7.2	3.6	7.5	33.1	79.4	98.7		(19.3)
Total Expenditure	9.1	5.5	9.4	42.5	102.0	120.9		(19.0)
Plan	13.7	2.1	8.4	36.6	87.8	104.4		
Gross Variance to Plan	(4.5)	3.3	1.0	5.9	14.2	16.6		
Reported Variance to Plan *	(4.5)	3.3	1.0	5.9	14.2	7.5		

Key Information

Month 3, June, increase in plan following the conversion of year to date core operational underspends to savings. The majority of the schemes identified related to pay vacancies £4.8m and drugs underspends £0.8m, offset by the savings target assumed within non-pay.

Month 4, July, reduction in expenditure largely due to a decrease in Capital Charges £4.0m, with a corresponding reduction in Revenue Resource Limit.

Month 7, October, onwards includes a reduction in expenditure due to mitigating actions requirement of £9.1m anticipated within Non-Pay to deliver from Month 7 to Month 12. Mitigating actions result in a risk for Non Pay due to the future months forecast being lower than year to date expenditure levels.

Month 12, March, includes Depreciation and Amortisation Impairments increase in expenditure of £14.3m, with a corresponding increase in Revenue Resource Limit. Note an opportunity within Executive Functions as forecast capital expenditure in future periods, particularly Month 12, is higher than year-to-date expenditure levels.

Forecast overspend of £16.6m largely relates to the £12.3m savings identification gap against target assumed within Non-Pay,

*Reported Variance to Plan for end of year includes £9.1m of assumed mitigating actions to deliver the £41.0m Planned Deficit.

Income Insights



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In-Month Actual
£7.3m



Variance to Plan **£(0.1)m**

YTD Actual
£35.8m



Variance to Plan **£(0.6)m**

EOY Forecast
£84.5m



Variance to Plan **£(0.6)m**

3-Year Growth
14.7%

2023-24 Outturn **£73.7m**

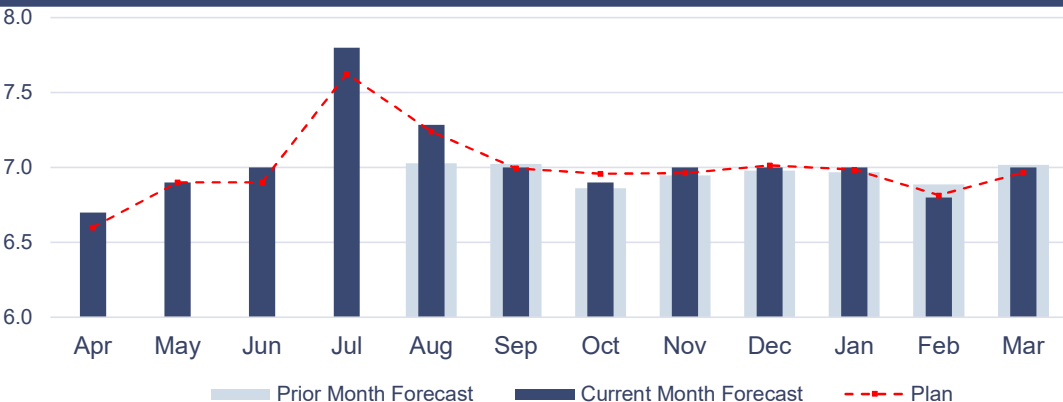
In-Year Growth
1.9%

2025-26 Outturn **£82.9m**

YTD Extrapolation
£85.9m

(Risk) / Opp **£1.4m**

Income Monthly Trend (£'m)



Income Trajectory Analysis (£'m)	P03-27	P04-27	P05-27	YTD	YTD Extrap.	EoY Forecast	EoY Var	Risk / (Opp)
Functions	7.0	7.7	7.3	35.8	85.9	84.5		1.4
Chief Operating Officer Management	-	-	-	0.2	0.4	0.4		-
Community and Integrated Medicine	0.4	0.3	0.4	1.8	4.2	4.0		0.2
Mental Health and Learning Disabilities	0.3	0.3	0.3	1.3	3.2	2.8		0.4
Operational Allied Health and Health Sciences	0.3	0.3	0.3	1.4	3.5	3.4		-
Planned and Specialist Care	0.5	0.5	0.5	2.6	6.2	5.9		0.4
Primary Care	0.2	0.2	0.2	1.0	2.3	2.3		-
Executive Functions	5.4	6.1	5.6	27.5	66.1	65.7		0.4
Total Income	7.0	7.7	7.3	35.8	85.9	84.5		1.4
Plan	6.9	7.6	7.2	35.2	84.4	83.9		
Gross Variance to Plan	0.1	0.1	0.1	0.6	1.5	0.6		

Key Information

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

Month 4, July, increase in income from prior month largely relating to Digital Health and Care Wales income for Digital initiative programmes expenditure £0.5m.

Month 5, August, increase in income from prior month forecast largely relating to additional Central Income activity £0.1m and additional Digital Health and Care Wales income £0.1m.

Monthly fluctuations largely relate to variations in Drugs rebate income.

Income overachievement of £0.6m largely relates to Central Income Non-Contracted Activity income £(0.9)m, Operational Allied Health training and secondment income £(0.5)m and Planned and Specialist Care Bowel Screening income £(0.3)m, offset by underachievement of Dental Income due to reduced activity and termination of Dental practices contracts £1.8m.

End of Year – Key Drivers vs Plan



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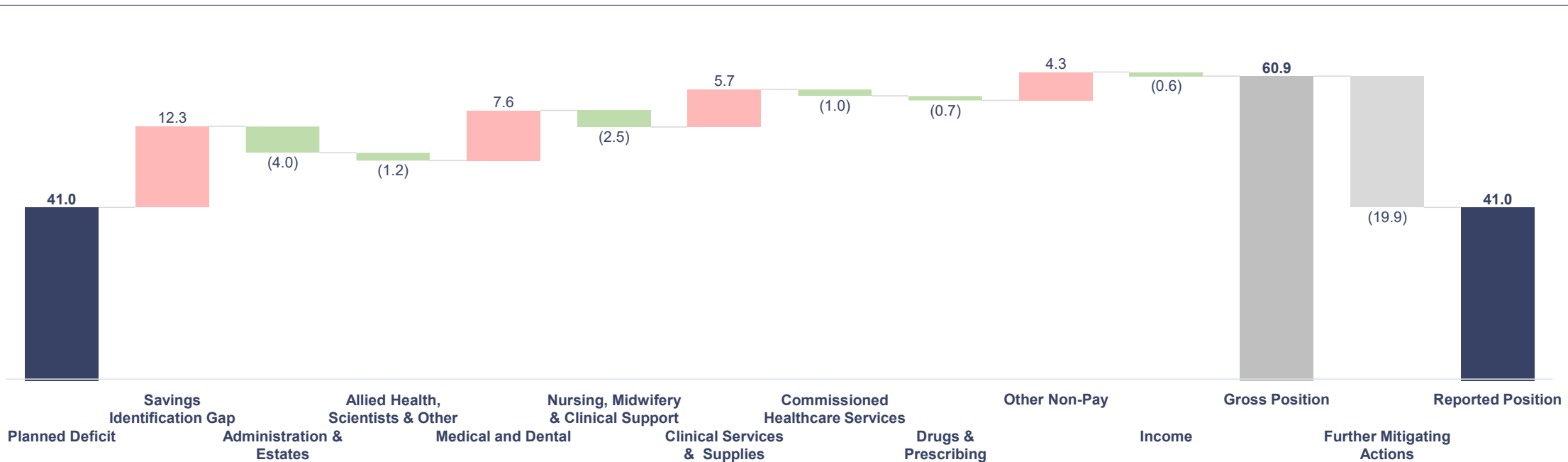
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Key Information

Savings Identification Gap – Savings identification of £30.5m against savings target of £42.8m, leaving a savings identification gap of £12.3m.

Administration & Estates – Improvement relating to Workforce Health Board Improvement programme £(0.8)m. Pay vacancies mainly within Workforce £(0.8)m, Primary Care £(0.7)m and Public Health £(0.7)m.

Medical and Dental – Community and Integrated Medicine high locum usage and agency costs to cover rota gaps, sickness and vacancies mainly within Pembrokeshire £2.9m and Carmarthenshire £1.1m. Planned Care dual running of Medical staff within Bronglais Obstetrics, Gynaecology and Paediatrics £1.8m, alongside Pathology £1.4m and Mental Health £1.0m locum usage to cover sickness and vacancies.

Clinical Services and Supplies – Theatres, Dermatology, Anaesthetics, Urology and Ophthalmology outsourcing offset by Ophthalmology drugs underspend within Planned and Specialist Care £2.3m, Radiology outsourcing and dual running of services offset by vacancies £2.2m and Community and Integrated Medicine purchases relating to insulin pumps, sleeping machines and other consumables £1.2m.

Other Non Pay – Estates and Facilities maintenance expenditure £1.2m, Operational Allied Health dual running of Radiology services and establishment expenses £1.0m and additional security costs, building maintenance and travel costs within Community and Integrated Medicine £1.0m.

End of Year – Key Deviations to Plan



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Key Deviation		£'m	Key Information
Planned Deficit		41.0	As per plan submitted to Welsh Government
Savings Delivery Gap		12.3	Green and Amber savings plans delivering of £30.5m against savings target of £42.8m
Overspends	Medical Stabilisation improvements not delivered	7.7	Agency impact for WGH absence and dual running (£2.9m), BGH W&C absence and dual running (£1.8m), Pathology (£1.4m) and Carmarthenshire (£1.1m) agency usage and MH&LD 4 premium agency (£1.0m)
	Continuing Healthcare	5.3	Demand increases on CHC packages (£3.9m) and Out of Area Mental Health placements (£1.4m)
	Theatre activity and increased outsourcing	3.3	Planned and Specialist Care outsourcing of activity above planned levels
	Primary Care Drugs Price and Concessions	2.0	Pharmacy increase in drugs price in line with June Prescribing Audit Report from £8.45 to £8.74 per item.
	Radiology outsourced services above vacancies	2.0	Double running of Radiology contracts and insourcing of ultrasound services
	Building Maintenance and repairs	1.7	Estates and Facilities £1.2m, Ceredigion Integrated System £0.5m
	Community and Integrated Medicine supplies	1.2	Continuous Positive Airway Pressure, insulin pumps, incontinence products, equipment including hoists
	Long Term Agreements	1.1	Non-elective short stay episodes attracting a disproportionate flat rate tariff within Swansea Bay
	Band 2/3 banding assumption changes	0.9	Increase in national framework assumptions and additional establishment conversion
Underspends	Primary Care	(9.7)	Dental contract handback £(7.1)m and General Medicine Services Supplementary Services £(2.0)m.
	Administrative vacancies	(3.9)	Workforce Health Board Improvement programme £(0.8)m. Pay vacancies across the majority of services.
	Clinical fill rates (non-medical)	(2.4)	Vacancies and reduced fill rates within Nursing and Allied Health roles
	Secondary Care Drugs	(0.9)	Annual Plan assumed increases not yet materialised, alongside lower vaccination uptake
	Income	(0.7)	Central Income £(0.9)m, Allied Health £(0.5)m, Planned Care £(0.3)m, Dental underachievement £1.8m
Gross Position		60.9	Report £41.0m to Welsh Government, with full mitigating actions assumed
Further Mitigating Actions		(19.9)	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	0.4	0.0	0.7	1.1	Savings non delivery plus Voluntary Early Retirement Scheme payments and Physiotherapy First Contact Point pay costs.
Community and Integrated Medicine	4.5	0.0	10.7	15.2	Savings non delivery plus continued use of premium Medical locums £4.4m and Nursing bank usage £0.6m to cover sickness and vacancies, Continuing Healthcare package acuity increases £3.0m, alongside clinical supplies £1.2m.
Mental Health and Learning Disabilities	3.4	0.0	1.6	5.0	Savings non delivery plus purchase of outsourced Psychiatric Intensive Care beds £1.4m, Continuing Healthcare packages increase £0.9m, Medical locum agency usage £1.0m offset by Allied Health and Nursing vacancies £(1.8)m.
Operational Allied Health & Health Sciences	3.2	0.0	1.5	4.7	Savings non delivery plus Radiology services outsourcing and dual running £2.2m, Medical agency locum usage within Pathology £0.5m, offset by pay vacancies £(1.4)m.
Planned and Specialist Care	3.8	0.0	3.1	6.9	Savings non delivery plus outsourcing of activity in Theatres, Dermatology, Anaesthetics and Urology £2.7m, Bronglais Medical dual running £1.9m and Nursing vacancies £(2.0)m.
Primary Care	(0.1)	0.0	(9.0)	(9.1)	Dental contracts handback underspends £(7.1)m and General Medicine Services Supplementary Services underspends £(2.0)m.
Executive Functions	(2.9)	0.0	(1.0)	(3.9)	Workforce Improvement Programme 3 – Administration and Clerical recruitment restrictions £(0.8)m, Central income over achievement and pay vacancies.
Sub Total	12.3	0.0	7.6	19.9	
Gross Position				60.9	
Further Mitigating Actions				(19.9)	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	(0.2)	0.0	(0.1)	(0.3)	Over-achievement of savings, Admin pay vacancies.
Digital	0.0	0.0	0.0	0.0	No material deviation.
Estates and Facilities	2.0	0.0	0.9	2.9	Under-achievement of savings, building and maintenance expenditure
Executive Allied Health	0.0	0.0	0.0	0.0	No material deviation.
Finance	(0.5)	0.0	(0.1)	(0.6)	Over-achievement of savings, Admin pay vacancies.
Health Board Wide	(3.4)	0.0	(1.7)	(5.1)	Drugs system process improvement review £(3.0)m, VAT Recovery review £(1.3)m, Central Income overachieved £(0.9)m, salary sacrifice £(0.6)m.
LTA's	1.3	0.0	1.1	2.4	Under-achievement of savings, Swansea Bay emergency activity
Medical	(0.1)	0.0	(0.1)	(0.2)	Over-achievement of savings, unconfirmed SIFT plans.
Nursing	(0.1)	0.0	0.2	0.1	Over-achievement of savings, increased non pay legal fees.
Pharmacy and Medicines Management	2.7	0.0	2.1	4.8	Under-achievement of savings, increase in drugs price in line with June Prescribing Audit Report from £8.45 to £8.74 per item
Public Health	(0.7)	0.0	(1.4)	(2.1)	Over-achievement of savings, Admin and Nursing pay vacancies and reduction in vaccination update
Strategy and Planning	(0.4)	0.0	(0.2)	(0.6)	Over-achievement of savings, Capital redesign income.
Workforce	(3.5)	0.0	(1.7)	(5.2)	Over-achievement of savings, admin pay vacancies and Workforce Improvement Programme 3 Admin Recruitment Restrictions
Sub Total	(2.9)	0.0	(1.0)	(3.9)	

End of Year – Key Performance vs Prior Month



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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
Planned Deficit				0.0	No change to Annual Plan Deficit of £41.0m
Chief Operating Officer Management	(0.1)	0.0	0.0	(0.1)	Additional savings identified in relation to parking facilities.
Community and Integrated Medicine	0.0	0.0	1.0	1.0	Increase in Medical agency locum usage to cover sickness and vacancies across sites.
Mental Health and Learning Disabilities	0.0	0.0	(0.3)	(0.3)	Reduction in high-cost Continuing Healthcare packages from prior month.
Operational Allied Health & Health Sciences	0.0	0.0	(0.6)	(0.6)	Reduction in Allied, Medical and Nursing variable pay alongside increase in vacancies, and reduction in Pathology drugs expenditure.
Planned and Specialist Care	0.0	0.0	0.2	0.2	Increase in Medical agency locum usage within Oncology.
Primary Care	0.0	0.0	0.1	0.1	No material deviation.
Executive Functions	(0.6)	0.0	0.8	0.2	Additional savings identified in relation to pay vacancy underspends, offset by June Prescribing Audit Report increase in drugs price and concessions.
Sub Total	(0.7)	0.0	1.2	0.5	
Gross Position				0.5	
Further Mitigating Actions				(0.5)	
Reported Position				0.0	No change to Reported Position of £41.0m

Trend – Total Key Performance vs Plan



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Clinical Care Groups and Executive Functions (£'m)	April EOY Forecast	May EOY Forecast	June EOY Forecast	July EOY Forecast	August EOY Forecast	Key Information
Annual Plan	41.0	41.0	41.0	41.0	41.0	As per plan submitted to Welsh Government
Chief Operating Officer Management	0.8	1.6	1.2	1.1	1.1	Static, relating to savings under delivery plus Voluntary Early Retirement Scheme payments and Physiotherapy First Contact Point pay
Community and Integrated Medicine	12.8	13.9	15.1	14.1	15.2	Deterioration, increase to Medical cover expenditure for sickness and vacancies. Other drivers relate to savings under delivery plus increase in Continuing Healthcare packages and clinical supplies.
Mental Health and Learning Disabilities	6.0	5.4	5.5	5.3	5.0	Slight improvement, largely relating to savings under delivery plus Medical locum usage, Continuing Healthcare packages increase and purchase of outsourced Psychiatric Intensive Care Unit beds
Operational Allied Health & Health Sciences	5.1	5.0	5.5	5.3	4.7	Improving, largely relating reduction in Pathology drugs in August. However, there continues to be savings under delivery, Medical Locum usage within Pathology and outsourcing of Radiology services.
Planned and Specialist Care	7.2	7.7	9.5	6.7	6.9	Slight deterioration, largely relating to recognition of run rate reduction of Medical variable pay. Overspend relating to outsourcing of services and Medical dual running and rate card, alongside a savings delivery gap
Primary Care	(12.4)	(12.4)	(10.7)	(9.0)	(9.1)	Static, General Medical Services increase in programme expenditure. Underspends relating to Dental contract handback £(7.1)m and General Medicine Services Supplementary Services £(2.0)m.
Executive Functions	3.1	(0.3)	(4.9)	(4.1)	(3.9)	Slight deterioration - June Prescribing Audit Report increase in drugs price and concessions £1.0m, offset by Workforce Improvement Programme 3 - Admin and Clerical £(0.8)m.
Adverse / (Favourable) Variance to Plan	22.6	20.9	21.2	19.4	19.9	
Gross Position	63.6	61.9	62.2	60.4	60.9	

Trend – Total Key Performance vs Plan Executive



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Executive Functions (£'m)	April EOY Forecast	May EOY Forecast	June EOY Forecast	July EOY Forecast	August EOY Forecast	Key Information
Chief Executive	(0.3)	(0.3)	(0.4)	(0.3)	(0.3)	No material change
Digital	0.4	0.4	0.1	0.1	0.0	No material change
Estates and Facilities	3.2	3.0	3.0	2.9	2.9	Static, relating to savings under delivery and maintenance costs
Executive Allied Health	0.0	0.0	0.0	0.0	0.0	No material change
Finance	(0.3)	(0.6)	(0.4)	(0.5)	(0.6)	No material change
Health Board Wide	0.9	(1.0)	(4.6)	(5.2)	(5.1)	Improving, Drugs process improvement £(3.0)m, VAT Recovery reviews £(1.3)m, Central Income overachievement £(0.9)m
LTA's	4.4	4.1	3.0	2.2	2.4	Improving, Swansea Bay Emergency Activity, offset by Joint Commissioning Committee risk share improvement
Medical	(1.1)	(1.1)	(0.4)	(0.2)	(0.2)	Deterioration, Value Based Healthcare plans confirmed
Nursing	(0.1)	0.0	0.0	0.1	0.1	No material change
Pharmacy and Medicines Management	2.0	1.9	1.9	3.6	4.8	Deterioration, savings under delivery and June Prescribing Audit Report increase in drugs price and concessions
Public Health	(2.4)	(2.2)	(2.2)	(1.8)	(2.1)	Pay vacancies, lower vaccination uptake and savings over delivery
Strategy and Planning	(0.4)	(0.6)	(0.5)	(0.5)	(0.6)	Static, relating to Capital redesign income.
Workforce	(3.2)	(3.9)	(4.4)	(4.5)	(5.2)	Improving, Workforce Improvement Programme 3 Admin and Clerical
Adverse / (Favourable) Variance to Plan	3.1	(0.3)	(4.9)	(4.1)	(3.9)	

End of Year – Core Operational Variation



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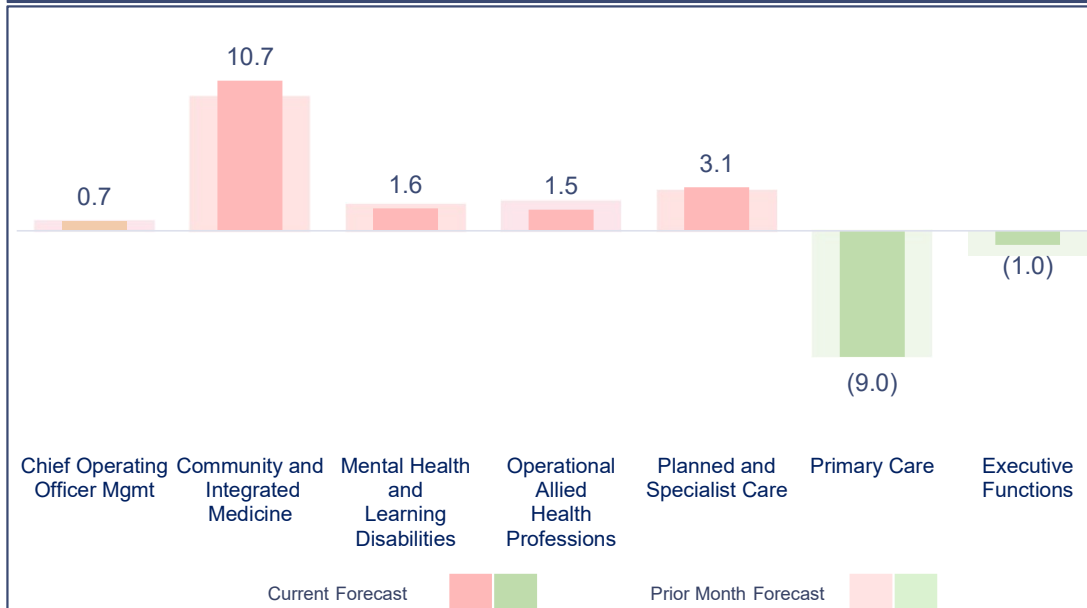
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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Portfolio	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.7	0.0	0.0	0.7
Community and Integrated Medicine	5.1	5.8	(0.2)	10.7
Mental Health and Learning Disabilities	(0.8)	2.4	0.0	1.6
Operational Allied Health and Health Sciences	(0.7)	2.7	(0.5)	1.5
Planned and Specialist Care	0.1	3.3	(0.3)	3.1
Primary Care	(0.6)	(10.2)	1.8	(9.0)
Executive Functions	(3.8)	4.2	(1.4)	(1.0)
Total	0.0	8.2	(0.6)	7.6

Key Information

Community and Integrated Medicine Medical locum usage to cover sickness and vacancies £4.4m, Continuing Healthcare increase in monthly average of commissioned care days due to additional packages £3.0m, increase in consumables expenditure relating to Continuous Positive Airway Pressure, insulin pumps and equipment including hoists £1.2m and security and building maintenance expenditure.

Mental Health Continuing Healthcare increase in monthly average commissioned care days due to additional packages and increase in purchase of outsourced Psychiatric Intensive Care Beds £2.3m.

Operational Allied Health Outsourcing and dual running of Radiology services and insourcing of ultrasound services £2.2m, offset by pay vacancies £(1.4)m..

Planned and Specialist Care Theatres, Dermatology, Anaesthetics, Ophthalmology and Urology outsourcing of activity £4.4m, offset by Ophthalmology drugs underspend £(1.7)m.

Primary Care Dental contracts handback £(7.1)m and General Medicine Services Supplementary Services underspends £(2.0)m, offset by underachievement of Dental income £1.8m.

Executive Functions Public Health vacancies and lower vaccination uptake £(1.4)m, Central Income overachievement £(0.9)m, Workforce Improvement programme Admin recruitment restrictions £(0.8)m offset by Pharmacy and Medicines Management increase in prescribing price £2.1m, Swansea Bay Long Term Agreement Emergency activity increase £1.1m and Estates maintenance expenditure £0.9m.

End of Year – Savings Performance Breakdown



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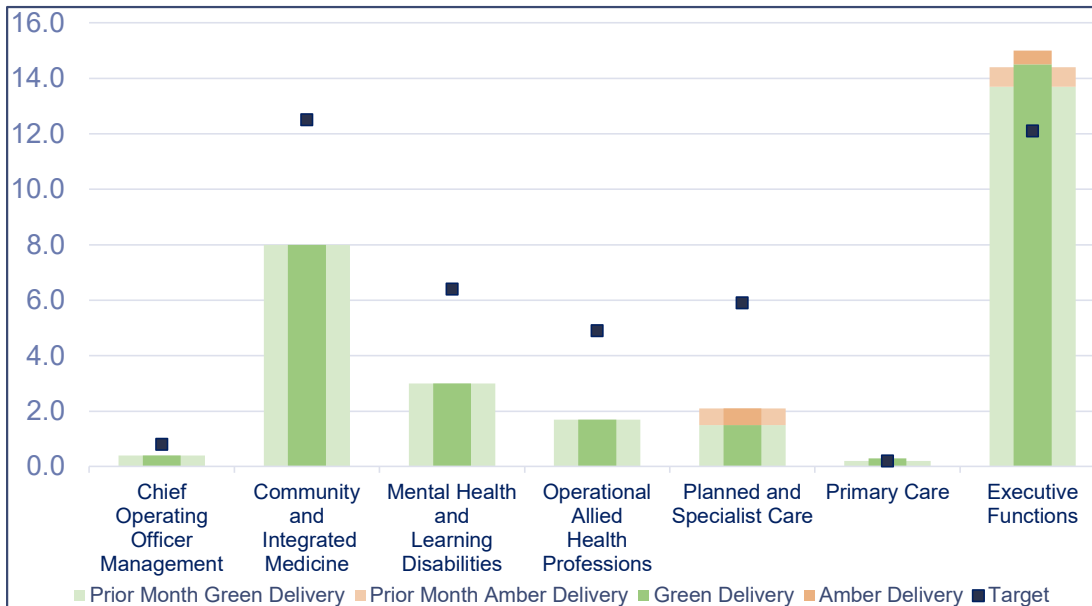
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Savings Performance Breakdown (£'m)



Savings Performance Breakdown (£'m)

Portfolio	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.8	0.4	0.4	0.4
Community and Integrated Medicine	12.5	8.0	8.0	4.5
Mental Health and Learning Disabilities	6.4	3.0	3.0	3.4
Operational Allied Health and Health Sciences	4.9	1.7	1.7	3.2
Planned and Specialist Care	5.9	2.1	2.1	3.8
Primary Care	0.2	0.3	0.3	(0.1)
Executive Functions	12.1	15.0	15.0	(2.9)
Grand Total	42.8	30.5	30.5	12.3

Key Information

Savings identification is £30.5m, with all savings forecast to fully deliver, leaving a savings under-identification gap of £12.3m against the £42.8m target.

The £12.3m under-identification of savings largely relates to Community and Integrated Medicine £4.5m, Mental Health £3.4m, Operational Allied Health £3.2m, Planned and Specialist Care £3.8m, offset by Executive functions over-identification of £(2.9)m. Executive functions over-identification largely relates to Workforce £(3.5)m and Health Board Wide £(3.3)m, Public Health £(0.7)m, offset by under-identification within Pharmacy and Medicines Management £2.7m, Estates and Facilities £2.1m and Long-Term Agreements £1.3m.

Newly identified schemes largely relate to conversion of core operational underspends to savings £0.5m and Central Income saving relating to Injury Cost Recovery £0.2m.

Of the schemes identified, £29.4m relate to green schemes, with £1.1m relating to amber schemes. £6.7m are recurrent savings with £23.8m 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

£36.1m

Target = £42.8m
Delivery = £6.7m



In-Year Non-Recurrent Gap

£(23.8)m

Target = £0.0m
Delivery = £23.8m



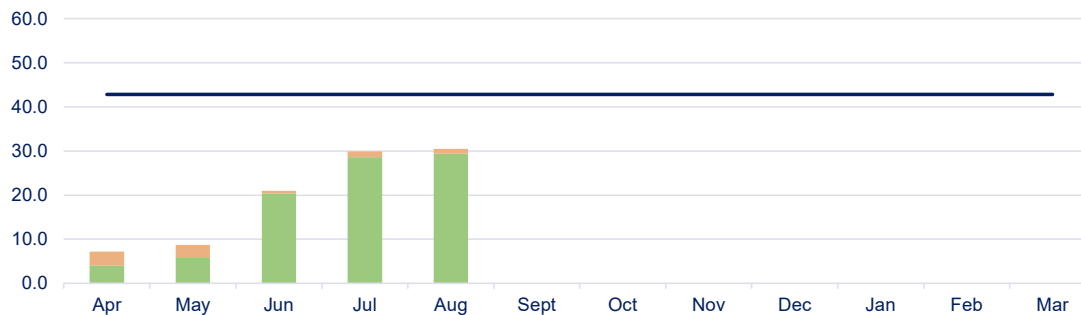
Full Year Recurrent Gap

£35.9m

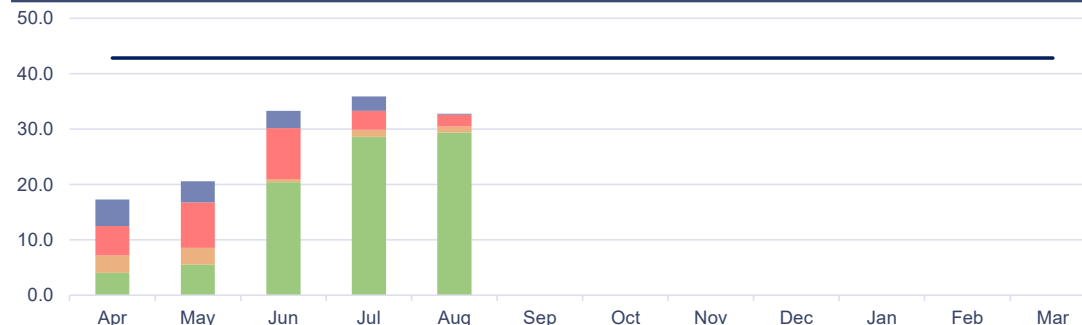
Target = £42.8m
Delivery = £6.9m



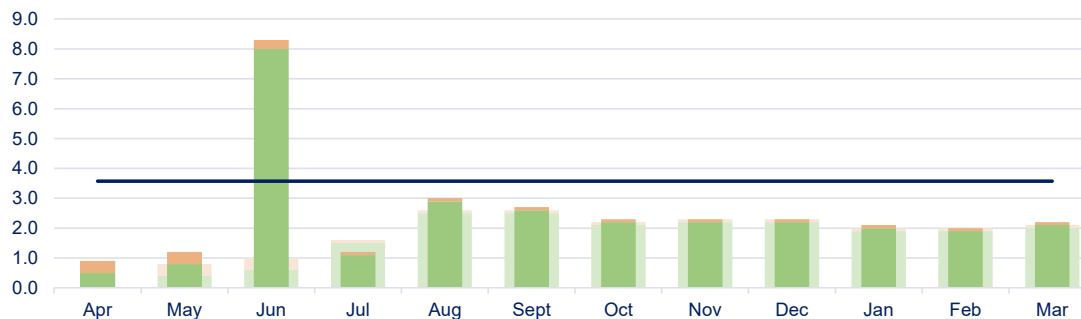
Monthly Trend of Annual In-Year Risk-Assessed Savings Delivery (£'m)



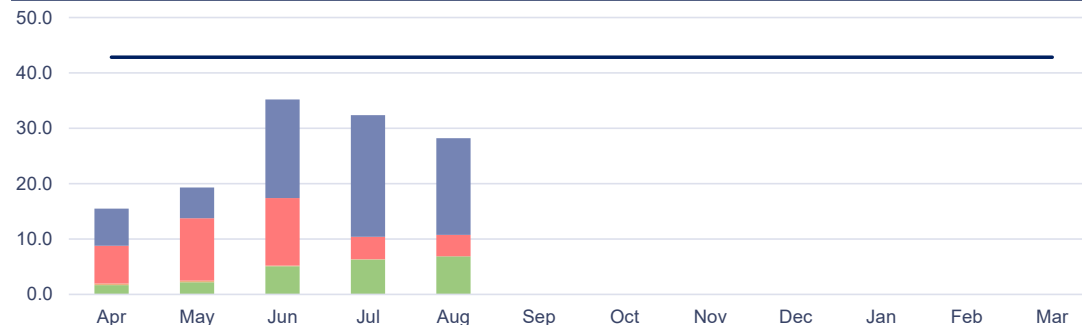
Monthly Trend of Annual In-Year Opportunity, Pipeline & Savings Plans (£'m)



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



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



In-Month – Key Drivers vs Plan



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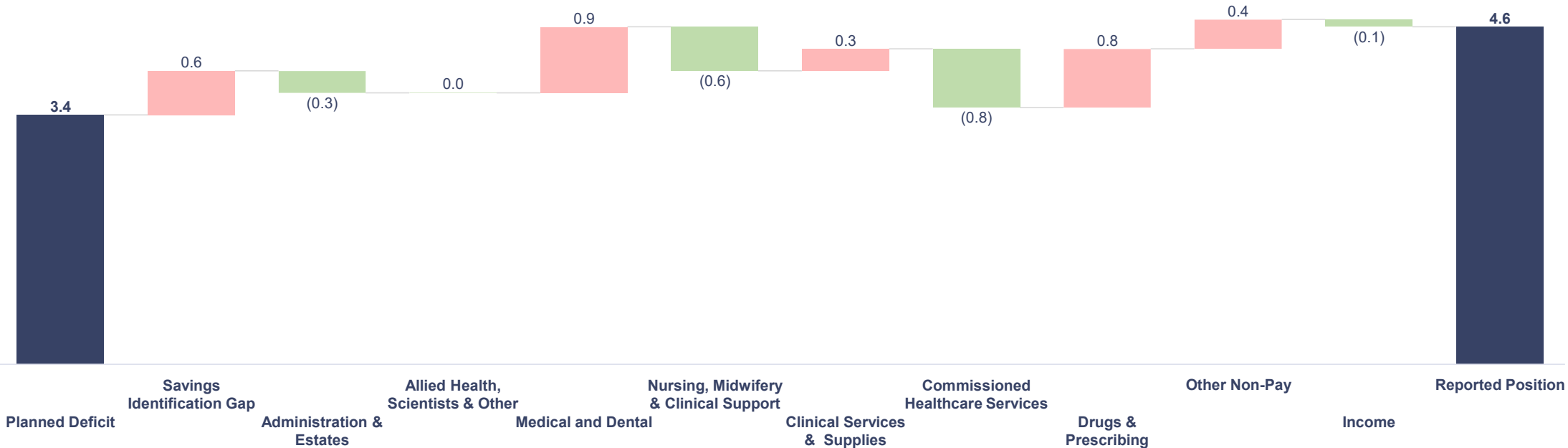
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Key Information

Savings Identification Gap – Savings identification of £3.0m against savings target of £3.6m, leaving a savings under identification gap of £0.6m.

Medical and Dental – Community and Integrated Medicine locum usage to cover sickness and vacancies £0.5m and Planned and Specialist Care dual running of staff in Bronglais £0.3m.

Nursing, Midwifery & Clinical Support – Vacancies and reduced variable pay within Planned & Specialist Care £(0.4)m, Community & Integrated Medicine £(0.1)m, Mental Health £(0.1)m.

Commissioned Healthcare Services – Primary Care General Medical Services supplementary services underspend £(0.9)m and Dental contracts handback £(0.5)m, offset by Continuing Healthcare packages within Community and Integrated Medicine and Mental Health £0.3m and purchase of outsourced Mental Health Psychiatric Intensive Care unit beds £0.1m.

Drugs and Prescribing – Pharmacy and Medicines Management increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with May Prescribing Audit Report.

In-Month – Key Deviations to Plan



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Key Deviation		£'m	Key Information
Planned Deficit		3.4	As per plan submitted to Welsh Government
Savings Delivery Gap		0.6	Green and Amber savings plans delivering of £3.0m against savings target of £3.6m
Overspends	Primacy Care Drugs Price and Concessions	1.0	Pharmacy and Medicines Management increase in drugs price, concessions and volume in line with May Prescribing Audit Report. Increase in price from £8.45 per item to £8.67 per item.
	Medical Stabilisation improvements not delivered	0.9	Agency usage to cover vacancies and sickness within Community and Integrated Medicine £0.5m, Planned and Specialist Care £0.3m and Mental Health £0.1m
	Continuing Healthcare	0.5	Demand increases on Continuing Healthcare packages within Community and Integrated Medicine and Mental Health, and purchase of outsourced Mental Health Psychiatric Intensive Care Unit beds
	Clinical Services and Supplies	0.3	Radiology outsourced services £0.2m, insulin pumps, cardiac and diabetic consumable purchases £0.1m
	Non Pay contracts	0.2	Digital initiative programmes contract expenditure
	Building Maintenance and repairs	0.2	Estates and Facilities £0.1m and Community and Integrated Medicine £0.1m
Underspends	Primary Care	(1.6)	General Medical Services supplementary services underspend £(0.9)m, Dental contracts handback £(0.5)m and delay in Primary Care cluster project plans £(0.2)m
	Nursing and Midwifery Pay	(0.6)	Vacancies and reduced variable pay usage within Planned and Specialist Care £(0.4)m, Community & Integrated Medicine £(0.1)m and Mental Health £(0.1)m
	Administrative vacancies	(0.3)	Across many services, mainly within Public Health £(0.1)m, Primary Care £(0.1)m and Estates £(0.1)m. Continued commitment to convert underspends to savings.
Reported Position		4.6	

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	0.0	0.0	(0.1)	(0.1)	No material deviation to plan
Community and Integrated Medicine	0.5	0.0	0.9	1.4	Savings non delivery plus Medical Agency locum usage to cover sickness and vacancies £0.5m, increase in Continuing Healthcare packages £0.3m.
Mental Health and Learning Disabilities	0.2	0.0	0.1	0.3	Savings non delivery plus purchase of outsourced Psychiatric Intensive Care Unit beds and increase in Continuing Health Care packages.
Operational Allied Health & Health Sciences	0.2	0.0	0.1	0.3	Savings non delivery plus outsourcing of Radiology services £0.1m.
Planned and Specialist Care	0.3	0.0	0.2	0.5	Savings non delivery plus Medical locum agency usage including dual running £0.4m, outsourcing of Theatre activity £0.2m offset by Nursing and Midwifery vacancies £(0.4)m.
Primary Care	0.0	0.0	(1.6)	(1.6)	General Medical Services supplementary services underspend £(0.9)m, Dental contracts handback £(0.5)m, delay in cluster project plans £(0.2)m
Executive Functions	(0.6)	0.0	1.0	0.4	Savings over delivery relating to Workforce pay, Controlled Drugs Stock Strategic Review and Injury Cost Recovery income. Increase in drugs volume, concessions and price from £8.45 to £8.67 per item.
Sub Total	0.6	0.0	0.6	1.2	
Gross Position				4.6	

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	0.2	0.2	Digital programmes contract expenditure
Estates and Facilities	0.1	0.0	0.0	0.1	Under-achieved savings
Executive Allied Health	0.0	0.0	0.0	0.0	No material deviation to plan
Finance	(0.1)	0.0	0.0	(0.1)	Over-achieved savings
Health Board Wide	(0.5)	0.0	(0.2)	(0.7)	Controlled Drugs Stock Strategic Review and Injury Cost Recovery income saving
LTA's	0.1	0.0	0.0	0.1	Under-achieved savings
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	0.2	0.0	1.1	1.3	Under-achieved savings, increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with May Prescribing Audit Report.
Public Health	0.0	0.0	(0.1)	(0.1)	Pay vacancies within all pay groups
Strategy and Planning	0.0	0.0	(0.1)	(0.1)	Pay vacancies and over-achieved income
Workforce	(0.4)	0.0	0.1	(0.3)	Over-achieved savings relating to pay vacancies
Sub Total	(0.6)	0.0	1.0	0.4	

In-Month – Key Performance vs Prior Month



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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
Planned Deficit				0.0	
Chief Operating Officer Management	0.1	0.0	(0.1)	0.0	No material movement to prior month.
Community and Integrated Medicine	(0.1)	0.0	0.1	0.0	No material movement to prior month.
Mental Health and Learning Disabilities	0.0	0.0	(0.2)	(0.2)	Reduction in Continuing Healthcare package volume from prior month, including a backdated retrospective element.
Operational Allied Health & Health Sciences	0.0	0.0	0.0	0.0	No material movement to prior month.
Planned and Specialist Care	(0.1)	0.0	(0.3)	(0.4)	Reduction in theatre consumables reflects lower elective activity alongside delay to phased implementation of nursing investment.
Primary Care	(1.8)	0.0	0.9	(0.9)	Primary Care Dental savings reclassified to core underspend in prior month, and delay in General Medical Services Global Sum expenditure.
Executive Functions	0.0	0.0	1.0	1.0	Pharmacy increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with May Prescribing Audit Report.
Sub Total	(1.9)	0.0	1.4	(0.5)	
Gross Position				(0.5)	

Trend – Total Key Performance vs Plan



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Clinical Care Groups and Executive Functions (£'m)	April	May	June	July	August	Year to Date	Key Information
Annual Plan	3.4	3.4	3.4	3.4	3.4	17.1	As per plan submitted to Welsh Government
Chief Operating Officer Management	0.1	0.5	0.1	0.0	(0.1)	0.7	Static, one-off Voluntary Early Retirement Scheme payments in May
Community and Integrated Medicine	1.0	1.2	1.6	1.3	1.4	6.5	Deterioration, increase in bank usage and fill rates in June to cover sickness. Reduction in enhanced payments in July
Mental Health and Learning Disabilities	0.4	0.5	0.3	0.5	0.3	2.1	Worsening, increase in the demand for outsourced Psychiatric Intensive Care Unit beds in July to 9 patients. Reduction in Continuing Healthcare packages in August.
Operational Allied Health & Health Sciences	0.3	0.4	0.5	0.4	0.3	1.9	Static, Medical agency usage within Pathology to cover vacancies
Planned and Specialist Care	0.6	0.8	1.3	0.8	0.5	3.9	Improving, June increase in Rheumatology drugs and Theatres outsourcing. July reduction relating to additional funding received for Horizon Scanning drugs. August reduction in activity and consumables spend.
Primary Care	(0.5)	(0.9)	(0.9)	(0.7)	(1.6)	(4.7)	Improving, largely relating to delay in General Medical Services Global Sum expenditure. Dental contracts handback and General Medical Services underspends.
Executive Functions	0.2	0.1	(1.2)	(0.6)	0.4	(1.2)	Worsening, transfer of Horizon Scanning drugs funding to Oncology and Pathology. Increase in May Prescribing Audit Report drugs price and concessions
Adverse / (Favourable) Variance to Plan	2.1	2.6	1.7	1.7	1.2	9.2	
Gross Position	5.5	6.0	5.1	5.1	4.6	26.3	

Trend – Total Key Performance vs Plan Executive



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Executive Functions (£'m)	April	May	June	July	August	Year to Date	Key Information
Chief Executive	(0.1)	0.0	0.0	0.0	0.0	(0.2)	Static
Digital	0.0	0.1	0.0	0.2	0.2	0.6	Worsening, Digital programmes contract expenditure
Estates and Facilities	0.3	0.3	0.4	0.1	0.1	1.3	Improving, Building and Estates maintenance expenditure reduction
Executive Allied Health	0.0	0.0	0.0	0.0	0.0	0.0	Static
Finance	0.0	0.0	(0.1)	0.0	(0.1)	(0.2)	Static
Health Board Wide	0.2	(0.1)	(1.1)	(0.8)	(0.7)	(2.4)	Improvement, VAT recovery year to date saving in June, alongside Controlled Drugs Stock Strategic Review and Central Income saving
LTA's	0.3	0.4	0.5	0.1	0.1	1.4	Improving, Swansea Bay emergency activity offset by improvement in July due to reduction in Joint Commissioning Committee risk share
Medical	(0.1)	0.0	0.0	0.0	0.0	(0.2)	Static
Nursing	0.0	0.0	0.0	0.0	0.0	(0.1)	Static
Pharmacy and Medicines Management	0.1	0.1	(0.1)	0.4	1.3	1.8	Worsening, Horizon Scanning funding transferred to other services. Increase in Prescribing Audit Report drugs price and concessions
Public Health	(0.1)	(0.3)	(0.2)	(0.1)	(0.1)	(0.8)	Static
Strategy and Planning	(0.1)	(0.1)	(0.1)	0.0	(0.1)	(0.5)	Static
Workforce	(0.3)	(0.3)	(0.5)	(0.5)	(0.3)	(1.9)	Static, additional Admin vacancies
Adverse / (Favourable) Variance to Plan	0.2	0.1	(1.2)	(0.6)	0.4	(1.2)	

In-Month – Core Operational Variation



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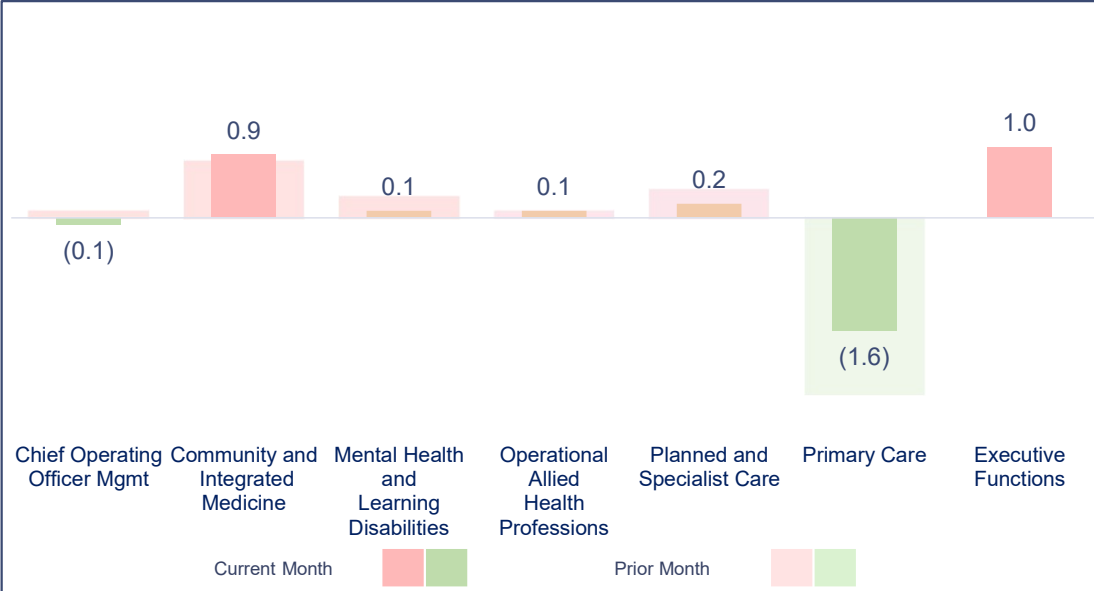
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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.0	(0.1)	0.0	(0.1)
Community and Integrated Medicine	0.4	0.6	(0.1)	0.9
Mental Health and Learning Disabilities	0.0	0.1	0.0	0.1
Operational Allied Health and Health Sciences	(0.1)	0.3	(0.1)	0.1
Planned and Specialist Care	0.1	0.1	0.0	0.2
Primary Care	(0.1)	(1.6)	0.1	(1.6)
Executive Functions	(0.3)	1.3	0.0	1.0
Total	0.0	0.7	(0.1)	0.6

Key Information

Community and Integrated Medicine Medical Agency locum usage to cover vacancies and sickness £0.5m and Continuing Healthcare packages volume increase £0.3m.

Primary Care General Medical Services supplementary services underspend £(0.9)m, Dental contracts handback £(0.5)m and delay in Primary Care cluster project plans £(0.2)m, offset by Dental income under achievement £0.1m.

Executive Functions Pharmacy and Medicines Management increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with May Prescribing Audit Report £1.0m, increase in Digital contracts expenditure £0.2m, offset by vacancies mainly within Public Health £(0.2)m and Estates and Facilities £(0.1)m.

In-Month – Savings Performance Breakdown



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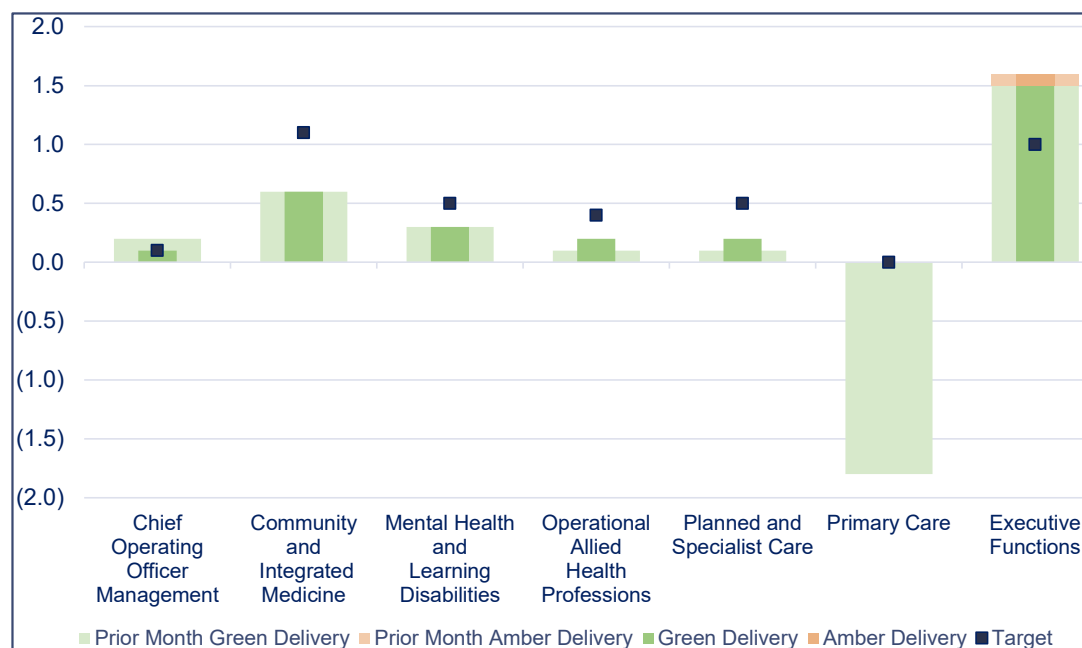
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Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.1	0.1	0.1	0.0
Community and Integrated Medicine	1.1	0.6	0.6	0.5
Mental Health and Learning Disabilities	0.5	0.3	0.3	0.2
Operational Allied Health and Health Sciences	0.4	0.2	0.2	0.2
Planned and Specialist Care	0.5	0.2	0.2	0.3
Primary Care	0.0	0.0	0.0	0.0
Executive Functions	1.0	1.6	1.6	(0.6)
Grand Total	3.6	3.0	3.0	0.6

Key Information

Overall savings identification and delivery of £3.0m has been achieved in Month 5, resulting in a £0.6m under-delivery against £3.6m target, with variations across Clinical Care Groups.

£0.6m under identification of savings largely relates to Community and Integrated Medicine £0.5m, Planned and Specialist Care £0.3m, Operational Allied Health £0.2m, Mental Health £0.2m, offset by over identification within Executive Functions £(0.6)m. Executive Functions includes over identification within Health Board Wide £(0.5)m and Workforce £(0.4)m, offset by under identification relating to Pharmacy and Medicines Management £0.2m, Estates and Facilities £0.2m and Long Term Agreements £0.1m.

Increase in savings identification from prior month largely relates to reclassification of Primary Care Dental savings to core operational underspend in prior month.

Year to Date – Key Drivers vs Plan



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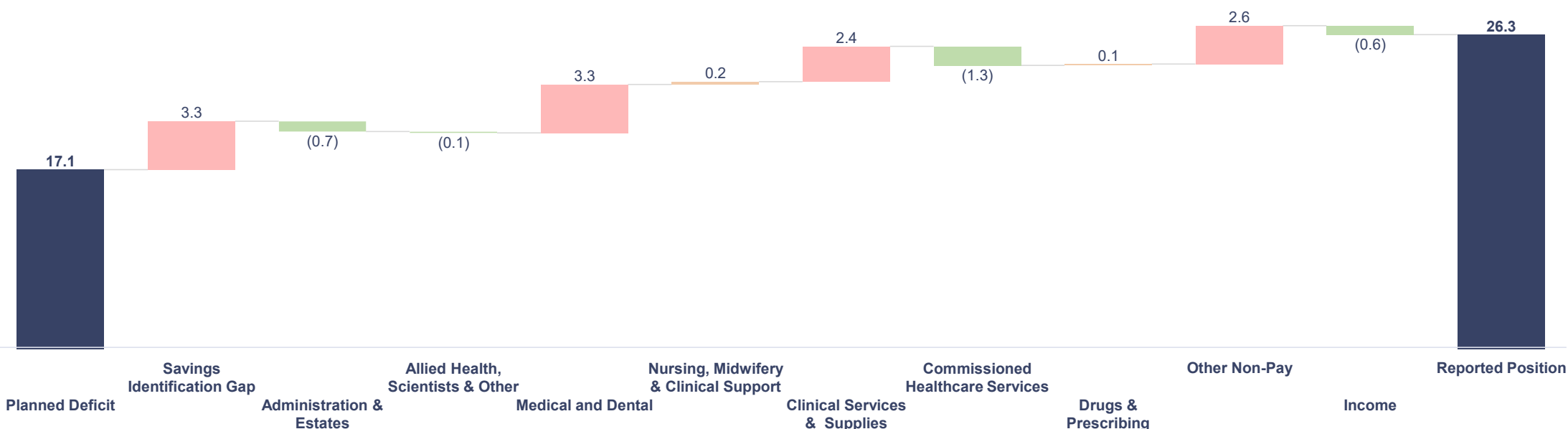
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Key Information

Savings Identification gap – Savings delivery of £14.5m achieved against a target of £17.8m leaving a savings delivery gap of £3.3m.

Medical & Dental – Community and Integrated Medicine locum and agency usage to cover sickness and vacancies mainly within Accident and Emergency and General Medicine £1.5m. Medical locum and agency usage including dual-running across Bronglais within Planned and Specialist Care, with continued use of premium rate card £1.2m.

Clinical Services & Supplies – Theatres, Endoscopy, Anaesthetics and Urology outsourcing within Planned and Specialist Care £1.1m, outsourcing of Radiology services within Operational Allied Health £0.8m and purchase of Cardiac and Diabetic consumables within Community and Integrated Medicine £0.5m.

Commissioned Healthcare Services – Primary Care Dental contract handbacks and General Medical Services underspend £(5.1)m, offset by increase in Continuing Healthcare packages within Mental Health and Community and Integrated Medicine £1.9m, Swansea Bay emergency activity increase £0.8m and Mental Health purchase of outsourced Psychiatric Intensive Care Unit Beds £0.6m.

Other Non-Pay – Digital initiative programmes contract expenditure £0.9m, Building and Estates maintenance expenditure £0.6m, alongside Building maintenance and repairs, patient security and transportation expenditure within Community and Integrated Medicine £0.5m.

Year to Date – Key Deviations to Plan



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Key Deviation		£'m	Key Information
Planned Deficit		17.1	As per plan submitted to Welsh Government
Savings Delivery Gap		3.3	Green and Amber savings plans delivering of £14.5m against savings target of £17.8m
Overspends	Medical Stabilisation improvements not delivered	3.3	Agency impact for vacancies, sickness cover and restricted duties (£1.5m), BGH W&C absence and restricted duties (£0.8m), Anaesthetist rate card extended (£0.4m), MH&LD 4 premium agency (£0.4m)
	Continuing Healthcare	2.5	Demand increases on CHC packages (£1.9m), Out of Area Mental Health placements (£0.6m)
	Theatre activity and increased outsourcing	2.0	Planned and Specialist Care activity above planned levels, alongside outsourcing of various services
	Clinical Services and Supplies	1.6	Radiology outsourced services £1.1m, insulin pumps, cardiac and diabetic consumable purchases £0.5m
	Primary Care Drugs Price and Concessions	1.0	Pharmacy and Medicines Management increase in drugs price, concessions and volume in line with May Prescribing Audit Report. Increase in price from £8.45 per item to £8.67 per item.
	Non Pay contracts	0.9	Digital initiative programmes contract expenditure
	Swansea Bay Long Term Agreement	0.8	Non-elective short stay episodes attracting a disproportionate flat rate tariff
	Building Maintenance and repairs	0.8	Estates and Facilities £0.6m and Ceredigion Integrated System £0.2m
	Band 2/3 banding assumption changes	0.3	Increase in national framework assumptions and additional establishment conversion
Underspends	Primary Care	(4.3)	Dental contracts handback £(2.6)m, General Medical Services supplementary services underspend £(1.7)m and delay in cluster project plans £(0.6)m, offset by Dental income underachievement £0.7m
	Income	(1.4)	Central Income £(0.3)m, Capital Design recharge income £(0.2)m and Velindre drugs rebates £(0.2)m
	Secondary Care Drugs	(0.9)	Annual Plan assumed price and volume increases not yet materialising
	Administrative vacancies	(0.7)	Across many services, mainly within Digital £(0.3)m, Public Health £(0.2)m and Primary Care £(0.2)m. Continued commitment to convert underspends to savings.
Reported Position		26.3	

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				17.1	
Chief Operating Officer Management	0.0	0.0	0.7	0.7	Voluntary Early Retirement Scheme payments.
Community and Integrated Medicine	1.9	0.0	4.6	6.5	Savings non delivery plus Medical locum agency £1.5m to cover sickness and vacancies and increase in Continuing Healthcare packages volume £1.2m, Cardiac and Diabetic consumables £0.5m.
Mental Health and Learning Disabilities	0.8	0.0	1.3	2.1	Savings non delivery plus Continuing Healthcare packages volume increase £0.6m and purchase of outsourced Psychiatric Intensive Care Unit beds £0.6m.
Operational Allied Health & Health Sciences	1.5	0.0	0.4	1.9	Savings non delivery plus Medical agency usage within Pathology to cover vacancies £0.4m, Radiology outsourcing of services £0.9m, offset by Radiology vacancies due to delayed recruitment £(0.9)m.
Planned and Specialist Care	1.7	0.0	2.2	3.9	Savings non delivery plus Medical locum agency usage, dual running and Medical rate card usage £1.2m. Outsourcing of activity within Ophthalmology, Theatres, Dermatology and Urology £1.0m.
Primary Care	(0.2)	0.0	(4.5)	(4.7)	Dental contracts handback £(2.6)m, General Medical Services supplementary services £(1.7)m, cluster project plans delay £(0.6)m
Executive Functions	(2.4)	0.0	1.2	(1.2)	Savings over delivery plus increase in drugs volume, concessions and price from £8.45 to £8.67 per item in line with May Prescribing Audit Report.
Sub Total	3.3	0.0	5.9	9.2	
Gross Position				26.3	

Year to Date – 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	(0.1)	(0.2)	No material deviation to plan
Digital	0.1	0.0	0.5	0.6	Increase in Digital initiative programmes contract expenditure
Estates and Facilities	0.8	0.0	0.5	1.3	Under delivery of savings, Building and Estates maintenance expenditure
Executive Allied Health	0.0	0.0	0.0	0.0	No material deviation to plan
Finance	(0.2)	0.0	0.0	(0.2)	No material deviation to plan
Health Board Wide	(1.7)	0.0	(0.7)	(2.4)	VAT recovery and drugs review saving, Central Income over achievement
LTA's	0.6	0.0	0.8	1.4	Under delivery of savings, Swansea Bay Emergency Activity increase
Medical	(0.1)	0.0	(0.1)	(0.2)	No material deviation to plan
Nursing	(0.1)	0.0	0.0	(0.1)	No material deviation to plan
Pharmacy and Medicines Management	0.8	0.0	1.0	1.8	Under delivery of savings, drugs price and concessions increases
Public Health	(0.5)	0.0	(0.3)	(0.8)	Pay underspends recognised as savings and lower vaccination uptake
Strategy and Planning	(0.2)	0.0	(0.3)	(0.5)	Income overachievement relating to Capital Design recharge income
Workforce	(1.8)	0.0	(0.1)	(1.9)	Overachievement of savings relating to pay vacancies
Sub Total	(2.4)	0.0	1.2	(1.2)	

Year to Date – Core Operational Variation



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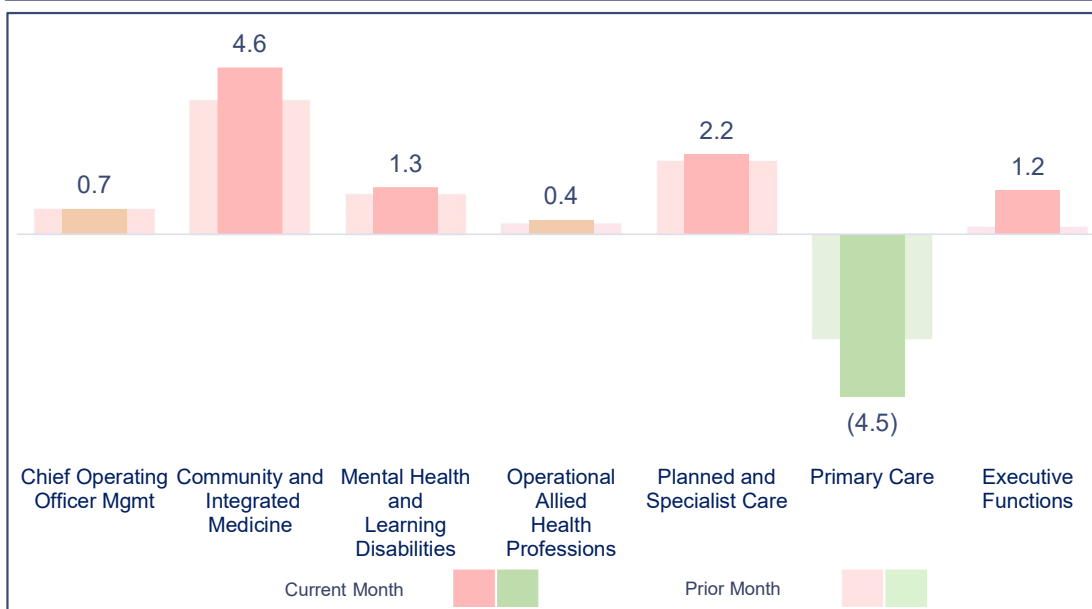
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Core Operational Variation (£'m)



Core Operational Variation (£'m)

Clinical Care Group	Pay	Non-Pay	Income	Total
Chief Operating Officer Management	0.7	0.0	0.0	0.7
Community and Integrated Medicine	2.1	2.6	(0.1)	4.6
Mental Health and Learning Disabilities	0.0	1.3	0.0	1.3
Operational Allied Health and Health Sciences	(0.2)	0.9	(0.3)	0.4
Planned and Specialist Care	1.0	1.4	(0.2)	2.2
Primary Care	(0.1)	(5.1)	0.7	(4.5)
Executive Functions	(0.7)	2.7	(0.8)	1.2
Total	2.8	3.8	(0.7)	5.9

Key Information

Community and Integrated Medicine Medical locum agency and Nursing bank usage to cover sickness and vacancies £2.0m, increase in Continuing Healthcare packages volume £1.2m.

Mental Health High-cost Continuing Healthcare packages volume increase £0.6m and purchase of outsourced Psychiatric Intensive Care Unit beds £0.6m.

Planned and Specialist Care Medical locum and agency usage including dual running and Medical rate card usage £1.2m. Outsourcing of activity within Ophthalmology, Theatres, Dermatology and Urology £2.0m, offset by Ophthalmology drugs underspend due to the service being outsourced as opposed to delivered in-house £(0.7)m.

Primary Care Dental contracts handback £(2.6)m, General Medical Services supplementary services underspend £(1.7)m and delay in cluster project plans £(0.6)m, offset by Dental income underachievement £0.7m.

Executive Functions Pharmacy and Medicines Management increase in drugs price, concessions and volume £1.0m, Digital initiative programmes contract expenditure £0.9m, Swansea Bay Emergency activity increase £0.8m, Estates maintenance contract uplift £0.6m, offset by income overachievement and administration pay vacancies across various service areas.

Year to Date – Savings Performance Breakdown



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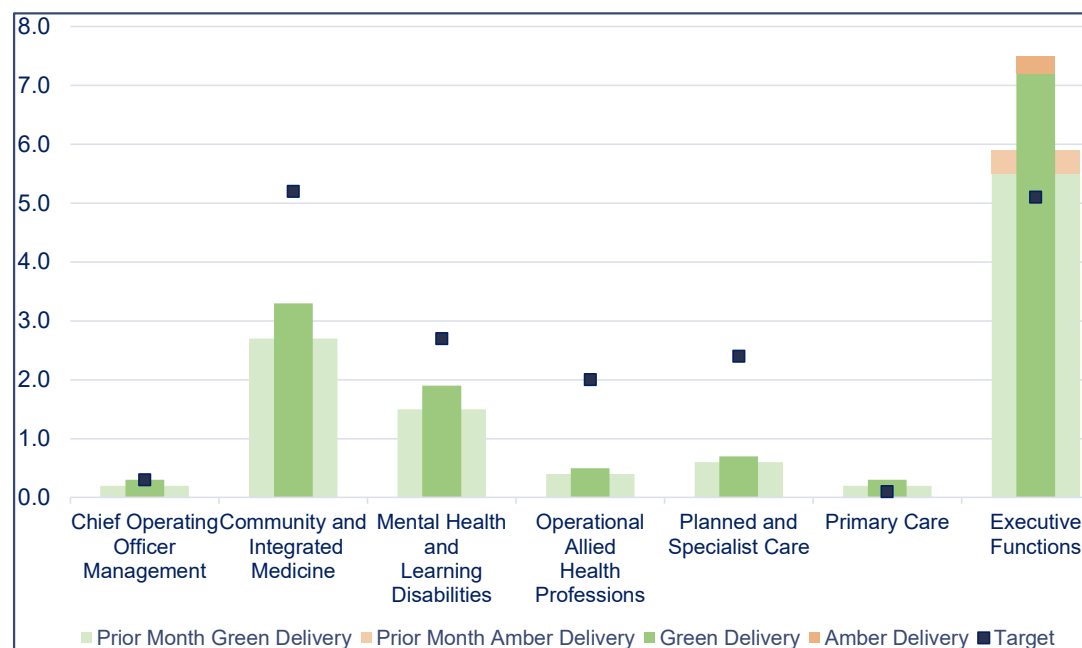
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Savings Delivery vs Target (£'m)



Savings Performance Breakdown (£'m)

Clinical Care Group	Target	Plan	Delivery	Gap
Chief Operating Officer Management	0.3	0.3	0.3	0.0
Community and Integrated Medicine	5.2	3.3	3.3	1.9
Mental Health and Learning Disabilities	2.7	1.9	1.9	0.8
Operational Allied Health and Health Sciences	2.0	0.5	0.5	1.5
Planned and Specialist Care	2.4	0.7	0.7	1.7
Primary Care	0.1	0.3	0.3	(0.2)
Executive Functions	5.1	7.5	7.5	(2.4)
Grand Total	17.8	14.5	14.5	3.3

Key Information

Overall savings identification and delivery of £14.5m, resulting in a £3.3m savings under-identification gap against £17.8m target, with variations across Clinical Care Groups.

Under-identification within Community and Integrated Medicine £1.9m, Planned and Specialist Care £1.7m, Operational Allied Health £1.5m, Mental Health £0.8m, offset by over-identification within Executive Functions £(2.4)m. Executive Functions includes over-identification within Workforce £(1.7)m, Health Board Wide £(1.7)m and Public Health £(0.5)m, offset by under-identification within Estates and Facilities £0.8m, Pharmacy and Medicines Management £0.8m and Long Term Agreements £0.6m.

The identified savings are mainly non-recurrent £12.2m, with only £2.3m being identified as recurrent savings.

Capital Performance



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Capital

Total Capital Performance

£38.0m



Annual Plan £38.0m

All Wales Capital

£29.9m



Annual Plan £29.9m

Discretionary Capital

£8.1m



Annual Plan £8.1m

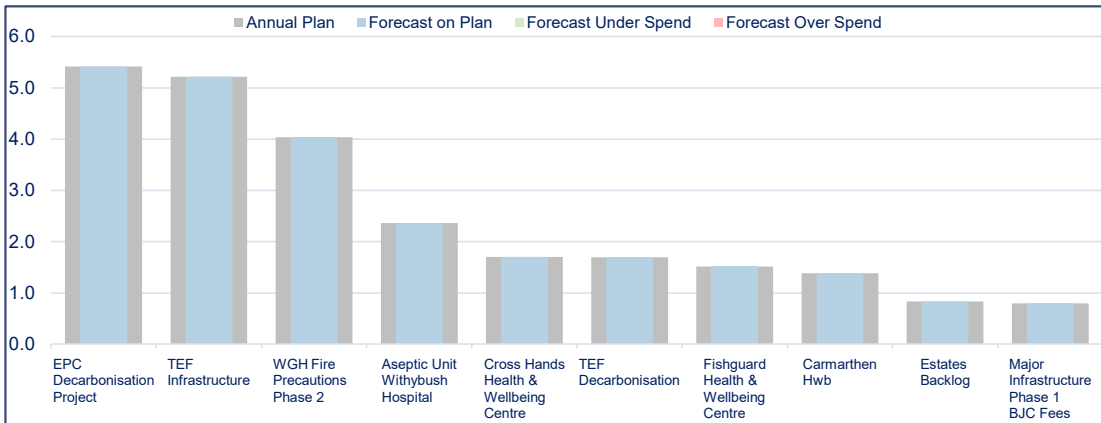
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£0.0m

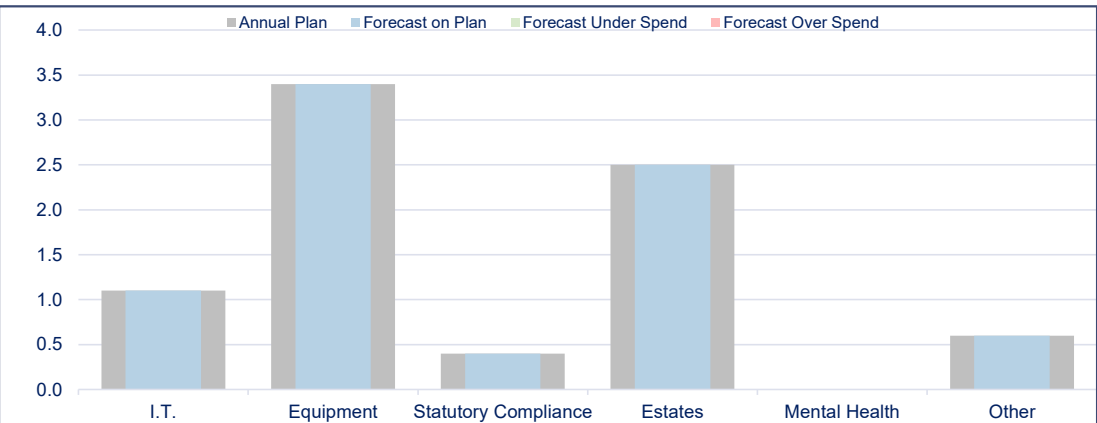


Capital Resource Limit £0.0m

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. A number of individual capital schemes have medium risks flagged against them; however, these are not expected currently to present a risk to overall delivery of the capital programme.

The Capital Programme is comprised of £29.9m All Wales Capital Programme funding and £8.1m discretionary funds. The discretionary value represents the net after adjustments to the gross allocation of £11.2m for contributions to Targeted Estates Fund, the ongoing payback for Picton Terrace, and adjustments relating to prior year outturn.

Trend Analysis – Non-Pay and Income



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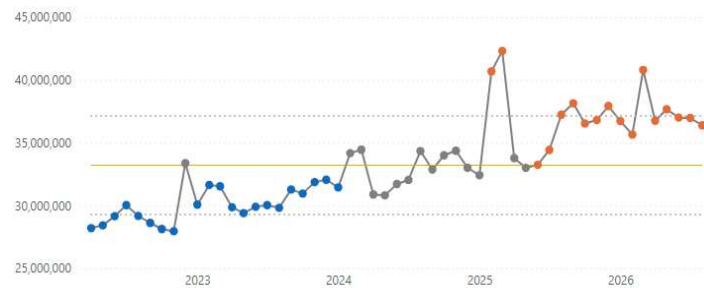
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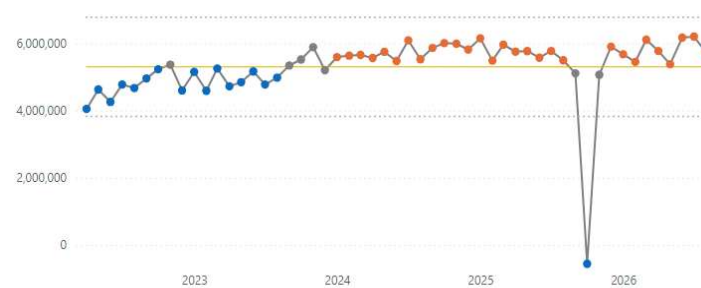
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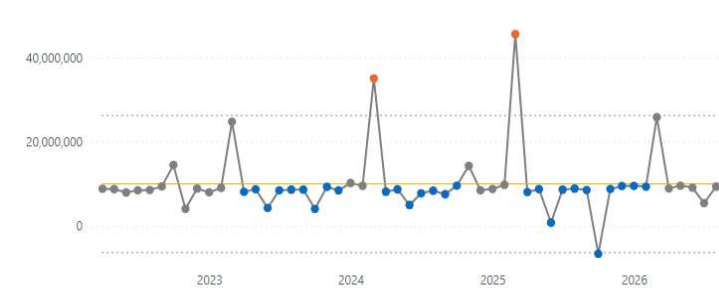
Commissioned Healthcare Services (£)



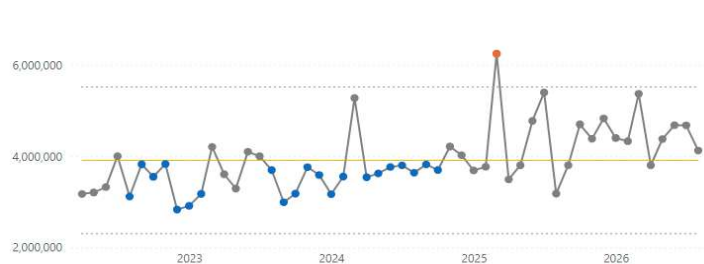
Secondary Care Drugs (£)



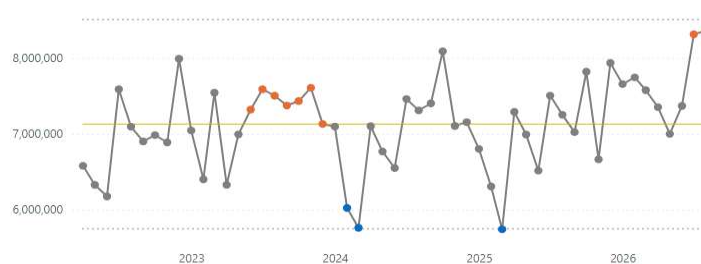
Other Non-Pay (£)



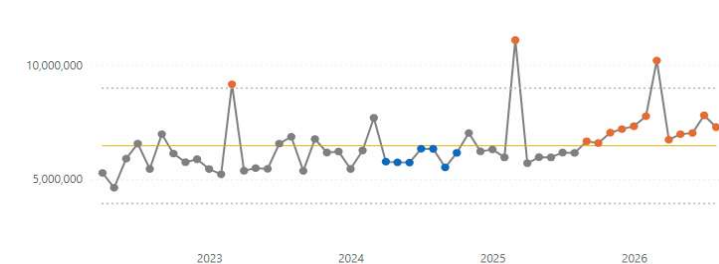
Clinical Services and Supplies (£)



Primary Care Prescribing (£)



Income (£)



Key Information

Secondary Care Drugs – Reduction in expenditure relating to Community and Integrated Medicine General Medicine and Planned and Specialist Care Oncology drugs.

Other Non Pay – Increase in expenditure from prior month due to Capital Depreciation and Impairments expenditure adjustments in prior month.

Clinical Services and Supplies - Reduction in theatre consumables reflects lower elective activity due to Anaesthetist shortages and the prioritisation of cancer pathway patients.

Primary Care Prescribing – Increase in drugs price, concessions and volume in line with May Prescribing Audit Report. Increase in price from £8.45 per item to £8.67 per item.

Income – Reduction in income relating to Digital Health and Care Wales year to date income for Digital Prioritisation Improvement Fund programmes being recognised in prior month.

Trend Analysis – Pay Agenda for Change



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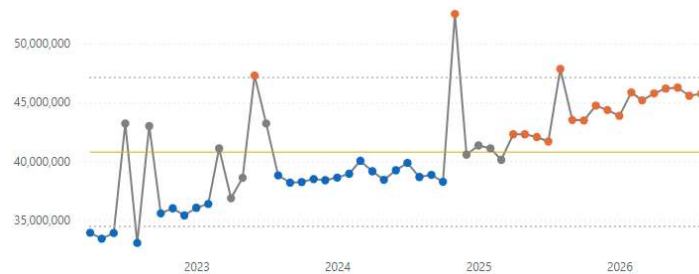
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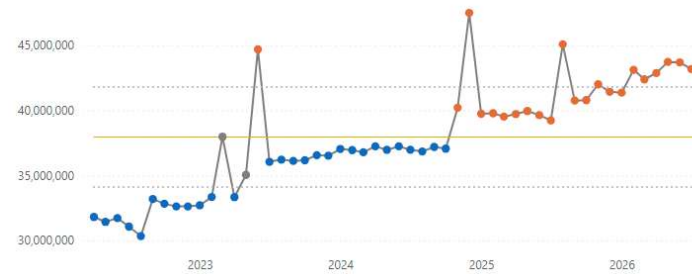
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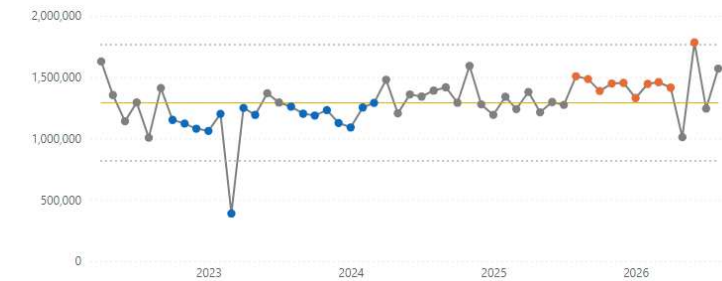
Total (£)



Substantive (£)



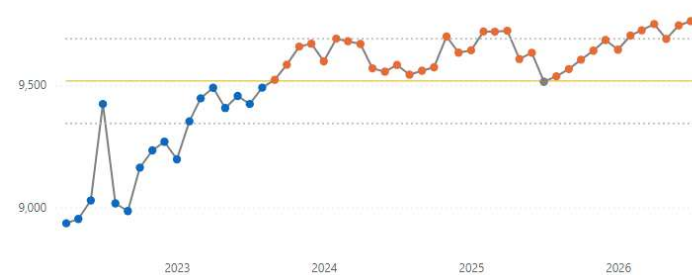
Bank (£)



Total (WTE)



Substantive (WTE)



Bank (WTE)



Key Information

Bank WTE and £ – Increase of 11 Bank WTE largely relating to Nursing and Healthcare Support Workers within Community and Integrated Medicine and Planned and Specialist Care.

Substantive WTE – Decrease of 11 WTE from the prior month. Workforce levels are 130 WTE higher than the same period last year, with the increase largely relating to Nursing and Midwifery. Despite this growth, staffing pressures remain due to ongoing vacancies and sickness absence.

Trend Analysis – Pay Agenda for Change



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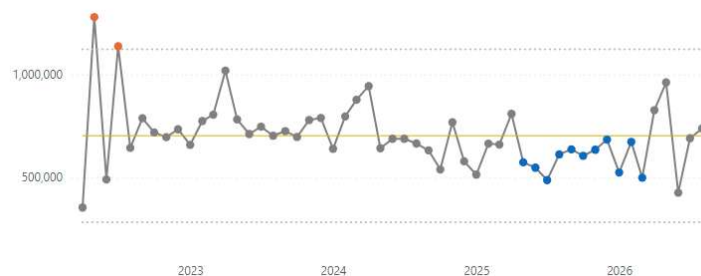
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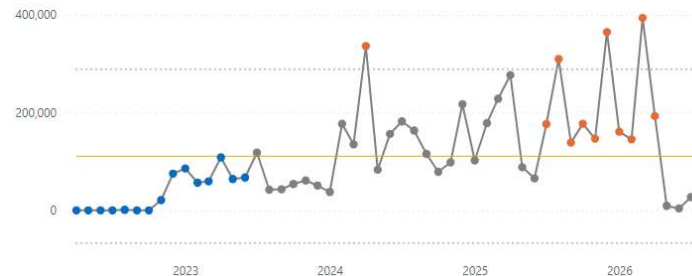
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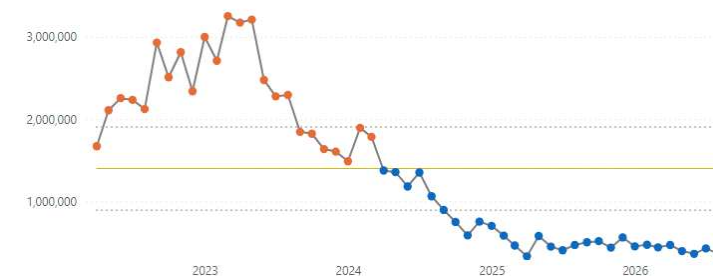
Overtime (£)



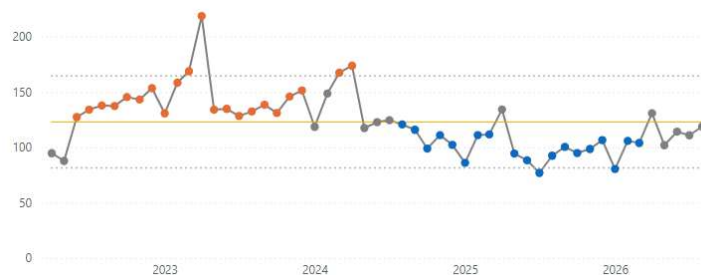
WLI (£)



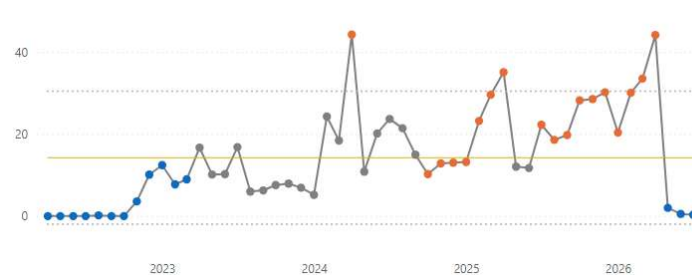
Agency (£)



Overtime (WTE)



WLI (WTE)



Agency (WTE)



Key Information

Overtime £ and WTE – Increase in Overtime expenditure largely within Community and Integrated Medicine and Planned and Specialist Care due to vacancies and high sickness level. Overall, overtime usage is considerably higher in 2026/27 compared to the average of 2025/26 to cover sickness gaps, as highlighted within the Whole Time Equivalents trend.

Waiting List Initiative £ and WTE – Reduction from prior year due to significantly less Waiting List Initiative activity being undertaken within Planned and Specialist Care this year.

Trend Analysis – Pay Medical and Dental



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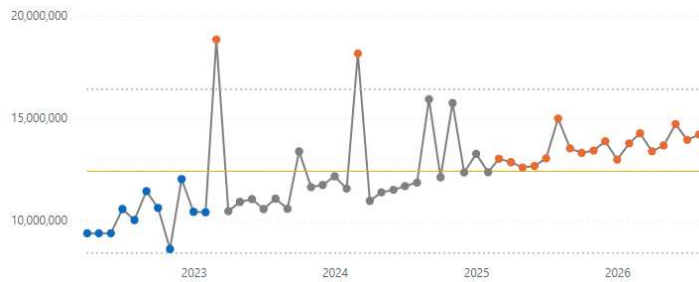
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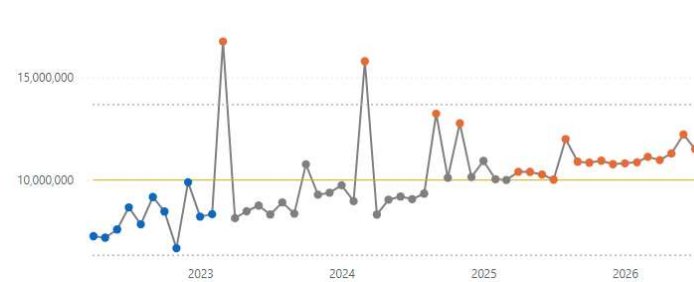
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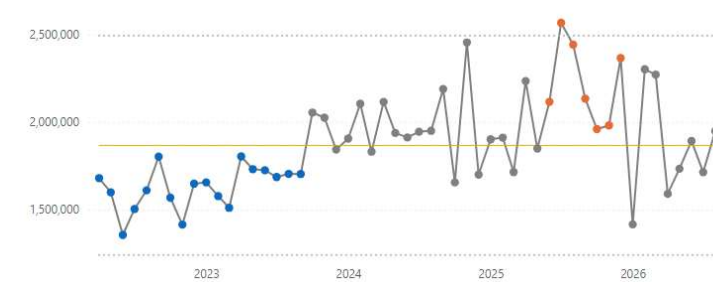
Total (£)



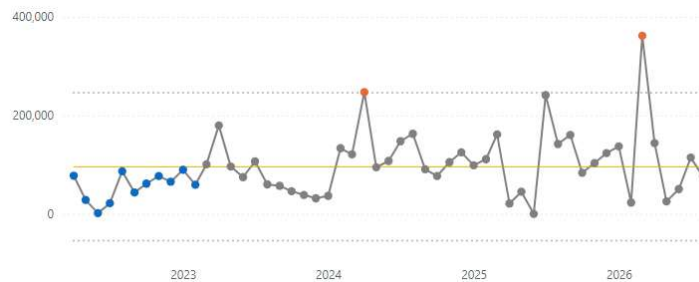
Substantive (£)



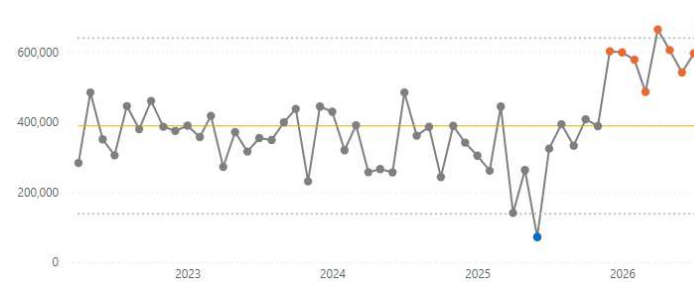
Additional Hours (£)



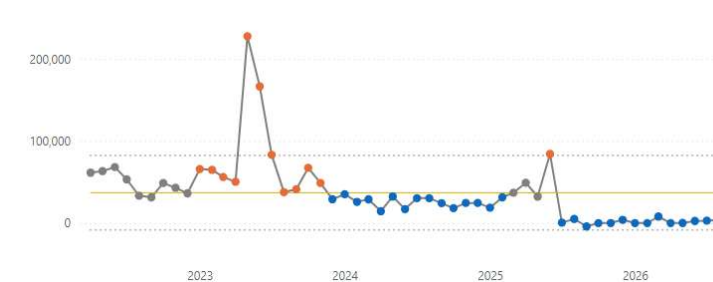
WLI (£)



On Contract Agency Premium (£)



Off Contract Agency Premium (£)



Key Information

Total £ – Increase in expenditure within Community and Integrated Medicine and Planned and Specialist Care due to increased agency and locum usage to cover sickness and vacancies.

Additional Hours £ – Increase in Additional Duty Hours from prior month largely within Planned and Specialist Care General Surgery and Community and Integrated Medicine Pembrokeshire Accident and Emergency and General Medicine service.

Waiting List Initiative £ – Reduction in Waiting List Initiative from prior month within Planned and Specialist Care, largely relating to Bowel Screening and Elective Recovery.

On Contract Agency Premium £ – Increase in agency expenditure from prior month largely within Community and Integrated Medicine Pembrokeshire General Medicine.

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%	2,641	2,315	(289)	281	38	33
Community and Integrated Medicine	103.2%	1,896	1,649	(217)	207	35	27
Carmarthenshire Integrated System	103.5%	1,148	1,008	(101)	126	12	38
Ceredigion Integrated System	107.5%	325	265	(58)	46	13	1
Pembrokeshire Integrated System	99.4%	423	376	(58)	35	10	(12)
Mental Health and Learning Disabilities	104.7%	287	236	(38)	50	1	13
Planned and Specialist Care	96.6%	458	430	(34)	24	2	(7)
Cancer and Scheduled Care	94.6%	162	149	(13)	9	2	(1)
Children, Women and Family Health	97.6%	296	281	(21)	15	-	(6)
Grand Total	102.2%	2,641	2,315	(289)	281	38	33

All Other Staffing Levels (WTE) Excluding Medical and Ward Nursing & HCSWs	Total Fill Rate	Total WTE	Substantive WTE	Substantive WTE Vacancy	Variable WTE	Agency (Premium) WTE	Total Over/(Under) Staffed
Chief Executive	90.6%	90	89	(7)	-	-	(6)
Chief Operating Officer	93.7%	5,297	5,154	(482)	136	2	(342)
Chief Operating Officer Management	81.6%	129	123	(5)	6	-	-
Community and Integrated Medicine	97.0%	1,422	1,379	(161)	40	1	(119)
Mental Health and Learning Disabilities	90.3%	927	911	(89)	15	-	(73)
Operational Allied Health and Health Sciences	97.2%	1,124	1,094	(80)	30	-	(50)
Planned and Specialist Care	95.0%	1,495	1,454	(109)	38	1	(69)
Primary Care	87.2%	200	193	(38)	7	-	(31)
Executive Director of Allied Health Professions and Health Sciences	95.2%	904	840	(81)	64	-	(16)
Executive Director of Finance	89.9%	435	428	(43)	7	-	(36)
Executive Director of Nursing, Quality and Patient Experience	90.9%	178	177	(14)	-	-	(13)
Executive Director of Public Health	87.6%	137	135	(44)	1	-	(43)
Executive Director of Strategy and Planning	93.9%	48	48	(2)	-	-	(2)
Executive Director of Workforce and Organisational Development	74.6%	222	220	(77)	2	-	(74)
Executive Medical Director	87.0%	322	319	(38)	2	-	(35)
Grand Total	92.7%	7,633	7,410	(788)	212	2	(567)

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	7							(22)	(0)	(15)
Chief Operating Officer	(78)	(12)	919	(566)	261	(935)	(121)	203	(25)	(353)
Chief Operating Officer Management	(27)	38	(18)	5	(27)	(3)		(35)	12	(55)
Community and Integrated Medicine	(19)	13	500	(105)	69	320	33	132	(72)	872
Mental Health and Learning Disabilities	(10)	2	86	(94)	(3)	121	9	24	(0)	135
Operational Allied Health and Health Sciences	(20)	(108)	16	41	189	32	(43)	87	(56)	138
Planned and Specialist Care	57	32	366	(381)	63	163	(124)	32	(53)	155
Primary Care	(58)	10	(30)	(33)	(30)	(1,569)	4	(36)	144	(1,598)
Executive Director of Allied Health Professions and Health Sciences	(46)	(19)		(6)	7	1	0	36	22	(6)
Estates and Facilities	(59)			(6)	7		0	36	22	0
Executive Allied Health Professions and Health Sciences	12	(19)				1		0		(6)
Executive Director of Finance	(8)	(0)	1	15		(5)		203	(9)	196
Digital	(33)	(0)	1	15		6		209	(7)	190
Finance	24					(11)		(5)	(1)	6
Executive Director of Nursing, Quality and Patient Experience	(35)	10		(7)	0	29		29	(26)	(1)
Executive Director of Public Health	(82)	(8)	(8)	(43)	3	1	(7)	21	0	(122)
Executive Director of Strategy and Planning	(38)	(0)	9			(18)	0	(35)	(49)	(132)
LTAs with other NHS Providers	2					(18)	0	(0)		(16)
Strategy and Planning	(40)	(0)	9			(0)		(35)	(49)	(116)
Executive Director of Workforce and Organisational Development	(10)	(3)		2	0	66	(4)	27	8	86
Executive Medical Director	(20)	61	12	16	(13)	13	1,000	9	(16)	1,061
Medical	(15)	7	12	19	1		(0)	(29)	(20)	(25)
Pharmacy and Medicines Management	(5)	54		(3)	(14)	13	1,000	38	4	1,087
Health Board Wide	(2)	2	(27)	(4)	4	12	(54)	(46)	50	(66)
Planned Deficit								3,417		3,417
Savings Identification								569		569
Grand Total	(313)	30	906	(594)	261	(837)	814	4,411	(45)	4,634

Year to Date – 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	(15)							(43)	(1)	(59)
Chief Operating Officer	(109)	(171)	3,528	194	2,353	(1,943)	(567)	1,213	141	4,639
Chief Operating Officer Management	140	206	(31)	362	44	2	0	(85)	(6)	631
Community and Integrated Medicine	(56)	160	1,523	435	537	1,240	333	543	(100)	4,615
Mental Health and Learning Disabilities	(4)	(77)	371	(295)	5	1,241	(35)	60	19	1,284
Operational Allied Health and Health Sciences	8	(687)	300	203	797	(53)	(266)	390	(260)	432
Planned and Specialist Care	36	116	1,231	(366)	1,098	694	(660)	281	(255)	2,175
Primary Care	(232)	112	133	(145)	(128)	(5,067)	60	24	743	(4,499)
Executive Director of Allied Health Professions and Health Sciences	10	(34)		(6)	24	3	4	558	12	570
Estates and Facilities	(53)			(6)	24		4	557	12	539
Executive Allied Health Professions and Health Sciences	63	(34)				3		0		32
Executive Director of Finance	(264)	(2)	2	62	0	(199)	0	890	(33)	456
Digital	(254)	(2)	2	62	0	(184)		892	(34)	483
Finance	(11)					(15)	0	(2)	1	(27)
Executive Director of Nursing, Quality and Patient Experience	(75)	(1)		(10)	(0)	56		63	11	44
Executive Director of Public Health	(152)	(15)	(18)	(93)	26	(38)	(214)	156	5	(343)
Executive Director of Strategy and Planning	7	(0)	45			802	0	(147)	(213)	493
LTAs with other NHS Providers	13					804	0	(2)		814
Strategy and Planning	(5)	(0)	45			(2)		(145)	(213)	(321)
Executive Director of Workforce and Organisational Development	(65)	(7)		1	8	53	(14)	(92)	(7)	(123)
Executive Medical Director	(45)	131	36	91	(62)	33	960	(24)	(189)	931
Medical	(38)	4	34	87	18		0	(182)	(23)	(99)
Pharmacy and Medicines Management	(7)	127	2	5	(80)	33	960	157	(165)	1,030
Health Board Wide	(4)	(3)	(258)	5	(3)	(50)	(115)	38	(363)	(753)
Planned Deficit								17,083		17,083
Savings Identification								3,325		3,325
Grand Total	(712)	(103)	3,335	244	2,345	(1,282)	54	23,018	(636)	26,263

End of Year – 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	(125)					1		(11)	(3)	(138)
Chief Operating Officer	(880)	(770)	7,908	(2,392)	5,711	(2,478)	(1,696)	2,462	792	8,658
Chief Operating Officer Management	65	393	(156)	412	288	5	0	(287)	2	721
Community and Integrated Medicine	(251)	339	4,419	574	1,183	2,963	607	1,027	(191)	10,670
Mental Health and Learning Disabilities	(51)	(597)	952	(1,158)	14	2,324	(43)	132	40	1,612
Operational Allied Health and Health Sciences	(14)	(1,350)	547	169	2,230	(161)	(427)	1,059	(531)	1,522
Planned and Specialist Care	28	232	1,908	(2,043)	2,303	2,138	(1,744)	636	(344)	3,115
Primary Care	(656)	214	239	(347)	(307)	(9,747)	(89)	(104)	1,816	(8,982)
Executive Director of Allied Health Professions and Health Sciences	(163)	(170)		(17)	13	8	5	1,195	2	873
Estates and Facilities	(313)			(17)	13		5	1,194	2	884
Executive Allied Health Professions and Health Sciences	150	(170)				8		1		(12)
Executive Director of Finance	(211)	(4)	8	166	0	(35)	0	(24)	(31)	(132)
Digital	(150)	(4)	8	166	0	1		(0)	(34)	(13)
Finance	(61)					(36)	0	(24)	3	(118)
Executive Director of Nursing, Quality and Patient Experience	35	(79)		(61)	(1)	134		152	16	197
Executive Director of Public Health	(727)	(71)	(73)	(388)	62	(31)	(444)	264	13	(1,396)
Executive Director of Strategy and Planning	(108)	(0)	111			1,117	0	26	(196)	951
LTAs with other NHS Providers	28					1,122	0	(6)		1,145
Strategy and Planning	(136)	(0)	111			(5)		32	(196)	(194)
Executive Director of Workforce and Organisational Development	(1,625)	(30)	0	22	13	127	(34)	(125)	(47)	(1,698)
Executive Medical Director	(158)	(85)	170	213	(66)	76	2,026	176	(281)	2,071
Medical	(117)	47	168	219	38		0	(339)	(92)	(75)
Pharmacy and Medicines Management	(41)	(132)	2	(6)	(103)	76	2,026	515	(189)	2,146
Health Board Wide	(2,171)	(1,135)	(4,155)	(3,842)	(2)	0	(557)	(8,895)	(913)	(21,670)
Planned Deficit								41,000		41,000
Savings Identification								12,285		12,285
Grand Total	(6,133)	(2,344)	3,968	(6,298)	5,730	(1,081)	(700)	48,505	(647)	41,000

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	(125)					1		(11)	(3)	(138)
Chief Operating Officer	(880)	(770)	7,908	(2,392)	5,711	(2,478)	(1,696)	2,462	792	8,658
Chief Operating Officer Management	65	393	(156)	412	288	5	0	(287)	2	721
Community and Integrated Medicine	(251)	339	4,419	574	1,183	2,963	607	1,027	(191)	10,670
Mental Health and Learning Disabilities	(51)	(597)	952	(1,158)	14	2,324	(43)	132	40	1,612
Operational Allied Health and Health Sciences	(14)	(1,350)	547	169	2,230	(161)	(427)	1,059	(531)	1,522
Planned and Specialist Care	28	232	1,908	(2,043)	2,303	2,138	(1,744)	636	(344)	3,115
Primary Care	(656)	214	239	(347)	(307)	(9,747)	(89)	(104)	1,816	(8,982)
Executive Director of Allied Health Professions and Health Sciences	(163)	(170)		(17)	13	8	5	1,195	2	873
Estates and Facilities	(313)			(17)	13		5	1,194	2	884
Executive Allied Health Professions and Health Sciences	150	(170)				8		1		(12)
Executive Director of Finance	(211)	(4)	8	166	0	(35)	0	(24)	(31)	(132)
Digital	(150)	(4)	8	166	0	1		(0)	(34)	(13)
Finance	(61)					(36)	0	(24)	3	(118)
Executive Director of Nursing, Quality and Patient Experience	35	(79)		(61)	(1)	134		152	16	197
Executive Director of Public Health	(727)	(71)	(73)	(388)	62	(31)	(444)	264	13	(1,396)
Executive Director of Strategy and Planning	(108)	(0)	111			1,117	0	26	(196)	951
LTAs with other NHS Providers	28					1,122	0	(6)		1,145
Strategy and Planning	(136)	(0)	111			(5)		32	(196)	(194)
Executive Director of Workforce and Organisational Development	(1,625)	(30)	0	22	13	127	(34)	(125)	(47)	(1,698)
Executive Medical Director	(158)	(85)	170	213	(66)	76	2,026	176	(281)	2,071
Medical	(117)	47	168	219	38		0	(339)	(92)	(75)
Pharmacy and Medicines Management	(41)	(132)	2	(6)	(103)	76	2,026	515	(189)	2,146
Health Board Wide	(6)	(12)	(465)	(43)	(2)	0	(557)	177	(913)	(1,819)
Planned Deficit								41,000		41,000
Savings Identification								12,285		12,285
Grand Total	(3,968)	(1,221)	7,659	(2,499)	5,730	(1,081)	(700)	57,577	(647)	60,850

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)	166	0	166	166	(191)	4.9%	0	(25)	0.0%
Chief Operating Officer	30,675	15,551	1,339	14,211	15,551	15,124	2.4%	1,430	29,245	0.2%
Chief Operating Officer Management	749	436	0	436	436	313	3.4%	0	749	0.0%
Community and Integrated Medicine	12,524	8,012	974	7,038	8,012	4,512	3.3%	1,057	11,467	0.4%
Mental Health and Learning Disabilities	6,441	3,045	30	3,015	3,045	3,396	2.9%	30	6,411	0.0%
Operational Allied Health and Health Sciences	4,848	1,680	22	1,658	1,680	3,169	2.1%	29	4,820	0.0%
Planned and Specialist Care	5,890	2,122	314	1,808	2,122	3,768	1.0%	314	5,576	0.1%
Primary Care	223	256	0	256	256	(33)	2.3%	0	223	0.0%
Executive Director Of Allied Health Professions and Health Sciences	2,715	692	509	184	692	2,023	1.4%	535	2,180	1.1%
Estates and Facilities	2,705	648	509	140	648	2,057	1.3%	535	2,170	1.1%
Executive Allied Health Professions and Health Sciences	10	44	0	44	44	(34)	19.2%	0	10	0.0%
Executive Director Of Finance	238	672	414	257	672	(433)	2.9%	467	(229)	2.0%
Digital	373	315	295	20	315	58	1.8%	348	24	2.0%
Finance	(134)	357	119	238	357	(491)	6.0%	119	(253)	2.0%
Executive Director Of Nursing, Quality and Patient Experience	0	130	0	130	130	(130)	1.4%	0	0	0.0%
Executive Director Of Public Health	131	834	0	834	834	(703)	12.7%	0	131	0.0%
Executive Director Of Strategy and Planning	2,035	1,114	74	1,040	1,114	921	1.8%	74	1,961	0.1%
LTAs With Other NHS Providers	1,961	655	0	655	655	1,306	1.2%	0	1,961	0.0%
Strategy and Planning	74	459	74	385	459	(385)	12.3%	74	0	2.0%
Executive Director Of Workforce and Organisational Development	(481)	3,039	302	2,737	3,039	(3,520)	20.0%	302	(783)	2.0%
Executive Medical Director	5,952	3,429	2,520	909	3,429	2,523	3.4%	2,520	3,432	2.5%
Medical	72	202	75	127	202	(130)	4.5%	75	(3)	1.7%
Pharmacy and Medicines Management	5,880	3,228	2,445	783	3,228	2,652	3.4%	2,445	3,435	2.6%
Health Board Wide	1,560	4,889	1,529	3,360	4,889	(3,329)	13.5%	1,546	14	4.3%
Grand Total	42,800	30,515	6,687	23,828	30,515	12,285	3.2%	6,875	35,925	0.7%



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Internal escalation update

September 2026



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The table below summarises key points to highlight from the latest escalation scoring:

Areas to highlight	Points to highlight	3A
Level 4	Level 4 enacted: In June, two clinical care groups (CCG) were escalated to level 4 (no assurance and insufficient actions or engagement) within the Finance domain i.e. Community & Integrated Medicine and Planned & Specialist Care. Both CCGs are forecasting large end of year overspends and are unable to meet their savings requirements for this financial year. Both CCGs remained in level 4 for August 2026.	Alert
Community and Integrated Medicine and Planned and Specialist Care	Both CCGs remain areas with the highest levels of concern: - Community & Integrated Medicine have 6 out of 7 domains in level 3 or above - Planned & Specialist Care have 5 out of 7 domains in level 3 or above Grip and control needs to be demonstrated for: incidents/complaints management, risk management, audit & inspection recommendations, budget and savings delivery, support for inpatient smokers, business continuity planning, PADR compliance, pay progression, ER cases, infection prevention control, national performance measures and fragile services.	Alert
Lack of improvement	No functions have been de-escalated for any domains this month. No functions have been de-escalated for the Finance, Performance or Planning & Fragile services domains in this financial year with little indication that this will change in the next 6 months.	Alert
Workforce domain	New threshold criteria have been introduced for the Workforce domain where functions are assigned an average score across all workforce measures. This has resulted in 4 functions being escalated in the Workforce domain, primarily due to improvements needed in PADR compliance.	For information Advise
Finance recovery meetings	Finance recovery meetings have been arranged in September for the following functions, which will focus on forecast, core budget and savings, with expectations around new savings or run rate improvements: - Community & Integrated Medicine - Estates and Facilities - Long Term Agreements - Mental Health & Learning Disabilities - Operational Allied Health & Health Sciences - Pharmacy	For information

Background and overview



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The [Our Improving Together Framework](#) was approved by Board in March 2025. It sets out our approach to embedding performance improvement through our organisation. The framework's ultimate aim is to improve outcomes for our patients, staff and population.

Improvements are focused around seven key domains:
(1) quality & safety,
(2) governance,
(3) workforce,
(4) finance,
(5) strategy, planning & fragile services,
(6) population health (introduced September 2025) and
(7) performance.

Health board escalation level overview as at 31st August 2026

1	Reasonable assurance	3	No assurance
2	Limited assurance	4	No assurance and insufficient actions/engagement

	Function	Quality & safety	Governance	Workforce	Finance	Strategy, planning and fragile services	Population Health	Performance
Clinical Care Groups	Community and Integrated Medicine	3	3	3	4	3	2	3
	Chief Operating Officer Management	1	1	2	2	1	1	n/a
	Mental Health and Learning Disabilities	3	1	2	3	3	3	3
	Planned and Specialist Care	3	2	3	4	3	2	3
	Primary Care	2	1	2	1	2	2	3
	Operational Allied Health and Health Sciences	2	1	2	3	3	1	3
Executive Functions	Estates and Facilities	2	1	2	3	1	2	3
	Executive Director of Finance	1	2	1	1	1	2	n/a
	Medical	1	1	2	1	1	2	n/a
	Pharmacy and Medicines Management	1	1	2	2	1	2	n/a
	Executive Director of Nursing, Quality and Patient Experience	1	2	1	1	1	2	3
	Executive Director of Public Health	1	1	3	1	1	1	2
	Executive Director of Strategy and Planning	1	1	1	1	1	3	n/a
	Long Term Agreements (LTAs)	n/a	n/a	n/a	3	n/a	n/a	n/a
	Executive Director of Workforce and Organisational Development	1	1	1	1	1	1	n/a
	Governance and Communication	1	1	1	1	1	2	n/a

Domain overview: Quality & Safety



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Escalation levels by function & month

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Domain overview: Workforce



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Escalation levels by function & month

Function	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26
Community & Integrated Medicine	2	2	2	2	2	2	2	2	2	2	2	3	3
Chief Operating Officer Management	2	2	1	1	2	2	2	2	2	2	2	2	2
Mental Health & Learning Disabilities	2	2	2	2	2	1	1	1	2	2	2	2	2
Planned & Specialist Care	2	2	2	2	2	2	2	2	2	3	3	3	3
Primary Care	n/a	n/a	n/a	n/a	1	1	1	1	1	2	2	2	2
Operational Allied Health & Health Sciences	2	2	2	2	2	2	2	2	2	2	2	2	2
Estates & Facilities	3	2	2	2	2	2	2	2	2	2	2	2	3
Executive Director of Finance	1	1	1	1	1	1	1	1	1	1	1	1	1
Executive Medical Director	2	1	2	2	2	2	2	2	1	1	1	2	2
Pharmacy & Medicines Management	n/a	n/a	n/a	n/a	2	2	2	1	1	2	2	2	2
Executive Director of Nursing, Quality & PE	2	2	2	2	2	2	2	2	2	2	2	1	2
Executive Director of Public Health	2	2	2	2	2	2	2	2	2	2	3	3	3
Executive Director of Strategy & Planning	1	1	1	1	1	1	1	1	1	1	1	1	2
Long Term Agreements (LTAs)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Executive Director of Workforce & OD	1	1	1	1	1	1	1	1	1	1	1	1	1
Governance & Communication	1	1	1	1	1	2	2	2	2	2	1	1	2

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Escalation levels by function & month

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Domain overview: Strategy, Planning & Fragile Services



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Escalation levels by function & month

Function	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May-26	Jun-26	Jul 26	Aug 26
Community & Integrated Medicine	3	3	3	3	3	3	n/a	3	3	3	3	3	3
Chief Operating Officer Management	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Mental Health & Learning Disabilities	2	2	2	2	2	3	n/a	3	3	3	3	3	3
Planned & Specialist Care	3	3	3	3	3	3	n/a	3	3	3	3	3	3
Primary Care	n/a	n/a	n/a	n/a	2	2	n/a	2	2	2	2	2	2
Operational Allied Health & Health Sciences	3	2	3	3	3	3	n/a	3	3	3	3	3	3
Estates & Facilities	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Executive Director of Finance	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Executive Medical Director	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Pharmacy & Medicines Management	n/a	n/a	n/a	n/a	2	2	n/a	1	1	1	1	1	1
Executive Director of Nursing, Quality & PE	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Executive Director of Public Health	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Executive Director of Strategy & Planning	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Long Term Agreements (LTAs)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	n/a	n/a	n/a	n/a	n/a
Executive Director of Workforce & OD	1	1	1	1	1	1	n/a	1	1	1	1	1	1
Governance & Communication	1	1	1	1	1	1	n/a	1	1	1	1	1	1

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Escalation levels by function & month

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Planned and Specialist Care: escalation levels by month and domain

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Escalation criteria



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Quality & Safety	Governance	Workforce	Finance	Strategy, Planning and Fragile Services	Population Health	Performance and Outcomes
Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Incidents 2. Complaints 3. Duty of Candour 4. HIW/CIW 5. Deteriorating patients 6. Patient experience	Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Risks 2. Audits/ inspections 3. WHCs/ Ministerial Directions 4. Governance arrangements 5. Policies	Assurance the directorate is managing the following appropriately, in terms of the scale, significance, timeliness and quality of response: 1. Employee relations cases 2. Sickness 3. PADRs 4. Turnover 5. Mandatory training 6. Overdue pay progressions 7. Rosters & job plans (includes agency use)	Assurance the directorate will: 1. Operate within budget or deliver a recovery plan which will return to budget in year. 2. Identify and delivery recurrent savings to the level required.	Assurance the directorate will manage the risk of a service failure occurring within the next six months through robust mitigating plans. Has a triangulated plan to operate services effectively for the year.	Determines if opportunities are being taken to encourage patients to embrace healthier lifestyles or to ensure that our population is resilient to future challenges.	Assurance the directorate will meet improvement trajectories to achieve target performance.



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Integrated Performance Assurance Report (IPAR) Overview

As at 31st August 2026

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



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Appendix A

[Summary Metric by Type](#)

The key metric summary table below has been revised to reflect changes to the 2026/27 performance framework, ministerial priorities and other local key performance metrics and is broken down by metric type in **Appendix A**.

Additional data, details of key issues and actions being taken to address can be found in the supporting document *IPAR overview*.

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

Metric	Target	Period	Actual	Variation	Assurance	Trajectory	3A
% sickness absence rate of staff	6.20%	Aug 2026	6.83%	n/a	n/a	n/a	Alert
Number of Pathways of Care delayed discharges	n/a	Aug 2026	250	● Usual	n/a	n/a	Alert
Total days delayed for Pathways of Care delayed discharges	n/a	Aug 2026	8,588	● Improving	n/a	n/a	Alert
Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	0	Aug 2026	4,165	● Concerning	■ Missing target	n/a	Alert
Pts waiting 8 wks+ for specified diagnostic	0	Aug 2026	7,565	● Concerning	■ Missing target	n/a	Alert
Patients spending > 12 hours in A&E/MIU Hywel Dda	0	Aug 2026	1,622	● Usual	■ Missing target	n/a	Alert
Ambulance handover > 4 hours Hywel Dda	0	Aug 2026	179	● Improving	■ Missing target	n/a	Alert
Ambulance handovers > 1 hour Hywel Dda	0	Aug 2026	727	● Improving	■ Missing target	n/a	Alert
Ambulance handover > 45 minutes Hywel Dda	0	Aug 2026	837	● Improving	■ Missing target	n/a	Alert
C. difficile: Number of confirmed cases (in-month)	5	Aug 2026	22	● Usual	■ Hit and miss	n/a	Alert
Waits over 52 weeks: new outpatient appointment	0	Aug 2026	457	● Improving	■ Missing target	n/a	Alert
Patients waiting 104 weeks+ RTT	0	Aug 2026	698	● Improving	■ Missing target	n/a	Alert
Patients waiting over 52 weeks RTT	0	Aug 2026	13,281	● Usual	■ Missing target	n/a	Alert
% uptake of RSV vacc - 75+ years	70%	Aug 2026	41.0%	n/a	n/a	n/a	Alert
% patients spending <4 hours in A&E/MIU Hywel Dda	95%	Aug 2026	67.1%	● Usual	■ Missing target	n/a	Alert
Median time ambulance arrest category calls	8	Jul 2026	9	n/a	n/a	n/a	Alert
Median time ambulance emergency category calls	8	Jul 2026	10	n/a	n/a	n/a	Alert
% pts on single cancer pathway within 62 days	75%	Jul 2026	61%	● Improving	■ Missing target	n/a	Alert
% adult psychological therapy waits <26 weeks	80%	Jul 2026	56.6%	● Concerning	■ Missing target	n/a	Alert
S. aureus (MSSA) BSI: Number of laboratory confirmed cases (in-month)	8	Aug 2026	13	● Usual	■ Hit and miss	n/a	Alert
Financial in month deficit	n/a	Aug 2026	£4,632,500	● Usual	n/a	◆ Trajectory missed by over 5%	Alert
Patients waiting 26 weeks+ new outpatient	0	Aug 2026	6,311	● Improving	■ Missing target	n/a	Advise
% R1 eyecare patients waiting within 25% delay to target date	95%	Jul 2026	46.0%	● Improving	■ Missing target	◆ Trajectory missed by over 5%	Advise
% of children who are up to date with scheduled vaccinations by age 5	95%	Mar 2026	87.2%	● Usual	■ Missing target	n/a	Advise
% child neurodevelopment assess waits <26 weeks	80%	Jul 2026	29.9%	● Improving	■ Missing target	n/a	Advise
Pts 12yrs+ with diabetes receiving all 8 NICE care processes	50%	Aug 2026	46.4%	● Improving	■ Missing target	n/a	Advise
% of children receiving HPV by age 15	90%	Mar 2026	79.0%	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
Follow-up appts - delayed >100%	11387	Aug 2026	14,009	● Improving	■ Missing target	n/a	Advise
E. coli BSI: Number of hospital onset cases (in-month)	5	Aug 2026	4	● Usual	■ Hit and miss	n/a	Advise
% therapy interven post LPMHSS assess (age 0-17)	80%	Jul 2026	81.4%	● Usual	■ Hit and miss	n/a	Assure
% MH assess within 28 days (age 0-17)	80%	Jul 2026	80.5%	● Usual	■ Hit and miss	n/a	Assure
% MH assess within 28 days (age 18+)	80%	Jul 2026	99.3%	● Usual	■ Hitting target	n/a	Assure
% therapy interven post LPMHSS assess (age 18+)	80%	Jul 2026	96.0%	● Usual	■ Hitting target	n/a	Assure
Coding: % clinically coded - 1 month post discharge	95%	Jun 2026	97.7%	● Usual	■ Hit and miss	n/a	Assure

Alert
(may require discussion)

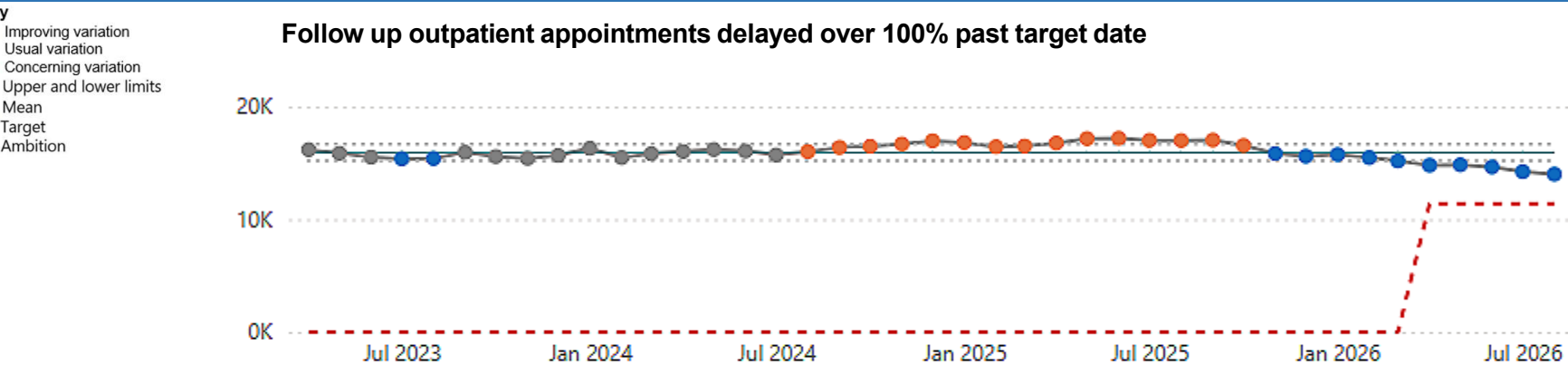
There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

Advise
(to monitor)

There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

Assure
(to note)

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



Performance is showing improving variation in August 2026. The number of follow ups delayed over 100% of their target date has reduced to 14,009, the lowest number ever recorded. Progress towards the national target of a reduction of 25% against the March 2026 baseline is steady (Target = 11,387).

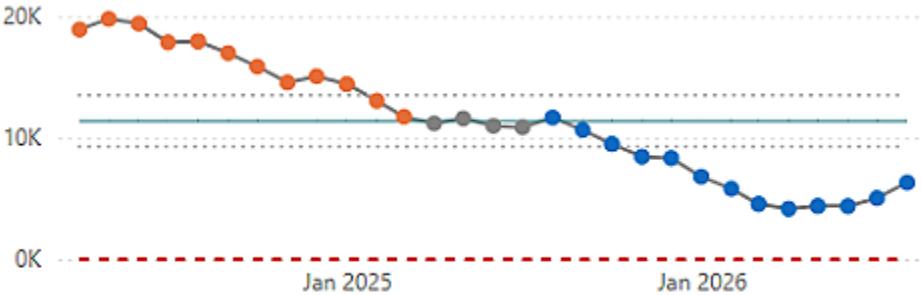
Key challenges / issues	Key actions / initiatives	Due date
- Initiatives for reducing new outpatient waits have increased follow-up waits as more patients progress through pathways. - Reducing follow up waiting lists continues to be challenging in terms of clinical engagement in some specialties. - Certain specialties have essential follow up pathways and may have additional pressure to reduce significantly due to case mix.	The Outpatient Transformation Programme, led by the Executive Medical Director, was launched in July 2026 to deliver the National Planned Care Programme priorities across all specialties. The programme focuses on referral management, clinical triage, pathway redesign, and the expansion of self-management approaches including See on Symptoms (SoS) and Patient Initiated Follow Up (PIFU).	31/03/27
	Specialty-level transformation plans are being implemented to reduce unnecessary follow-up activity, improve outpatient productivity, strengthen clinical validation processes, and enhance patient access and outcomes.	31/03/27
	Significant progress has been made in the conversion of long-waiting follow-up patients to SoS/PIFU pathways. All specialties have completed this work, with the exception of Ophthalmology, where a dedicated transformation programme continues to deliver sustained improvements, including a reduction of more than 1,000 delayed follow-ups during 2026.	31/03/27
	Although the national ambition to reduce delayed follow-up waits to below 12,000 was not achieved by March 2026, sustained improvements have been demonstrated throughout 2026/27. This has been supported by enhanced clinical validation, implementation of Clinical Implementation Network (CIN) guidance, and pathway redesign initiatives including the transfer of appropriate glaucoma patients to primary care management.	31/03/27
	The Executive Medical Director-led transformation programme provides the clinical leadership, governance, and specialty accountability required to accelerate improvement. Based on current trajectories and planned interventions, the Health Board is expected to achieve and exceed the March 2027 target of 11,387 delayed follow-up waits, delivering the lowest position recorded and establishing a sustainable foundation for continued reduction.	31/03/27

Waits over 26 and 52 weeks for a first outpatient appointment

(Enhanced monitoring condition and Ministerial priority)

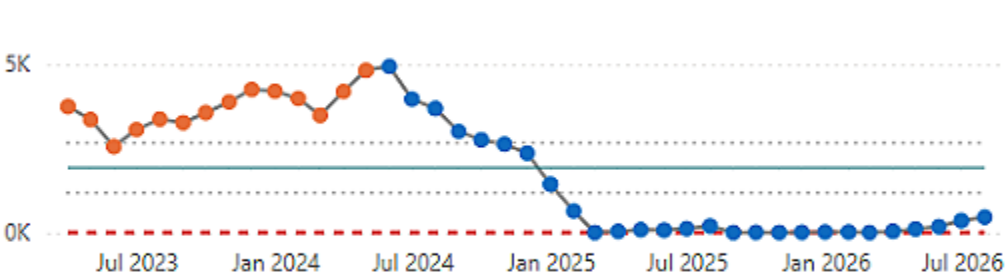
- Key
- Improving variation
 - Usual variation
 - Concerning variation
 - Upper and lower limits
 - Mean
 - Target
 - Ambition

Patients waiting >26 weeks for a first outpatient appointment



Performance is showing improving variation with 6,311 breaches in August 2026. However, breaches have increased for the last 2 months.

Patients waiting >52 weeks for first outpatient appointment

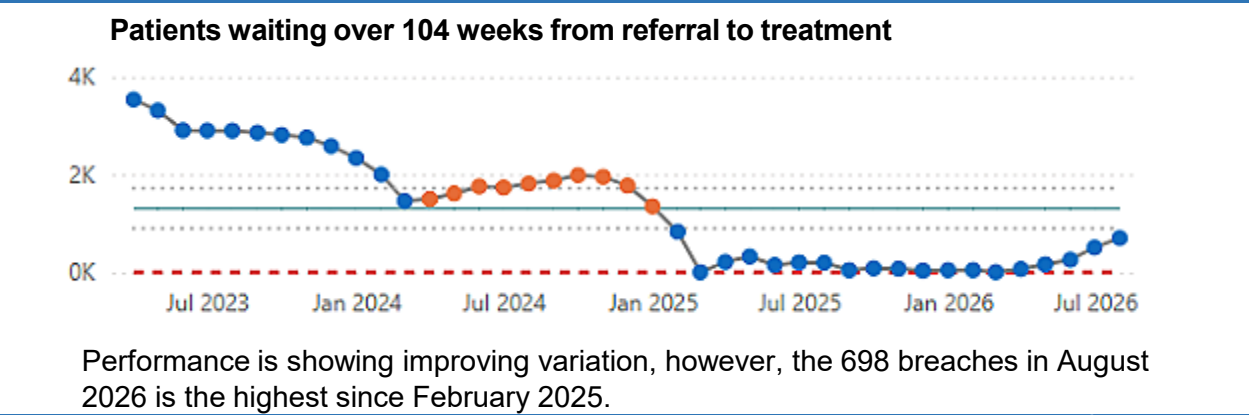
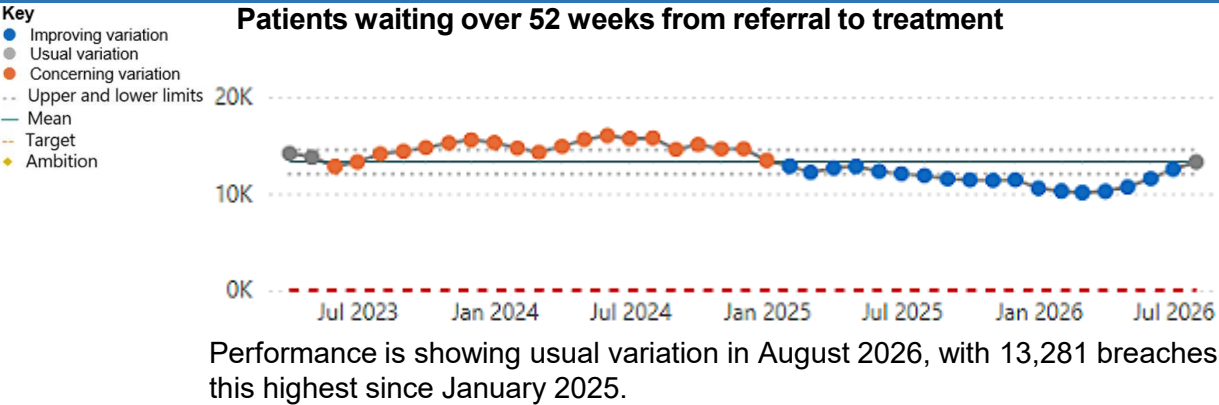


Performance is showing improving variation, however, the 457 breaches in August 2026 is the highest since February 2025.

Key challenges / issues	Key actions / initiatives	Due date
- The Health Board reported 457 breaches of the 52-week outpatient target in August 2026, primarily within General Medicine, Rheumatology, Care of the Elderly and Neurology. Performance continues to be impacted by a combination of workforce and capacity constraints, increasing demand, pathway complexity and the need to prioritise urgent and cancer pathways. - Recovery plans are in place across all affected specialties, supported by outpatient transformation, demand and capacity management and targeted performance oversight. Colorectal, Vascular, Gastroenterology, Diabetic Medicine and Rehabilitation Medicine achieved the 26-week target of zero breaches. Current performance remains within the forecast trajectory reflected in the Annual Plan.	- The Health Board continues to focus on maintaining and improving waiting time performance during 2026/27 through the use of robust demand and capacity modelling, enabling risks to be identified early and investment to be targeted where it will have the greatest impact on recovery and sustainability. - The Outpatient Transformation Programme, led by the Executive Medical Director, is driving specialty-level improvement plans across all National Planned Care Programme priorities, including referral management, clinical triage, pathway redesign, expansion of SOS/PIFU models, and outpatient productivity improvement. - Specialty recovery plans are being progressed through targeted pathway validation, active management of long-waiting patients, Did Not Attend (DNA) reduction initiatives and a continued focus on productivity and utilisation. Actions include improved patient communication, digital reminders and strengthened appointment-list validation to maximise existing outpatient capacity and support reductions in 26 and 52-week waits. - Performance metrics are reviewed weekly across all outpatient pathways, with focused management of patients waiting over 26, 36 and 52 weeks. Specialty trajectories, DNA performance, clinic utilisation and follow-up demand are monitored through formal performance review processes to ensure recovery plans remain on track. - The combination of targeted recovery investment, outpatient transformation, and DNA reduction initiatives is expected to improve outpatient productivity, increase available appointment capacity, reduce waiting times, and support delivery of the Health Board's planned care recovery objectives during 2026/27.	31/03/27 31/03/27 31/12/26 31/03/27 31/03/27

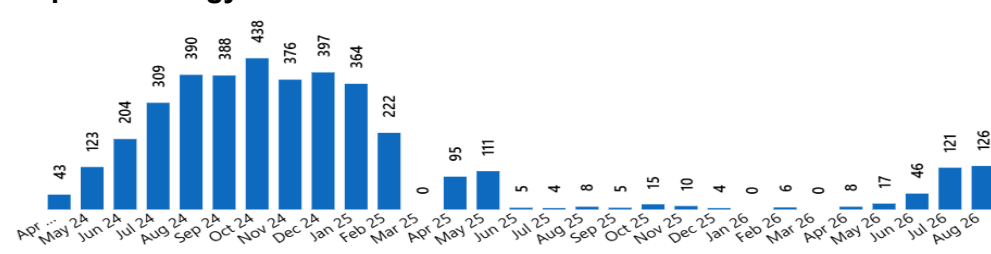
Waits over 52 and 104 weeks from referral to treatment (RTT)

(Enhanced monitoring condition and Ministerial priority)

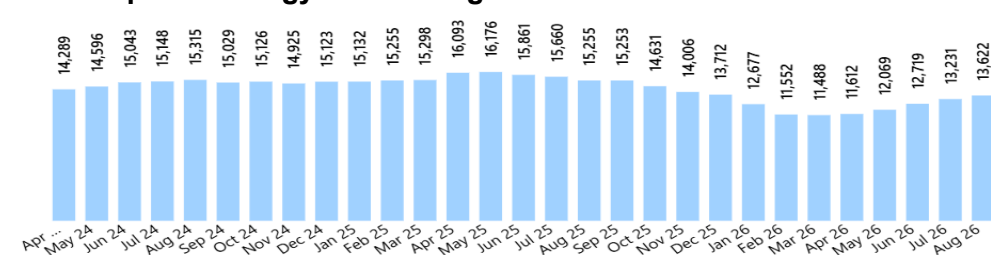


Key challenges / issues		Key actions / initiatives	Due date
104-week performance improved significantly, 698 patients remained waiting over 104 weeks at the end of August 2026 as per the Annual Plan trajectory, requiring continued focus on long-wait recovery trajectories and specialty-level delivery plans. - Delivery of the Health Board's 2026/27 recovery ambitions remains dependent upon securing and deploying additional capacity, whilst balancing increasing demand, workforce constraints and financial sustainability requirements. - Achievement of revised recovery trajectories is reliant upon delivery of Tranche 1 recovery funded schemes, securing further planned care funding allocations, and maintaining progress within Ophthalmology and Orthopaedics, with the largest long-wait cohorts. - Reducing unwarranted variation in productivity across specialties and sites remains a key challenge. Delivery of recovery funding is linked to demonstrating agreed productivity standards, including seven cataract procedures per operating list in Ophthalmology and four joint replacement procedures per list in Trauma & Orthopaedics, alongside wider getting it right first time (GIRFT) productivity requirements. - Sustained delivery of a robust Stage 2 and Stage 3 administrative and clinical validation programme is required to ensure waiting lists remain accurate; patients are clinically prioritised appropriately and recovery resources directed towards patients requiring treatment. - Workforce availability, theatre utilisation, late starts, early finishes and the availability of specialist staffing continue to impact the ability to maximise elective capacity and maintain recovery trajectories. - Continued delivery of the Theatre Optimisation Workstream and Outpatient Transformation Programme will be critical to achieving sustainable reductions in long waits and reducing reliance on non-recurrent recovery solutions.		We continue to focus on maintaining waiting time targets in 2026/27, as agreed by the Health Board, using demand and capacity modelling to identify delivery risks, target recovery actions and inform investment decisions.	31/03/27
		Approved Welsh Government Planned Care Recovery funding is being deployed to deliver targeted waiting list initiatives, clinical and administrative validation, and additional diagnostic and treatment capacity focused on the longest-waiting patients, accelerating reductions in waits over 104 weeks and overall waiting list size.	31/03/27
		- Delivery trajectories remain under continuous review through robust demand and capacity planning arrangements, with a continued focus on achieving national planned care standards, reducing long waits and improving the long-term sustainability of services. - The Theatre Optimisation Workstream, led by the Clinical Care Group and supported by the Executive Medical Director, is a key component of the Planned Care Recovery Programme. The workstream aims to improve theatre productivity and support delivery of GIRFT standards across specialties through a comprehensive review of staffing models, theatre utilisation, list loading and procedural productivity. Evidence-based standards are being implemented to reduce unwarranted variation between sites, maximise available capacity and support sustainable improvements in planned care performance.	31/03/27

Ophthalmology RTT waits over 104 weeks

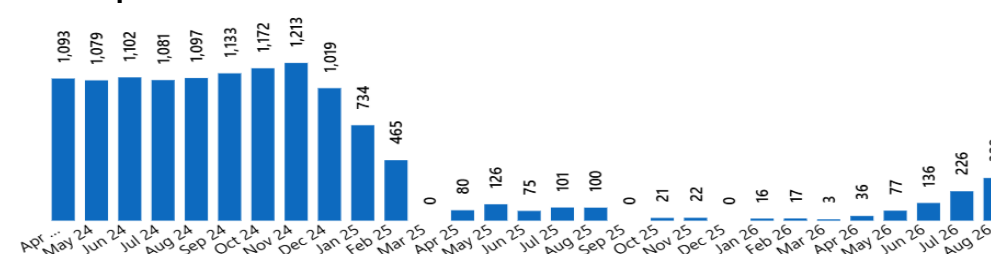


Total Ophthalmology RTT waiting list

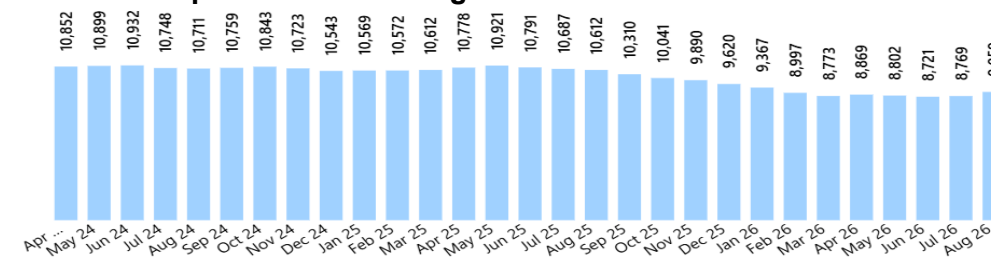


104-week RTT waits for Ophthalmology have increased for the last 5 months whilst the total waiting list volume has increased by 2,000 in the same period.

Orthopaedics RTT waits over 104 weeks



Total Orthopaedics RTT waiting list



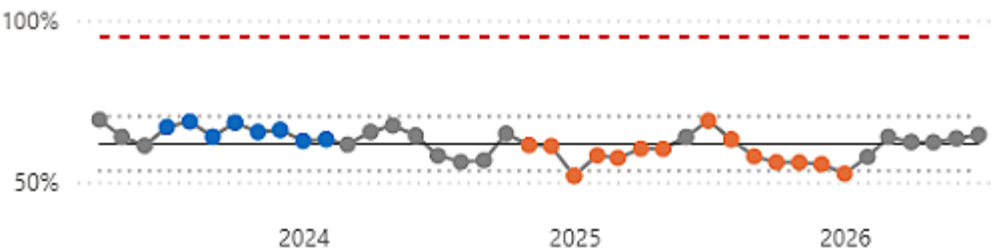
104-week RTT waits for Orthopaedics have increased for the last 5 months, however, the total waiting list volume is steady.

Key challenges / issues	Key actions / initiatives	Due date
- Continued Stage 2 and Stage 3 (awaiting diagnostic/post diagnostic pathway) administrative and clinical validation is required to ensure RTT pathways remain accurate and clinically prioritised, although currently meeting the Annual Plan trajectory. - Delivery of 104-week recovery trajectories remains dependent on securing sufficient treatment capacity and maintaining reductions in long-wait cohorts within Orthopaedics (T&O) and Ophthalmology. - Sustained productivity improvement required to achieve recovery ambitions, including delivery of 4 joint replacements per list and 7 cataract procedures per list where T&O and Ophthalmology form part of the allocation. - Required focus on maximising internal capacity via Treat in Turn principles, theatre utilisation, pathway optimisation and reduction of unwarranted cross-site variation.	- Administrative validation of all Stage 2 and 3 patients is on track for completion by 30 September 2026, followed by clinical validation and pathway review to ensure patients are appropriately prioritised and pathway data remains accurate. - Revised monthly recovery trajectories have been agreed and underpin delivery plans for both Orthopaedics and Ophthalmology, strengthening accountability for reducing 104-week waits. £4.5m Tranche 1 Planned Care Recovery Funding is supporting additional treatment capacity, waiting list reduction activity and accelerated management of long-waiting patients within T&O and Ophthalmology. - Ophthalmology recovery actions include additional cataract capacity, outsourcing activity and pathway optimisation to maintain reductions in the longest waits. - Orthopaedic recovery actions include targeted insourcing/outsourcing, strengthened waiting list management and enhanced theatre utilisation to reduce 104-week waits. - The Theatre Optimisation Workstream is implementing agreed productivity standards, including 7 cataracts per list, 4 joint replacements per list, improved theatre utilisation and getting it right first time-aligned practices. - Continued delivery of Treat in Turn principles, pathway optimisation and productivity improvements will support sustainable recovery and maximise use of internal capacity.	31/12/26 31/03/27 31/03/27 31/03/27 31/03/27 31/03/27 31/03/27

Key

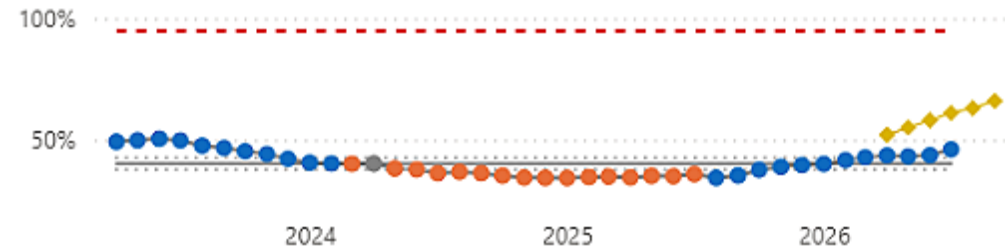
- Improving variation
- Usual variation
- Concerning variation
- Upper and lower limits
- Mean
- Target
- Ambition

% R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



Performance in July 2026 (64.6%) is showing usual variation. This is the best performance since July 2025.

% R1 appointments waiting within their clinical target date or within 25% beyond their clinical target date



Performance in July 2026 (46%) is showing improving variation. This is the best performance in almost three years.

Key challenges / issues

- The advice from Welsh Government is to focus on patients waiting as these are higher risk, and by booking these patients, performance will improve. However, this will directly affect the appointments attended trajectory as booked patients have already breached. Once corrected, performance for R1 appointments attended will improve as capacity grows and backlog reduces.
- Increasing outpatient delivery has been stalled by outpatient staffing and medical records constraints along with staff sickness.
- Reduced workforce continues to impact delivery, with vacancies across key delivery roles e.g. Consultant, 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 and is now on long term sick.
- One Consultant and one SAS doctor took urgent special leave of four weeks and ten weeks respectively, with a combined loss of 16 sessions per week.
- One regional consultant post has recently been recruited into but is yet to start. This has impacted the ability for additional outpatient sessions for medical retinopathy patients.
- 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.

Key actions / initiatives

- The action below are to improve performance inline with the forecast volumes agreed as part of the annual plan process.
- 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 key next step is to expand the IVT service into Amman Valley Hospital (AVH) outpatient settings. Periphery sites are also being scoped to support patients having treatment closer to home (i.e., Debenhams Carmarthen and Cross Hands Integrated Care Centre).
 - Outpatient staff will be increased to support outpatient activity in the blue suite in Glangwili Hospital (GGH), allowing for incremental increases in clinic delivery. 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 reliance on nursing resource and ensures all staff are working to their licence.
 - One Consultant post being progressed via the NHS recruitment (TRAC) system.
 - One SAS doctor has been recruited, which will help support fragile outpatient service.
 - Working with regional colleagues to create a deliverable, sustainable cataract plan for 2026/27 whilst also scoping a plan to meet the 104-week RTT target by 1st April 2027.

Due date

01/11/26

01/11/26

01/11/26

01/09/26

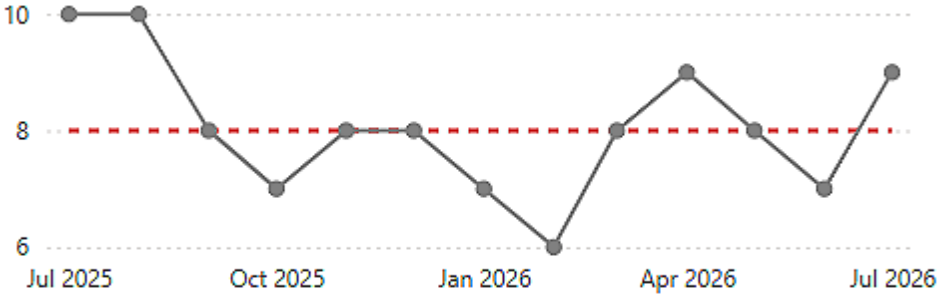
01/01/27

01/04/27

Key

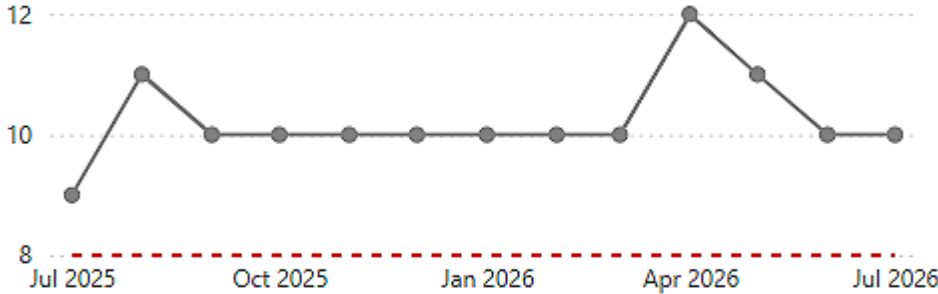
- Improving variation
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- Ambition

Median emergency ambulance response time to purple: arrest category calls



In July, the median response time was 09:27 minutes for ARREST (Purple) Calls. There were 136 ARREST calls. Official WAST data is delayed by 1 additional reporting month.

Median emergency ambulance response time to red: emergency category calls



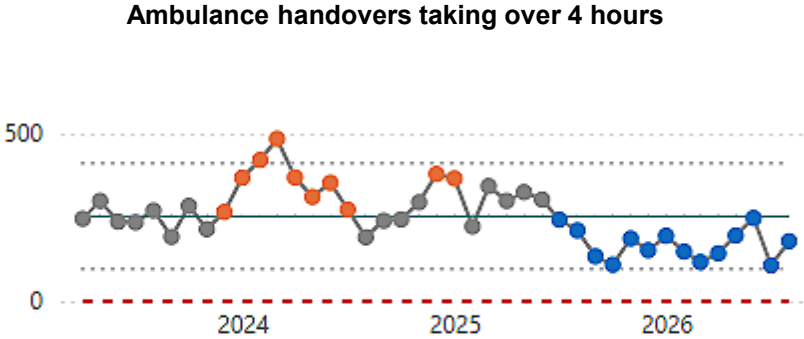
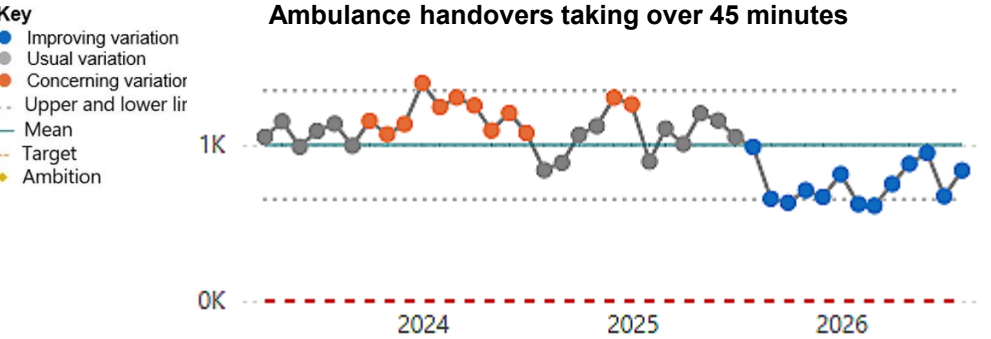
In July the median response time was 10:15 minutes for RED (Emergency) calls there were 647 calls. Official WAST data is delayed by 1 additional reporting month

Key challenges / issues

- Unverified August performance was 08:45 minutes for arrest (132 incidents) and 10:59 minutes for emergency calls (608 incidents). Overall attended demand in Hywel Dda Health Board area for August 2026 has been almost as forecast.
- Hospital delays in ambulance handover for Welsh Ambulance Service Trust (WAST) ambulance crews, 2,355 hours lost at the 4 acute Hywel Dda hospital sites during August 2026, again showing slight improvement in performance from July 2026, as joint Handover 45 Actions are going live in collaboration between WAST and Hywel Dda UHB Trust-wide.
- Notification to Handover within 15 minutes was at 34.9% in August for the 4 acute general hospitals, showing slight deterioration over July 2026, despite an overall improvement in hours lost.
- Orange NOW calls totaled 1689 calls, with WAST providing an at scene attendance at 1466 of these incidents.
- NOW response Median was 01:15 hours and the 90th Percentile was 05:11 hours across the Health Board for August 2026.

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.
- Call before convey, a new initiative to streamline ambulance arrivals across all 4 Acute Hospital sites is in the final stages of approval, aiming at reducing unnecessary conveyances and increasing alternative pathway to hospital uptake, particularly through the agrees Single Point of Access (SPoA) model.
- Plans to agree an ambulance arrivals process standardised across the Health Board are making early progress.
- WAST resourcing reviews and targeted overtime allocation.
- Wait 45 initiative implemented, which will reduce length of ambulance wait times outside emergency departments, and project group now established with Senior Managers to deliver NHS Performance & Improvement actions. These meetings are now weekly for urgent progress.
- WAST managers joining 10 am Patient Flow call from May 2026 to further support integrated working and collaboration, furthering joint understanding of risk and flow.

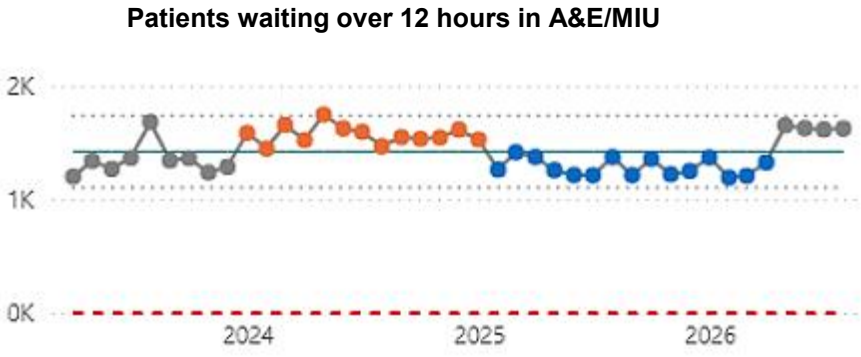
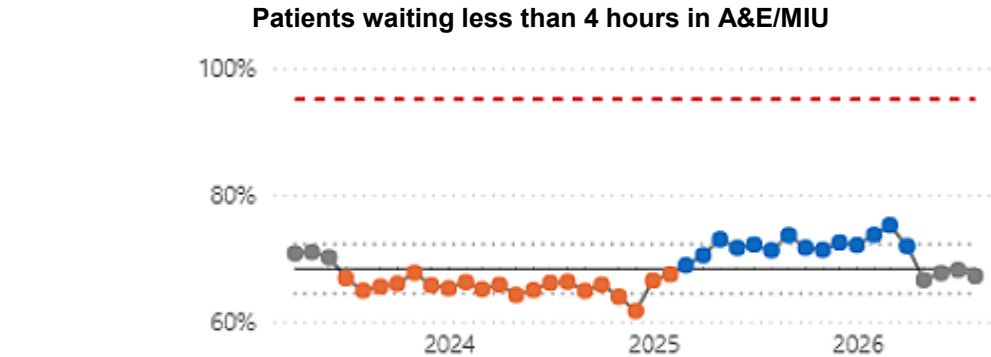


>45 Minutes handovers:

Latest data is showing improving variation, 837 handovers > 45 minutes out of a total of 2,161 handovers.

>4 hours handovers:

Latest data is showing improving variation, 179 handovers > 4 hour out of a total of 2,161, 8%.



Waits < 4 hours:

Latest data is showing usual variation 11,253 patients out of 16,763 new attendances seen in < 4 hours, 67%.

Waits > 12 hours:

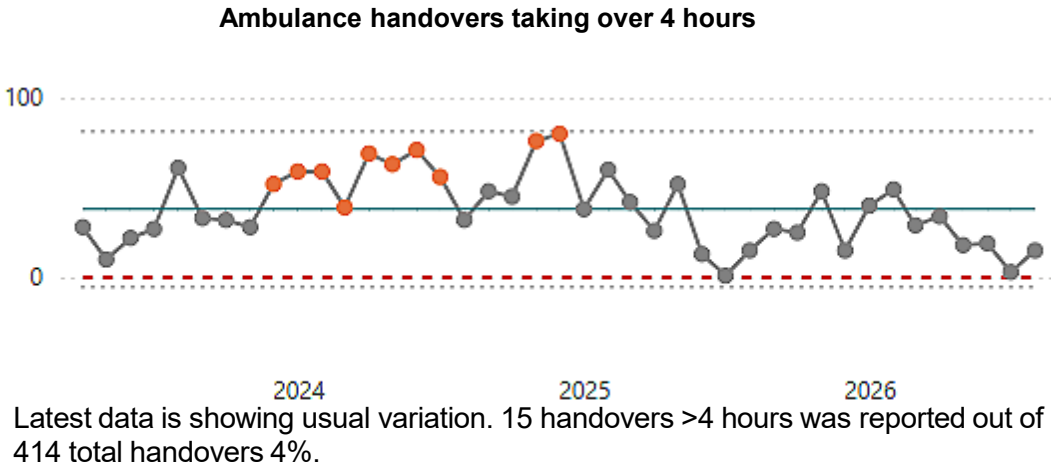
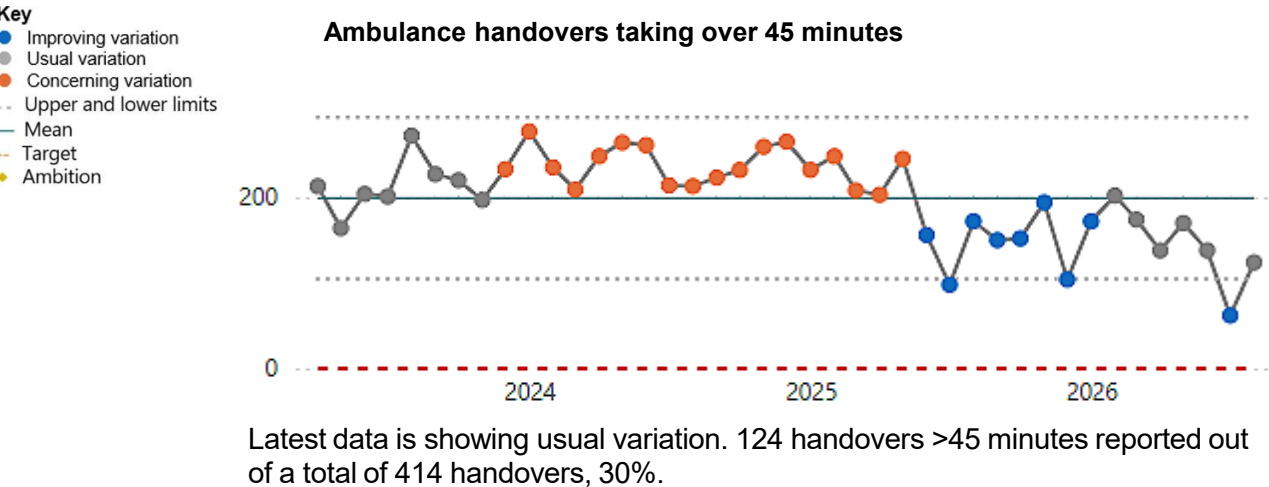
Latest data is usual variation. 1,622 patients waited over 12 hours, out of 16,763 new attendances, 9.7%.

Key actions / initiatives – tactical urgent and emergency programme

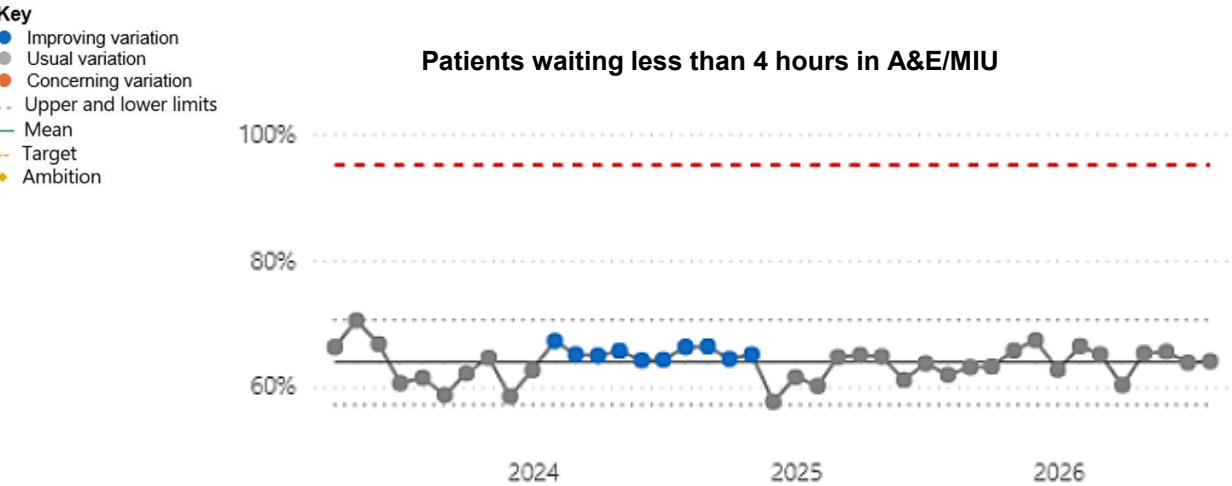
Hywel Dda's Urgent and Emergency Care (UEC) Programme delivery is focused on implementing the national Three Pillars approach through a whole-system approach, including strengthening community-based alternatives (e.g. falls response and prevention services), improving front-door streaming and Same Day Emergency Care (SDEC), and reducing avoidable admissions and discharge delays. The three pillars are based on pre-hospital and community care, the hospital front door and first 72 hours care and ward based patient flow and discharge. Central to this is the implementation of the Seven-Day Clinical Streaming, Hospital@Home and SDEC business case, the co-development of a 45-minute ambulance handover improvement plan and the continued roll out of the Optimal Hospital Flow programme. These aims to improve patient flow, enhance outcomes, and align with ministerial priorities by enabling earlier intervention, reducing emergency department demand, and supporting a sustainable 'shift-left' model of care across acute and community pathways. Currently the Go-Live date for Seven-Day Clinical Streaming and Hospital@Home is November 2026, and the 7-day WGH SDEC is planned to be phased in from January 2027.

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

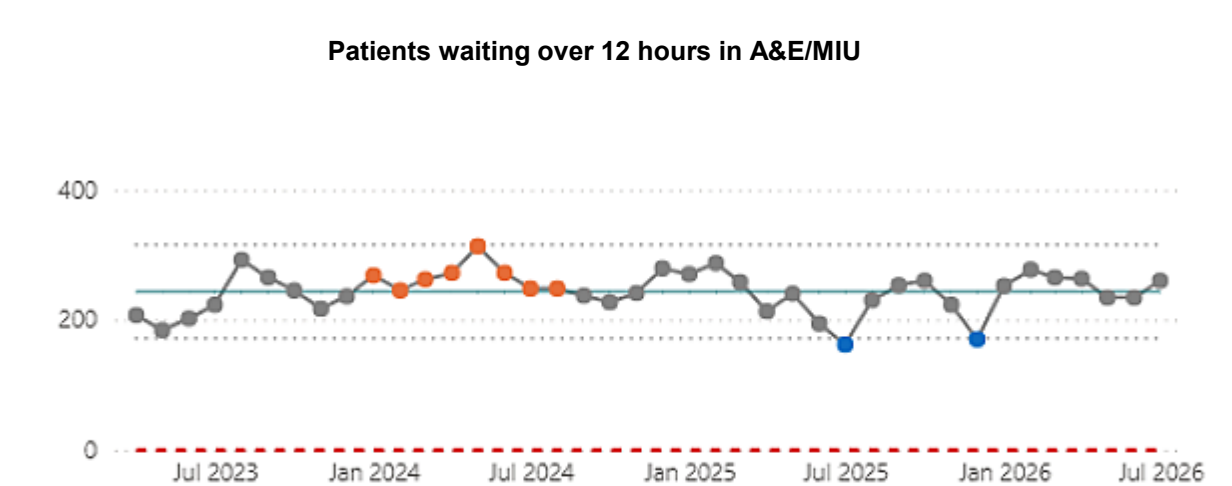
- [Bronglais Hospital](#) [Prince Philip Hospital](#)
- [Glangwili Hospital](#) [Withybush Hospital](#)



Key challenges / issues	Key actions / initiatives	Due date
- Emergency Department (ED) crowding leading to a lack of available clinical space. - High patient acuity and complexity requiring longer assessment times before handover. Extreme Heat events have contributed to increased acuity and has triggered peaks in demand. - Insufficient inpatient bed capacity causing delays in patient flow through the hospital. - Delayed discharges creating bottlenecks and reducing ED capacity. High levels of clinically optimised patients occupying inpatient beds impacting timely transfers to wards. Delayed transfers of care affecting patient flow - downstream capacity. - Surges in patient demand (winter pressures, seasonal illnesses, major incidents) causing greater demand than capacity. - Ambulances arriving in batches of 3 or 4 within a short space of time causes delays. - Accurately reporting handover times is often a challenge. Requirement of dual pin to ensure handover times are recorded appropriately. - Limited community capacity and social care packages. - Sustained emergency demand above available capacity. - Increase in infection across ward areas resulting in closed beds. - Limited surge bed capacity across the Acute site. - Ongoing dual pin challenges with ambulance sign off screen	- Band 8 Senior Nurse Manager appointed and onboarding. - Reconfiguration of the Emergency Department footprint to enhance flow throughout the department – multi disciplinary team (MDT) approach to design. - ED module for Miya patient flow being introduced - Maintaining close operational integration with WAST to identify emerging opportunities for improvement through shared performance intelligence, proactive escalation, and collaborative action to improve ambulance handover performance, patient flow, and overall system resilience	30/09/26 30/09/26 31/10/26
Embedded improvement actions		
- Increased consultant oversight following appointment of second consultant. - Enhanced senior ED Navigator oversight through senior sisters. - Site-wide ward manager meetings with ED Navigators. - Shared ownership of 45-minute handover performance across Ceredigion Integrated System. - Senior medical roster review to support decision-making. - Daily review of clinically optimised patients. - Real-time senior escalation of ambulance handover performance. - Enhanced senior clinical decision-making at the front door. - Newly established weekly MDT touchpoint meeting to review ambulance handover performance, monitor improvement actions, and identify further change ideas, chaired by Assistant General Manager.		

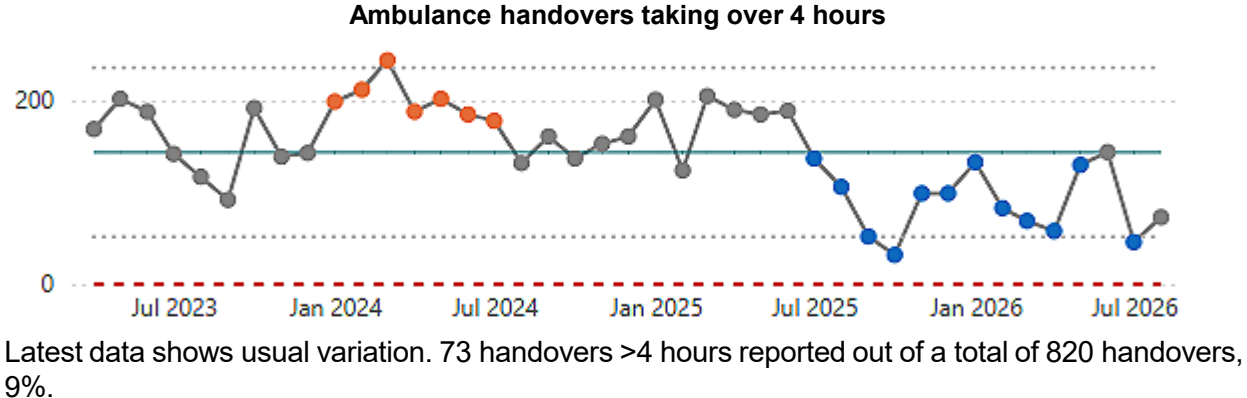
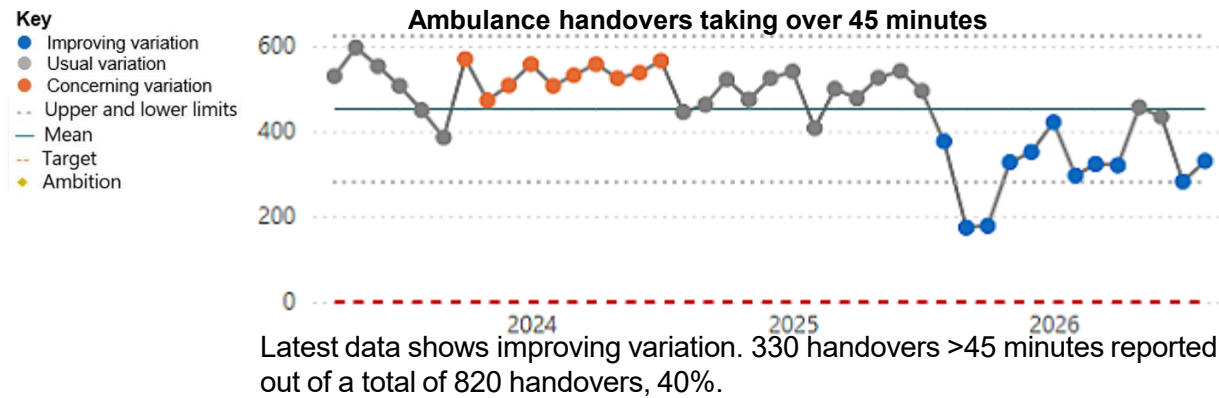


64% latest data, 1,024 breaches out of 2,846 new attendances. Chart is showing usual variation.

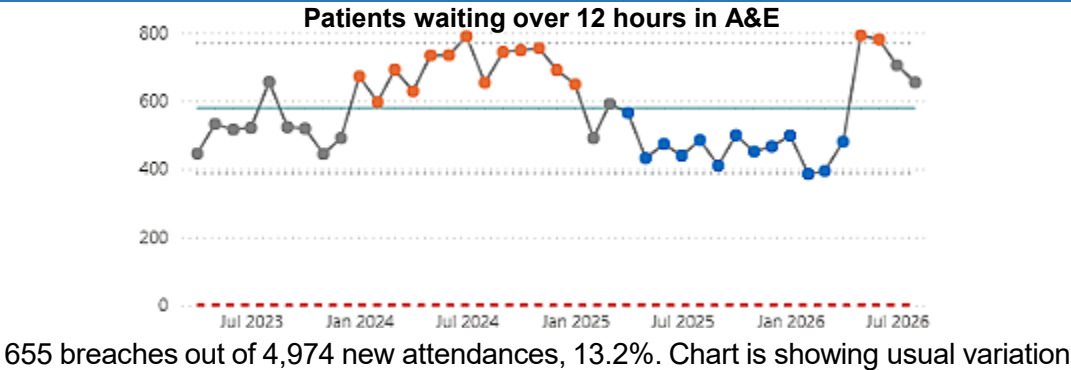
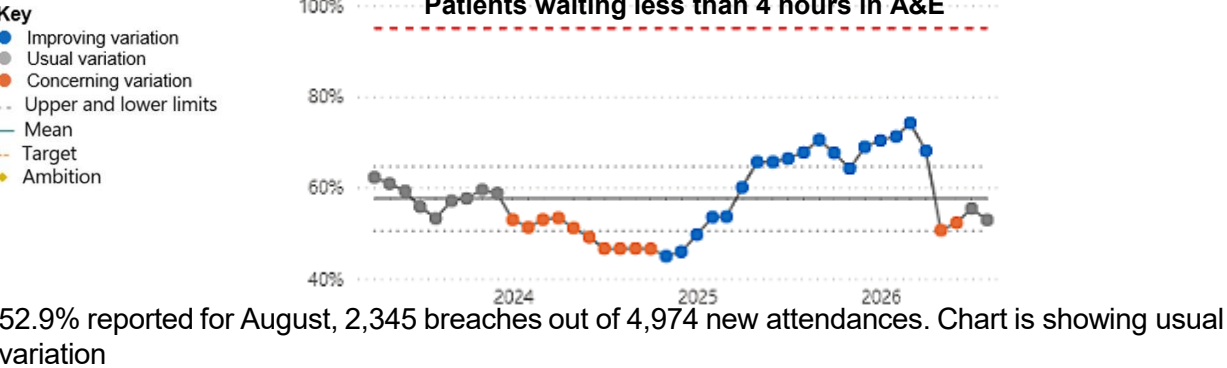


260 breaches out of 2,846 new attendances, 9%. The chart is showing usual variation.

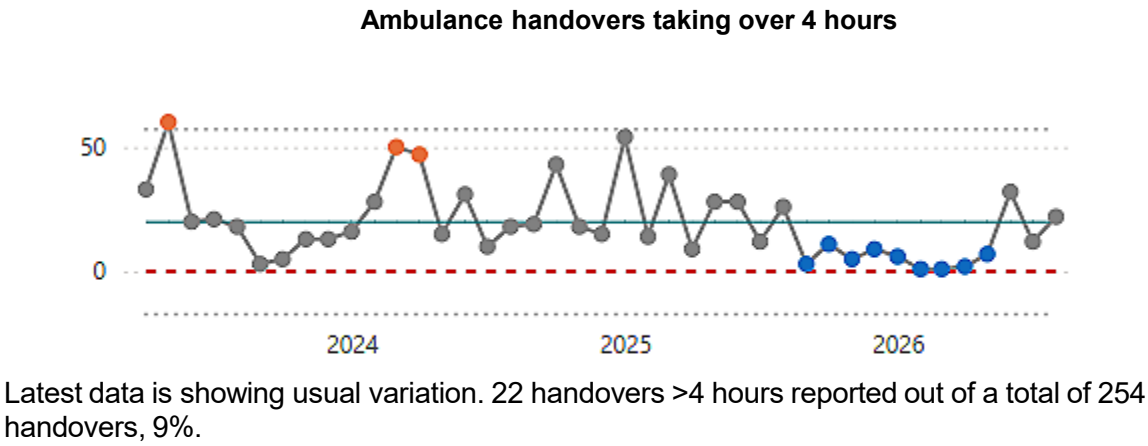
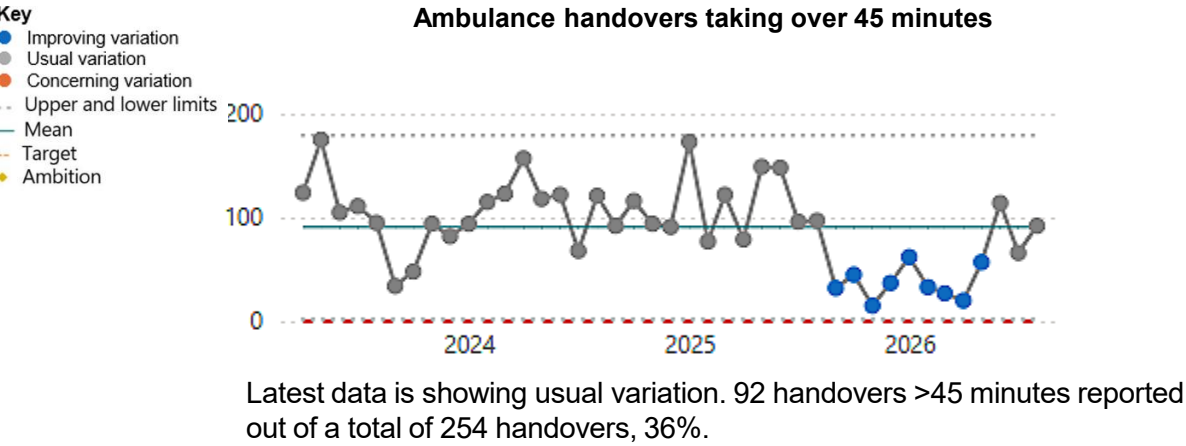
Key challenges / issues	Key actions / initiatives	Due date
- Physical space limitations within the Emergency Department footprint including limited assessment and trolley spaces to absorb ambulance arrivals during peak times leading to overcrowding and corridor usage. - Limited senior medical workforce 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. - Delays in access to NCEPOD theatres contributes to poorer outcomes for patients and subsequent increased length of stay.	Reconfiguration of the Emergency Department footprint to enhance flow throughout the department - MDT approach to design.	30/09/26
	Review of clinical pathways across the Ceredigion Acute & Community System.	30/09/26
	Quality Improvement Projects to be initiated across the Emergency Department led by the senior sister team.	01/11/26
	Focussed daily scrutiny on prevention and reduction of 12 hour breaches.	30/09/26
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 with escalation SOP embedded - Daily review of all clinically optimised patients - Focus on earlier in the day discharges - Bedside handover standard operating procedure (SOP) implemented - Escalation of delayed pathway of care patients - Strengthened partnership working with Local Authority to minimise delays in discharge		



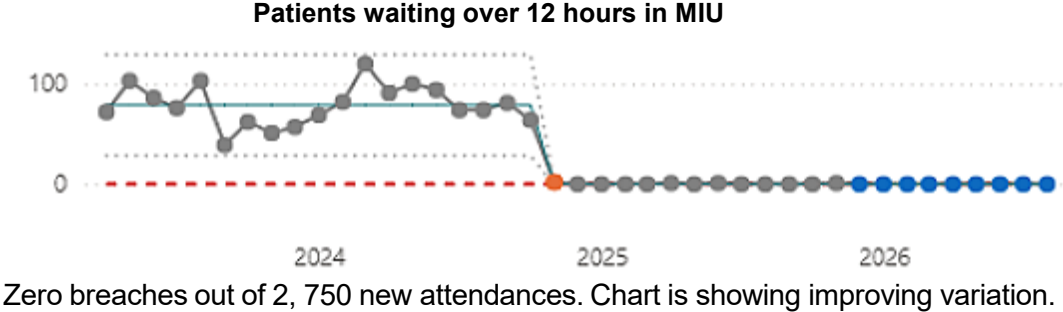
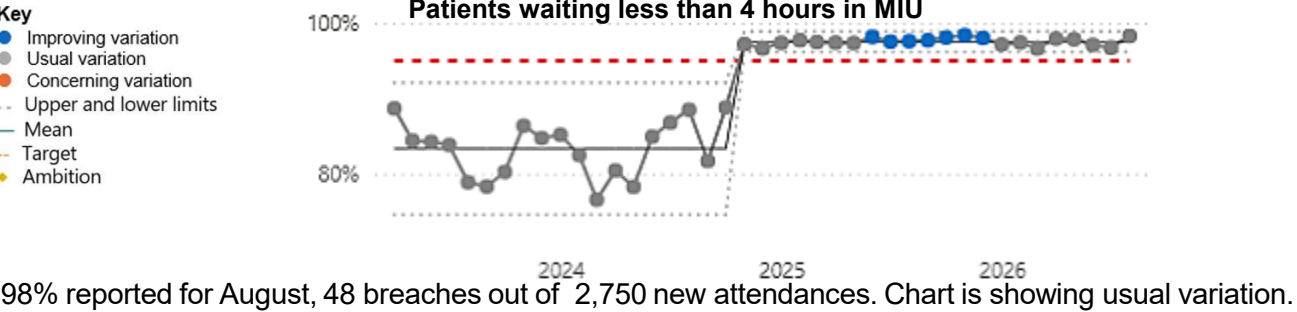
Key challenges / issues	Key actions / initiatives	Due date
The ED continues to experience significant overcrowding and sustained surge pressures. Whilst there are some encouraging signs of improvement, demand across the system remains extremely challenging. The factors below contribute to ongoing pressure. We have seen a small reduction in ambulance arrivals compared to the same period last year; however, overall ED attendances have increased, resulting in continued pressure on capacity and resources. Despite the reduction in ambulance conveyances, combined with the increased volume of patients attending the department's, the overall patient flow has remained static. Patient flow out of the ED remained slow, which affected our ability to create sufficient capacity for timely ambulance handovers. As a result, achieving the 45-minute ambulance handover target remained challenging, with delays occurring during periods of peak demand. Continued poor flow through the hospital is closely linked to the increasing number of clinically optimised patients who are ready to leave hospital but are awaiting onward care or discharge arrangements. The number of these patients within GGH has increased further this month, placing additional pressure on inpatient bed capacity and consequently impacting patient flow from the ED. Operational pressures further exacerbated by significant workforce challenges. During August, we experienced substantial nursing workforce shortfalls due to additional sickness absence on top of and planned annual leave. Similar pressures observed within the medical workforce, compounded by the annual junior doctor changeover period, which has impacted staffing availability and service resilience across the site.	<i>Redline</i> standard operating procedures (SOP) signed off and implemented, this initially could impact negatively (in reducing boarding space), however this should maintain clinical spaces, to allow timely handover and a safer department. - Handover 45 minute action plan drafted and being worked up by Clinical Care Group and individual hospitals. - Developing a QR code to "man mark" ambulance handover delays, this will give us a tool to monitor the delays and support change which is in our sphere of influence. - Planning stage discussions taking place to develop an ambulance handover hub in the Minor Injury Unit (MIU) (whilst MIU pilot continues in Same Day Emergency Care (SDEC)). - Need to strengthen "call before convey" through the clinical streaming hub. - Further work is required to streamline clinical pathways. Patients requiring a specialty bed should have timely access to the appropriate bed and should not attend the ED solely for bed allocation. - Further work is required regarding the falls and head injuries pathway in Carmarthenshire. To ensure a pathway review is undertaken, and only appropriate patients are transferred to Glangwili.	30/11/26 31/10/26 31/10/26 31/10/26 31/12/26 31/12/26 31/12/26
Embedded improvement actions		
Continue to monitoring early discharges and the utilisation of the discharge lounge. Out of area patient cohort being monitored twice weekly. This enables specialty patient pathways to be managed. Clinically optimised patients are reviewed through a structured senior nurse team. Escalation process embedded regarding any delay in patent care or patient care pathways delays. Same Day Emergency Care (SDEC) team actively "pull" from ED. Daily Site Flow Coordination. Site flow calls are embedded to provide real-time oversight of capacity, patient movement, and escalation requirements, ensuring timely decision-making and prioritisation of transfers. Myia flow being monitored with the EEDs and actual discharges. Monthly collaborative meetings with GGH operational team and WAST.		



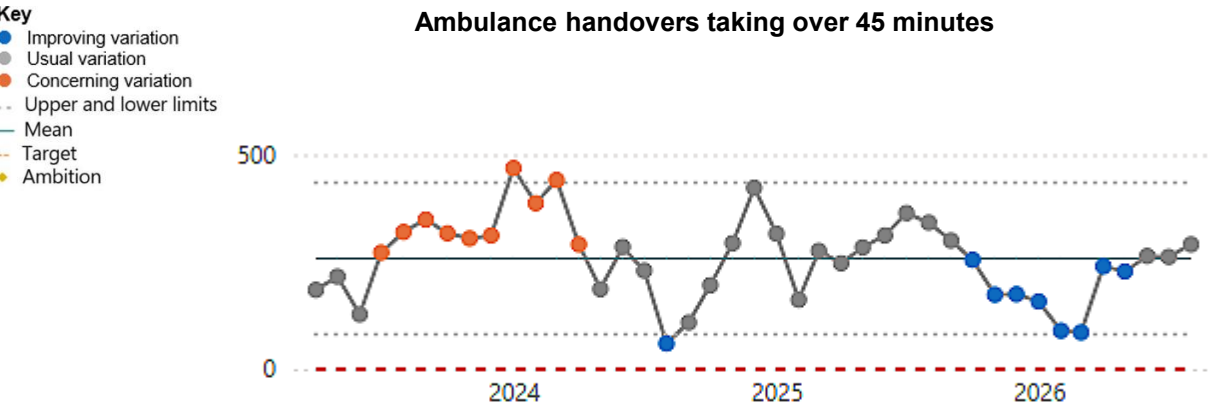
Key challenges / issues	Key actions / initiatives	Due date
Performance continues to be impacted by sustained demand, high patient acuity and ongoing challenges in maintaining patient flow through the hospital. Delays in transferring patients from the ED to wards reduced available ED capacity, contributing to longer waits for assessment, treatment and admission. Demand remained particularly high among medical patients, with delays in discharge and onward care arrangements continuing to place significant pressure on overall ED performance. The drivers of 12-hour waits are inpatient capacity constraints, delayed discharges and extended lengths of stay for patients with complex medical and social care needs. These factors limited bed availability and restricted patient flow across the UEC pathway. During periods of heightened demand, these pressures intensify, resulting in an increased number of patients experiencing prolonged stays within the ED. 4-hour 12-hour performance remained below target but showed no significant deterioration, indicating a stable yet pressured system. Continued focus on whole-system patient flow, discharge optimisation and reducing delays in discharge and onward care will be essential to improving performance and reducing the number of patients experiencing extended waits within the ED.	To mitigate these challenges, operational and clinical teams continue to prioritise patient flow through early senior clinical review, maximising SDEC and ambulatory care pathways, and expediting discharge processes. Daily oversight of long-wait patients, supported by multidisciplinary flow meetings and strengthened escalation arrangements, helps facilitate timely decision-making and minimise delays across the patient pathway. • Maintain a “Home First” ethos, actively exploring opportunities to avoid unnecessary admission and facilitate discharge where clinically appropriate. • Utilise the Liaison Medical Team to provide proactive clinical oversight of patients experiencing extended waits within the ED, ensuring patients are medically managed whilst awaiting definitive placement. • Provide assurance that all patients received a clinical review and documented management plan. • Ensure that patients requiring admission are on an agreed specialty pathway, with clear ownership and escalation where delays occur. • Work collaboratively with community, therapy, discharge and patient flow teams to maximise opportunities to support patients out of hospital and improve flow across the system. Integrated community and medicine 7 day working. • Explore opportunities to utilise Clinical Decision Unit, SDEC and MIU capacity for appropriate patients requiring monitoring and observation, reducing pressure within the ED. • To undertake a twice-daily review of the ten patients experiencing the longest waits in the ED, identifying themes, delays, risks and opportunities for learning and improvement. • Standard Operating Procedure for repatriation process between our Health Board hospitals has been signed off and is to be implemented.	30/09/26 30/09/26 30/09/26 30/09/26 04/01/27 02/11/26 30/09/26 04/01/27
Embedded improvement actions		
Track and monitor all patients waiting more than 12 hours through the site management meetings, ensuring timely escalation and oversight of prolonged waits .Continue to monitoring early discharges and the utilisation of the discharge lounge. Out of area patient cohort being monitored twice weekly. This enables specialty patient pathways to be managed. Clinically optimised patients 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.		



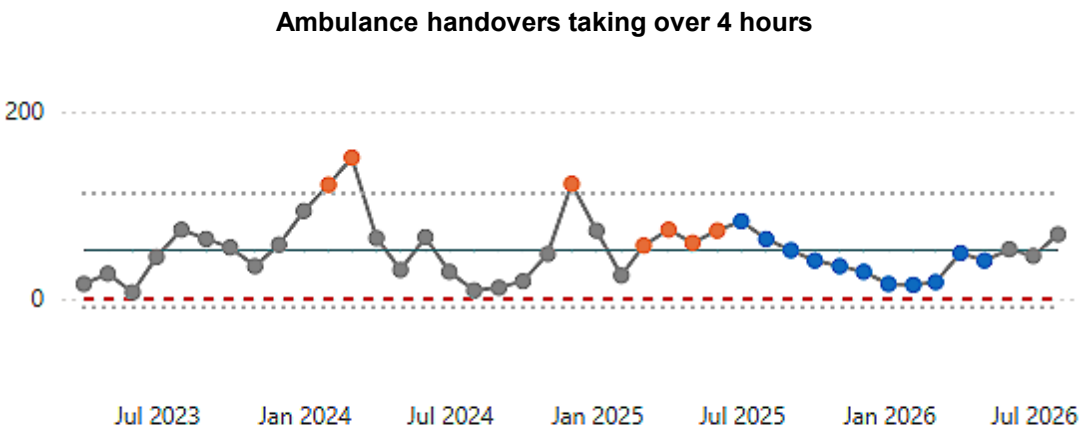
Key challenges / issues	Key actions / initiatives	Due date
- Key challenges continue to relate to sustained levels of unscheduled care demand, high occupancy levels, delayed discharges and workforce pressures. These factors impact bed availability and patient flow across the site, contributing to pressure within the Emergency Department and assessment areas. Additional challenges include delays associated with complex discharge arrangements, patients accommodated within escalation areas, and maintaining ambulance handover performance during periods of peak demand. High level of demand, resulting in delays. This affected patients through longer waiting times for assessment, treatment and discharge, prolonged stays within the department, and a less timely patient experience overall impact on handover times. - We have continued to achieve the 45-minute ambulance handover target, enabling timely transfer of patients from ambulance crews. However, this has increased pressure internally across ward areas, requiring the use of surge capacity to maintain flow. IP&C requirements have also contributed to delays, with clinical areas requiring more frequent deep cleans, impacting bed turnaround times. - Infection Prevention and Control (IPC) issues continued throughout the summer months, requiring the closure of several ward bays. This resulted in a number of beds being unavailable for use, reducing overall capacity and creating additional pressure on patient flow, admissions and timely placement of patients	Continue to mitigate the challenges associated with Infection Prevention and Control (IPC) through regular testing and rapid swabbing of suspected cases. Patients are isolated where appropriate to minimise the risk of transmission and protect bed capacity. At the height of the recent pressures, a 24-hour surge ward was opened on Ward 6 to accommodate patients who were close to discharge, allowing additional capacity to be created within the Acute Medical Assessment Unit (AMAU). The surge ward was deactivated the following day. Embedded improvement actions Ambulance handovers: Ambulance handovers: Continue focus on the 45-minute ambulance handover target through close operational oversight, real-time monitoring, and clear escalation processes. The Patient Flow Unit coordinates capacity and demand across sites, enabling earlier identification of pressures, faster decision-making, and timely actions to maintain patient flow and minimise delays. MIU to AMAU transfers: Medical patients in Minor Injury Unit MIU are prioritised for transfer to AMAU following Registrar referral, ensuring they receive care in the most appropriate setting. Patients are reviewed daily and tracked until transfer. Barriers are escalated promptly, helping improve patient flow, reduce MIU congestion, and protect capacity for urgent injury care. Our Next Patient process: Multidisciplinary teams actively identify and prepare the next patient for assessment, transfer, admission, or discharge. The 'Our Next Patient' boarding protocol supports early movement into available areas, reducing delays and creating capacity. Escalations are managed through patient flow meetings and the Manager of the Day process to support timely patient placement.	30/09/26



Key challenges / issues	Key actions / initiatives	Due date
- A sustained reduction in patients presenting with major conditions has been observed, although a small cohort of higher-acuity and medical patients continue to attend and require monitoring, which has supported the control of breach targets. - Key challenges continue to relate to sustained levels of unscheduled care demand, high occupancy levels, delayed discharges and workforce pressures. These factors impact bed availability and patient flow across the site, contributing to pressure within the Emergency Department and assessment areas. Additional challenges include delays associated with complex discharge arrangements, patients accommodated within escalation areas, and maintaining ambulance handover performance during periods of peak demand. High level of demand, resulting in delays. This affected patients through longer waiting times for assessment, treatment and discharge, prolonged stays within the department, and a less timely patient experience overall impact on handover times. - Infection Prevention and Control (IPC) issues continued throughout the summer months, requiring the closure of several ward bays. This resulted in a number of beds being unavailable for use, reducing overall capacity and creating additional pressure on patient flow, admissions and timely placement of patients	Consultant-led Hot Clinics have improved patient flow by facilitating early specialist review, supporting safe discharge, reducing avoidable admissions, and minimising unnecessary follow-up appointments, thereby releasing capacity within the acute care pathway. The service will continue to be reviewed to maximise its effectiveness, with opportunities to expand provision being considered as part of the development of the new Urgent Care Centre model, supporting further improvements in patient flow, clinical outcomes, and timely access to specialist care	30/11/26
	The Urgent Care Centre (UCC) task-and-finish workstreams have continued to progress the development of a sustainable operating model, workforce plan, and integrated approach across MIU and SDEC services. Work has focused on the design of future patient pathways, clinical streaming processes, governance arrangements, and workforce requirements to ensure the model is responsive to local demand. Collaborative working between teams has strengthened service integration, identified opportunities for role development and skill-mix optimisation, and supported the development of a more flexible workforce capable of meeting the needs of the future urgent care system. Good progress has been made across the programme, with all medical pathway Standard Operating Procedures (SOPs) now undergoing review by medical and nursing teams to ensure pathways are clinically robust, operationally effective, and aligned to the future UCC model.	30/11/26
Embedded improvement actions		
- Daily monitoring of patient presentation types through morning flow meetings has improved operational oversight and supported service planning. This has improved patient flow, reduced waiting times, enhanced patient experience, and supported overall departmental performance - Continue joint working with community health, social care and discharge teams to reduce the number of medically optimised patients awaiting discharge, supporting improved patient flow and timely access to inpatient capacity. - Implement enhanced daily multidisciplinary review of patients with complex discharge requirements through Flow MDT meetings, ensuring early identification and mitigation of discharge barriers. - Continue weekly UCC task-and-finish group meetings to progress the future operating model, workforce arrangements, clinical pathways, and governance structures, supporting the delivery of an integrated urgent care system. - Complete the multidisciplinary review of all medical pathway Standard Operating Procedures (SOPs) to ensure pathways are clinically robust, operationally effective, and aligned to the future Urgent Care Centre model.		

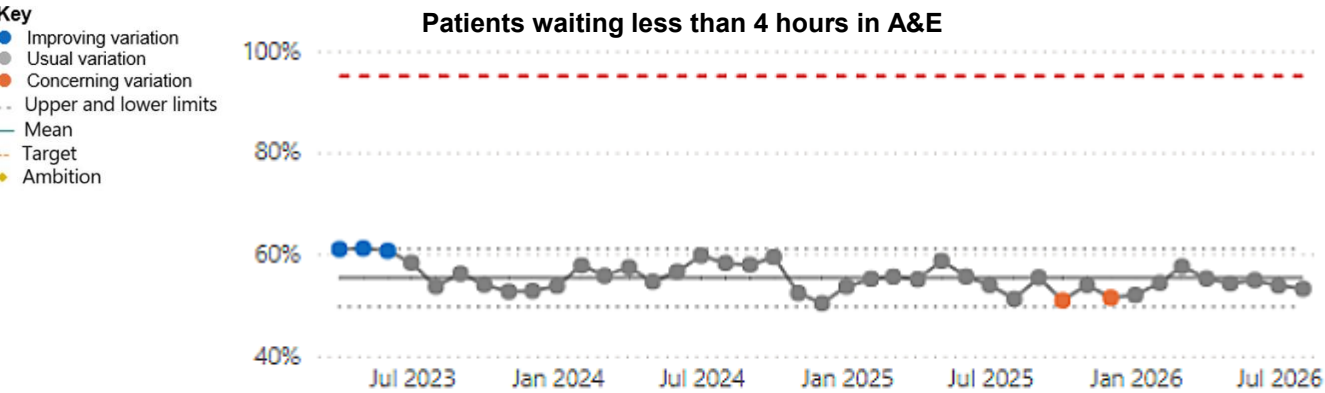


Latest data is showing usual variation. 291 handovers >45 minutes reported out of a total of 673 handovers, 43%.

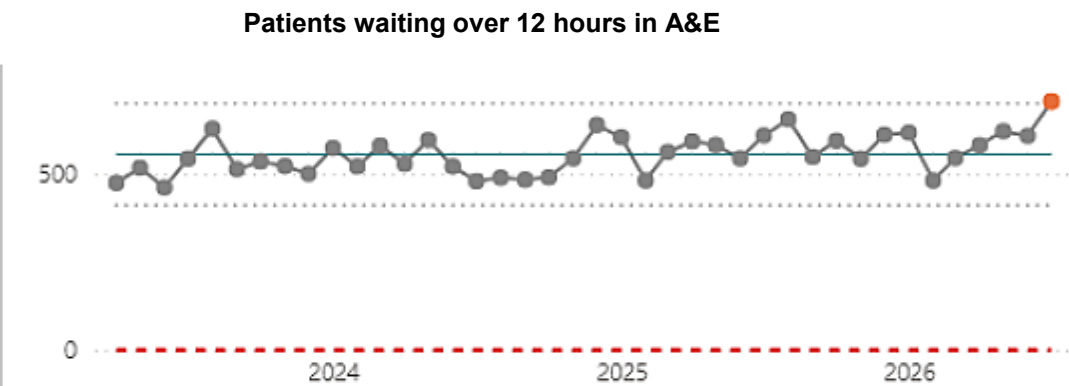


Latest data is showing usual variation. 69 handovers >4 hours reported out of a total of 673 handovers, 10%.

Key challenges / issues	Key actions / initiatives	Due date
- Trend of increasing monthly total ambulance conveyances seen month on month since April 2026. - Increased total monthly ED attendances trend since April 2026 with a peak in July of 4,504 followed by August on 4,466. For context April saw 3,873 attendances at Withybush ED. - Inconsistent coverage across the month of August from WAST with the Advanced Paramedic Practitioner role as part of our Clinical Streaming Hub. - Whole system challenges seen across August as all agencies struggled to meet operational capacity challenges due to a mixture of planned leave and increased sickness rates.	Implementation of trial ambulance changeover/handover rooms in ED w/c 22nd June 2026 – supporting WAST with dedicated space for handover of patients at end of shift for ambulance reviews	30/09/26
	Coordinate with WAST regarding Advanced Paramedic Practitioner Navigator support in our Clinical Streaming Hub (daily presence required)	30/09/26
	Reinforce ring-fenced capacity protocols in ED	30/09/26
Embedded improvement actions		
- MIYA flow process (digital bed management) - Dedicated resource (Band 6 nurse) allocated to “<i>Pitstop</i>” to lead on ambulance handover coordination - Direct referrals from WAST into the Clinical Streaming Hub, Frailty Same Day Emergency Care and Medical Same Day Emergency Care.		



53% reported for August, 2,077 breaches out of 4,435 new attendances. Chart is showing usual variation.

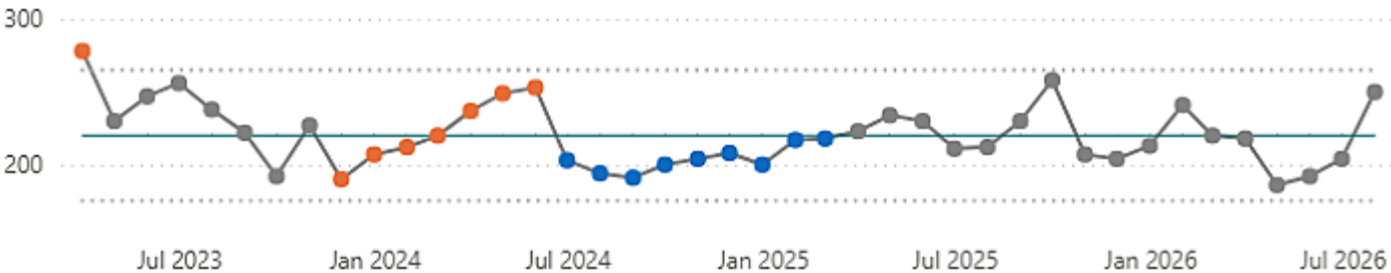


707 breaches out of 4,435 new attendances, 15.9%. Chart is showing concerning variation.

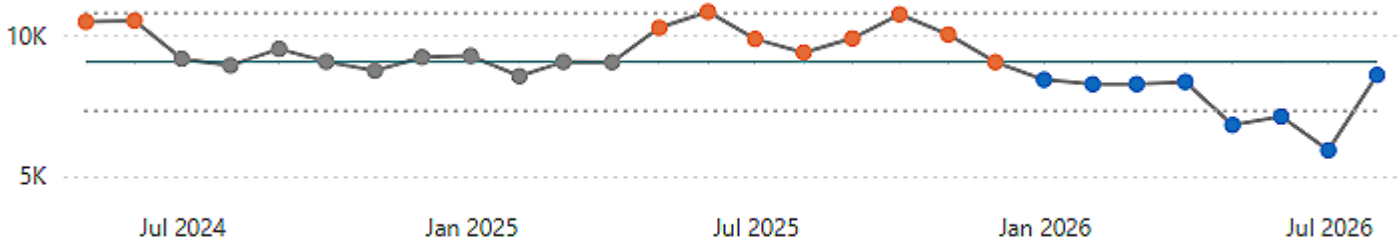
Key challenges / issues	Key actions / initiatives	Due date
- Increased total monthly ED attendances trend since April 2026 with a peak in July of 4,504 followed by August on 4,466. For context April saw 3,873 attendances at Witherbush ED. - Periods of high demand matched with high acuity of patient caseload with the ED department. Inpatient capacity compounded by limited flow out of the acute with a noted increased discharge delays across August – Pathway Of Care Delays in part due to multi-agency challenges maintaining operational capacity across August due to annual leave and sickness. - Additional challenges seen with increased mental health attendances including for mental health patients already admitted to an Hywel Dda Mental Health inpatient service – plans now in place to better support direct admissions to medicine for those cases from inpatient Mental Health services to eliminate the unnecessary visit to ED.	- Expand Medical Same Day Emergency Care unit into 7 day model - Deploy senior decision maker role to front door alongside frailty rapid assessment model - Drive average patient length of stay reduction targeting 0 cases over 50 days in the acute hospital setting, improving flow and admitting capacity	30/11/26 31/12/26 31/01/27
Embedded improvement actions		
- Frequent reviews of 12 hour ED waits to ensure they are marked for the correct ward and pathway - Wards to attend ED at start of shift to review patients waiting beds and develop plans/timelines for transfer to ward - MIYA flow process (digital bed management) - Direct referrals from WAST into the Clinical Streaming Hub, Frailty Same Day Emergency Care and Medical Same Day Emergency Care. - Acute medicine and specialty in-reach into ED - Proactive Frailty Screening and pull through of Frailty patients from ED into the Acute Frailty Unit or Frailty SDEC		

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

Total number of pathways of care delayed discharges (non-MH + MH & LD)



Total days delayed for Pathways of Care delayed discharges (non-MH + MH & LD)



- Number of pathway of care delays as at 19th August 2026 census was 250 patients, and the chart shows usual variation.
- The total days delayed for non-mental health increased in August to 7,954 days from 5,401 in July. Mental health and learning disability delays increased in August to 634 from 518 in July.
- Assessment issues remain the largest proportion of grouped delays reasons.
- The census count is based on any patients delayed in one of our hospitals, regardless of their area of residence i.e. will include patients living outside of Carmarthenshire, Ceredigion and Pembrokeshire.

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

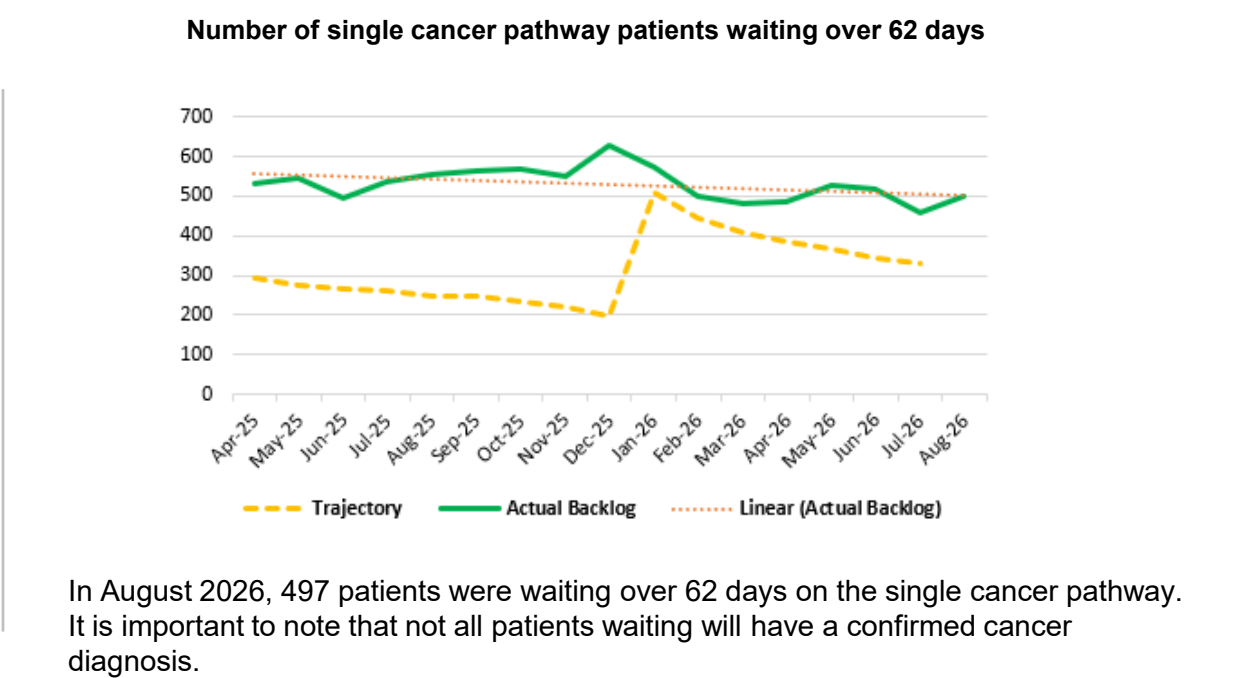
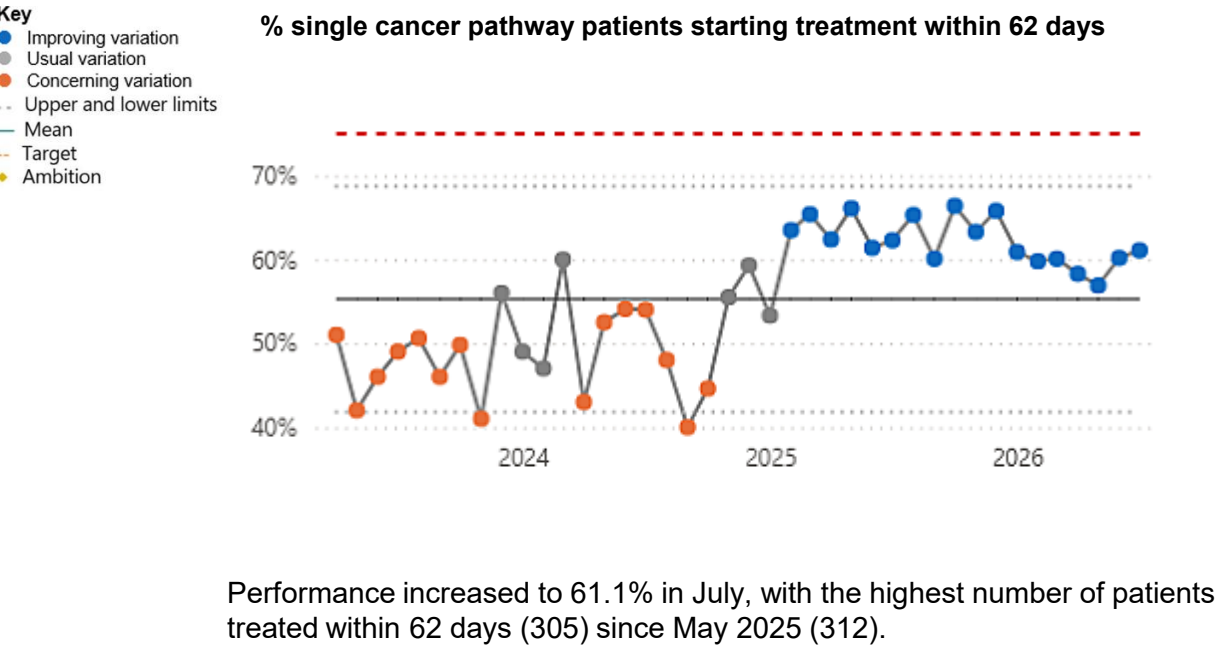
Delay Reason	Carmarthenshire	Ceredigion	Pembrokeshire	Out of area	Total Patient Count	Total Days Delayed	Average days
Awaiting start of new community care package funded by social care	16	6	7	1	30	1,309	44
Awaiting completion of assessment by social care	40	0	7		47	1,176	25
Awaiting reablement community care package	37	3	3		43	1,055	25
Identifying Residential Home	10	1	2		13	729	56
No suitable abode - requires re housing	4	1	1		6	419	70
Mental Capacity Assessment Delays	4	1	3		8	304	38
Awaiting RH availability	1	1	3		5	284	57
Awaiting care home manager to visit assess and provide outcome (Nursing)	2	0	1	1	4	283	71
Awaiting joint assessment	3	3	3		9	228	25
Awaiting completion of best interest decision	1	2	6		9	209	23
Other	28	13	33	2	76	2,592	34
Total	146	31	69	4	250	8588	34

Key challenges / issues	Key actions / initiatives	Due date
Non Mental Health: Increasing challenge accessing local authority (LA) resources to support discharge (new community care packages, social work assessments, reablement) especially within the Carmarthenshire system. Ongoing wider acute and community system pressures and ambulance handover improvements increasing surge and boarding. Staffing shortages, sickness, recruitment issues and annual leave impacting discharge planning and 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. In hospital deconditioning and limited rehabilitation capacity due to the allied health professional (AHP)/ therapy staffing position causing delays to assessments, reablement and discharge care packages. Housing, homelessness and care home capacity challenges delaying onward placement and discharge. Mental Health & Learning Difficulties: Overall POCD position increased from 10 to 16 cases since July, reflecting growth within both Adult Mental Health (AMH) and Older Adult Mental Health (OAMH) cohorts and increased system-related discharge barriers. OAMH accounts for most delays (12/16 cases), concentrated across Bryngolau, Enlli and St Non’s Wards, with ongoing challenges securing residential, nursing, dementia and specialist placements. Two POCD cases now exceed 100 days (St Caradog Ward, 135 days; Enlli Ward, 125 days), indicating continued challenges securing solutions for individuals with complex placement and housing requirements. Placement-related delays remain the predominant driver of POCD, including dementia nursing, residential, specialist mental health and step-down care home provision, with a smaller number of cases awaiting funding decisions, social care assessment or care package implementation. Housing-related delays remain evident within both AMH and OAMH services, including cases requiring rehousing or alternative accommodation prior to discharge.	Non Mental Health: 3 Pillars programme – Executive Director of Nursing, Quality and Patient Experience identified as clinical executive sponsor for flow and POCD workstream. • Wider system deep dive into POCD and internal audit being completed. • Memorandum of Understanding between Health and LA partners signed off. • National Performance and Improvement site visit to support flow improvement plan and opportunities (awaiting formal report). • Proposal for Discharge to Assess (D2A) pathway capacity developed (commissioned care home beds). • Health Board Working Group established to focus on Rehabilitation pathways/ levels • Working with AHP leads to develop a prioritisation and escalation tool. Mental Health & Learning Difficulties: Targeted scrutiny of >100-day POCD cases within Enlli and St Caradog Wards, with continued implementation of the OAMH clinical governance improvement plan and strengthened oversight of complex discharge pathways. • System-level engagement with LA, commissioning teams and independent sector providers to increase access to residential, nursing, dementia and specialist mental health placements and reduce placement-related delays. • Focused management of housing and accommodation-related delays continues across AMH and OAMH services, including strengthened multi-agency liaison with LA housing teams. • Continued scrutiny of funding decision timelines, social care assessments and community care package implementation to ensure timely progression of discharge plans. • Focused review of AMH homelessness and accommodation-related delays continues, including multi-agency engagement with LA housing services and policing partners. Development of a multi-agency workshop remains ongoing to reduce recurrence of POCD associated with non-clinical discharge barriers.	31/12/26 31/10/26 Complete 30/09/26 30/09/26 31/10/26 31/10/26 31/10/26 30/09/26 30/09/26 30/09/26 31/10/26

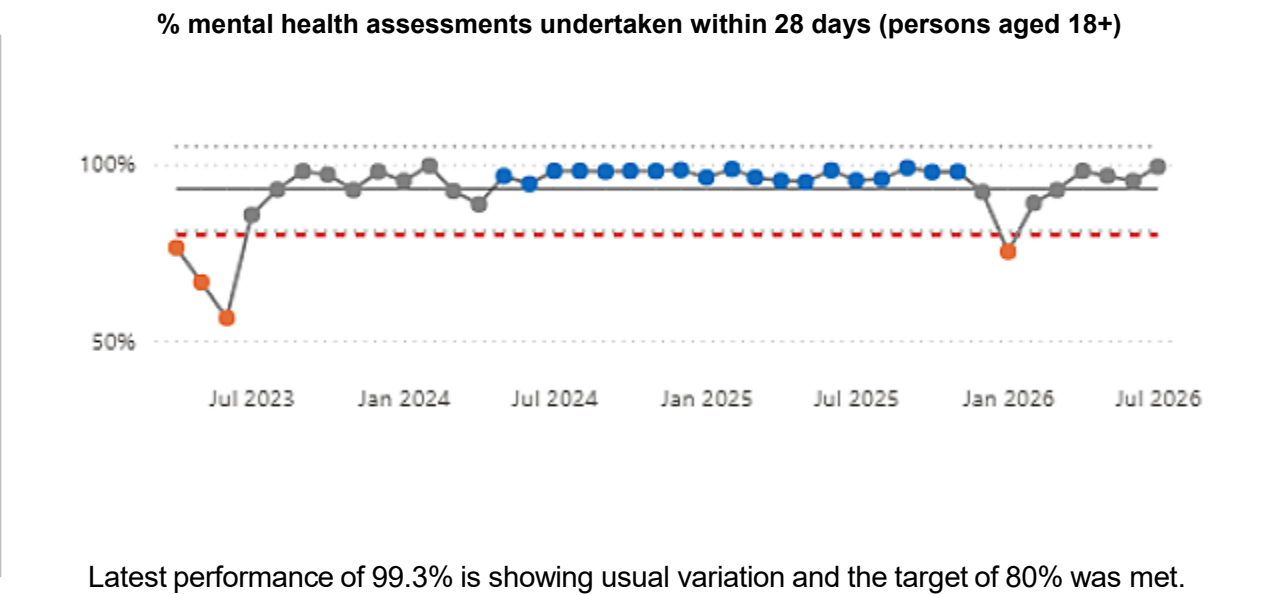
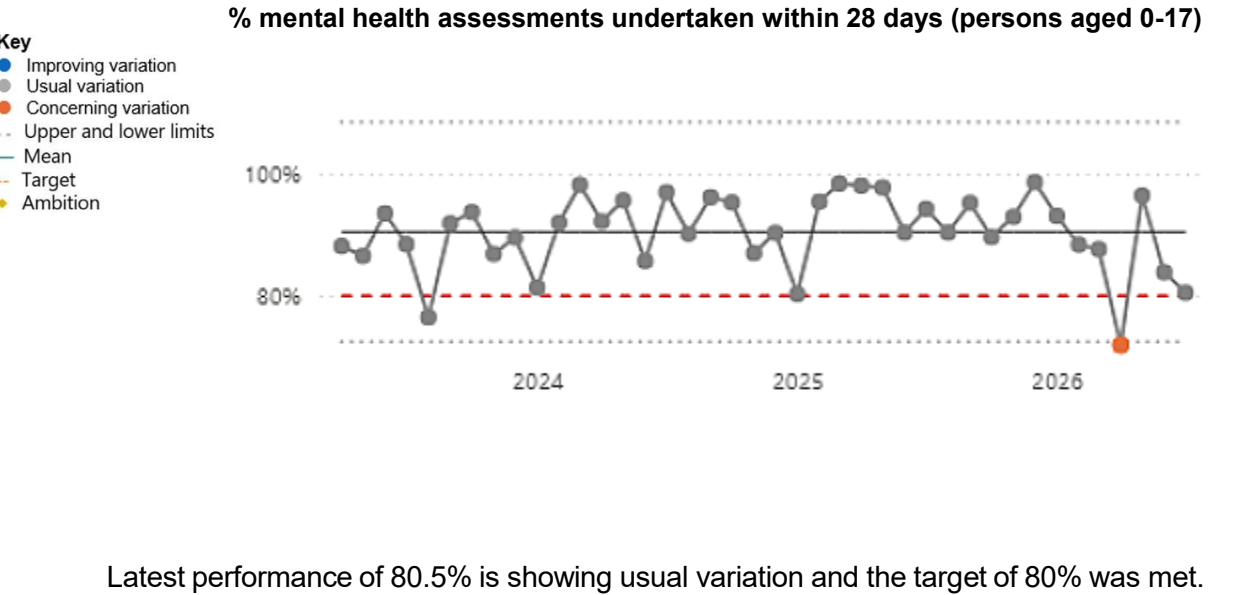
Embedded improvement actions

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 reablement capacity from WG funding, strength- based collaborative communication approach being embedded. Electronic Patient Flow system introduced to support flow and discharge planning, working closely with local authority to address issues around housing.

Mental Health & Learning Disabilities: Daily multidisciplinary and multi-agency escalation arrangements remain embedded across AMH inpatient services, alongside daily OAMH Acute Pathway oversight. Weekly POCD deep-dive and escalation meetings across AMH and OAMH remain established, supporting senior validation, challenge and system escalation. Discharge to Recover and Assess principles remain embedded, supporting early discharge planning and proactive management of discharge barriers. Dementia Wellbeing stepped-care model remains established across regional care homes, supporting admission avoidance, discharge planning and system flow. Multi-agency working with LA remains embedded, including routine validation of POCD status, shared accountability for delays and escalation of complex placement requirements



Key challenges / issues	Key actions / initiatives	Due date
Single cancer pathway Performance in July 2026 for patients on the Single Cancer Pathway improved by 0.9%, driven by higher activity through recovery actions in radiology, pathology and urology.	Outsourcing MRI for prostate patients started in November 2025, extended for Q2 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.	30/09/26
Backlog and Diagnostics August 2026 backlog pathways for patients were predominantly in Urology (186), Gynaecology (86) and Lower Gastrointestinal (71). The Planned Care Delivery and Sustainability Plan 2026/27 submitted to Welsh Government on the 31/07/26, requests in-year recovery funding of £15,497,081 part of which seeks to address 7- day turnaround for Radiology and Pathology single cancer pathway diagnostics. Tranche 1 of funding allocation is £4.5m. This does not include any cancer monies. Tranche 2 is expected shortly.	£168k committed via recovery money for Urology Diagnostics for Q2 Residual recovery funds allocated for Pathology turnaround for Q2 Outsourcing CT scans equates to 260 scans per month with a 7-day reporting turnaround, extended to end of September 2026 Awaiting confirmation recovery funding for the 7-day turnaround diagnostics	30/09/26 30/09/26 30/09/26 30/09/26



Key challenges / issues

% mental health assessments undertaken within 28 days (persons aged 0-17):
88 assessments were carried out in July, an increase of 42% on June's activity. Compliance was maintained despite this increase. Average compliance since April 2026 is 83.2%.

% mental health assessments undertaken within 28 days (persons aged 18+):
Performance has increased by 4% from last month and remains high above target. The service continues to monitor assessment times which can impact on compliance. Two teams are experiencing high volumes of sickness which could potentially impact on compliance over the next month or two.

Key actions / initiatives

% mental health assessments undertaken within 28 days (persons aged 0-17):
Enabling Quality Improvement in Practice (EQliP) 'demonstrator project' to move to a more preventative and responsive 'One at a Time' approach as part of the implementation of Welsh Government Mental Health strategy.

Due date

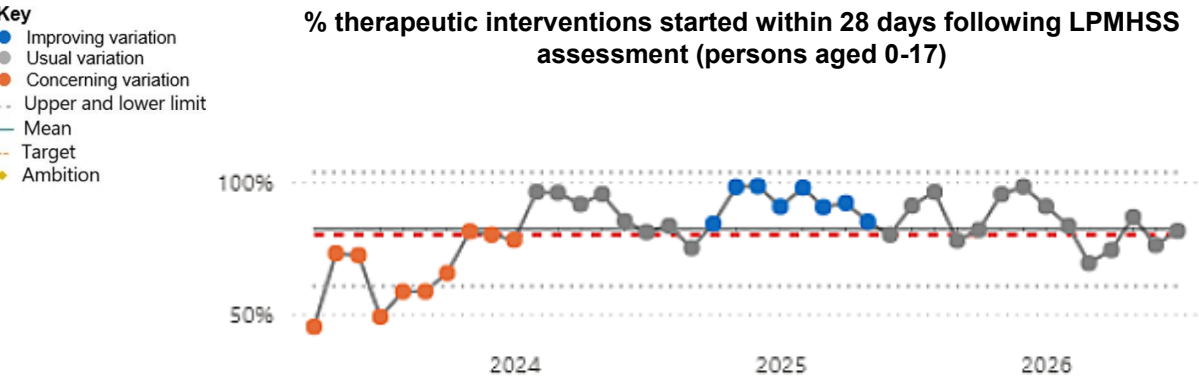
31/03/27

Embedded improvement actions

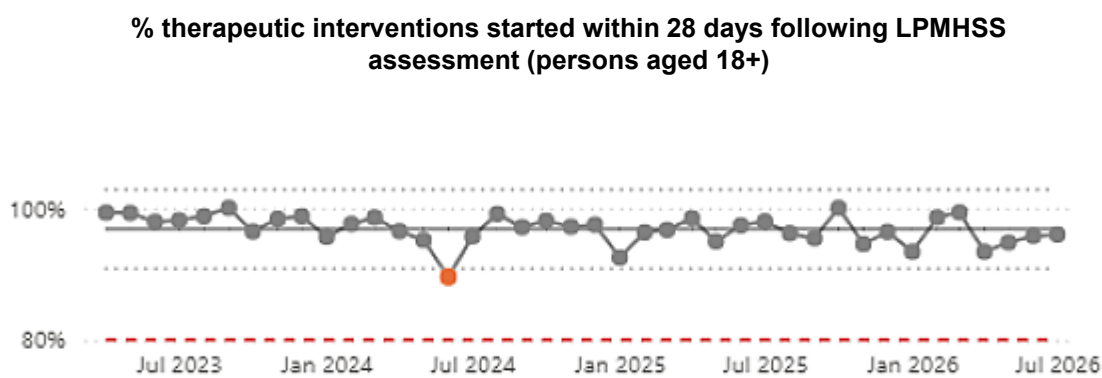
% mental health assessments undertaken within 28 days (persons aged 0-17):
Strengthen weekly monitoring of capacity and demand, coordinate assessment and intervention resources across localities, and improve the timeliness of follow-up contact and the start of interventions.

% mental health assessments undertaken within 28 days (persons aged 18+):

- All teams are utilising the Primary Care Liaison Service (PCLS) at the point of referral supporting reducing pressure on Local Primary Mental Health Support Services, enhancing the patient journey.
- Compliance is well above target – staff to continue with current service plans and management of assessments.



Latest performance of 81.4% is showing usual variation and the target of 80% was met.



Latest performance of 96% is showing usual variation and the target of 80% was met.

Key challenges / issues	Key actions / initiatives	Due date
% therapeutic interventions started within 28 days following LPMHSS (Local Primary Mental Health Support Service) assessment (persons aged 0-17): 59 interventions commenced in July, a decrease in activity from June. Family availability in the summer holidays can mean difficulty arranging assessments within timeframes. We anticipate continued compliance despite this. % therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+): Compliance continues to increase, well above target, reflecting 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. Withdrawal of the SPRING trauma intervention is being supplemented with Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). Staff are accessing training when available and any effects of withdrawal are being monitored across Wales.	% therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17): Enabling Quality Improvement in Practice (EQIIP) 'demonstrator project' to move to a more preventative and responsive 'One at a Time' approach as part of the implementation of Welsh Government Mental Health strategy. Embedded improvement actions % therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 0-17): Strengthen weekly monitoring of capacity and demand, coordinate assessment and intervention resources across localities, and improve the timeliness of follow-up contact and the start of interventions. % therapeutic interventions started within 28 days following LPMHSS assessment (persons aged 18+): - Utilisation of supportive intervention options through the third sector, SilverCloud and our Primary Care Liaison Service (PCLS) which is operating across the three counties with positive outcomes of reducing potential referrals to LPMHSS. - A focus on group interventions remains; however, as a service we will be reviewing the current treatment menu to ensure effectiveness in treatment options.	31/03/27



Performance in July of 56.6% shows concerning variation and the target of 80% was not met.

- 477 out of 841 (56.7%) patients were waiting <26 weeks to start an integrated psychological therapy;
- 2 out of 5 (40%) were waiting <26 weeks to start an adult psychology assessment;
- 42 out of 71 (59.2%) were waiting <26 weeks to start a learning disability psychology within 26 weeks.

Key challenges / issues

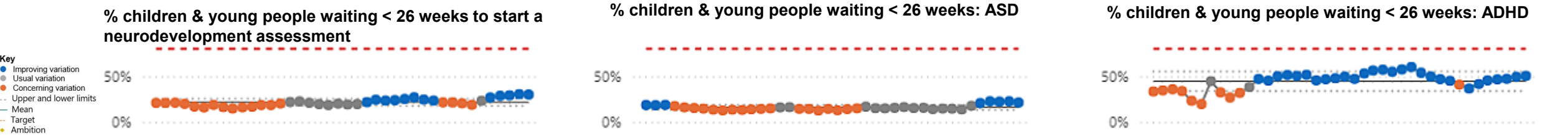
Integrated Psychological Therapies Service (IPTS):
Compliance has dipped 2.7% since last month. This is directly linked to the Attend Anywhere (AA) to MEDIO digital consultation transition. To avoid any groups being disrupted part-way through the transfer window, the decision was taken to reschedule or stagger those that would have fallen during that period. Whilst operationally correct, this has had a short-term impact on referral-to-treatment (RTT) performance. We are awaiting commencement dates for newly qualified nursing (NQN) workforce.

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):
Our waiting list backlog for our 26-week target to start an adult psychology assessment is the lowest recorded since April 2021 with 5 patients.

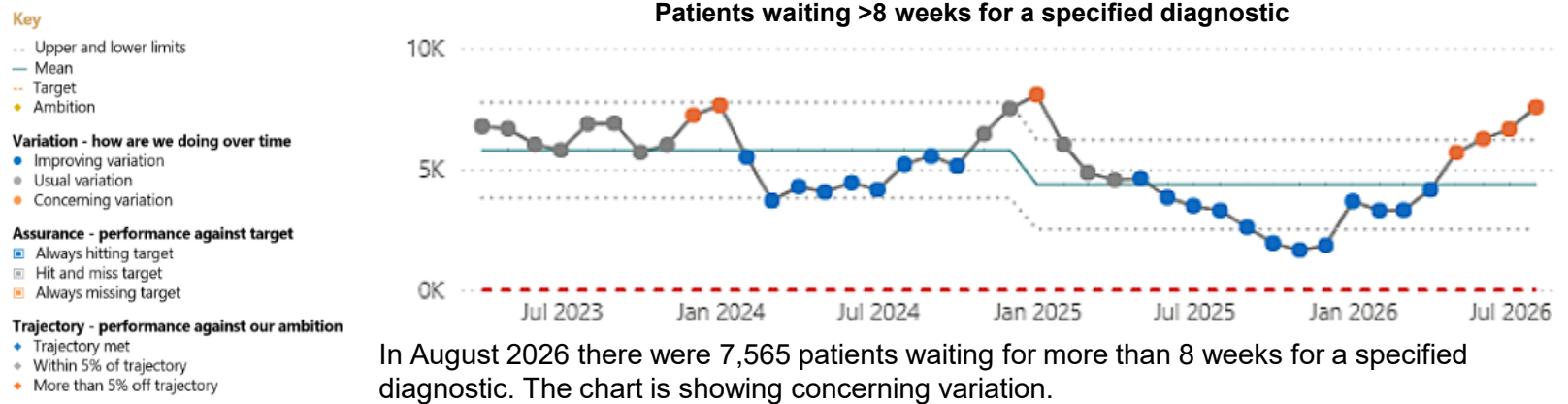
Key actions / initiatives	Due date
IPTS: - A Patients Know Best (PKB) pilot is due to commence in late September, supporting patient communication, outcome measures, questionnaires and therapeutic resources. LDs: - Develop the Memory Clinic pathway and the Behaviour that Challenges pathway which aim to upskill other colleagues to reduce lower-level demands on P&Bs. - Two new Assistant Psychology posts approved to cover Carmarthenshire/Pembrokeshire & Ceredigion to make up for shortfall in hours is now out for advert.	01/10/26 30/09/26 30/09/26
Embedded improvement actions	
IPTS: - Recent training has positively impacted trauma waiting times. - High-intensity group interventions is now embedded, delivering positive patient outcomes. - Therapy session caps and regular waiting list oversight continue to support capacity management. - Therapist job plans are aligned to maximise service capacity. 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 Your Workforce' plans are in place.	

Neurodevelopmental assessment waits
(Performance framework)



The overarching neurodevelopmental assessment metric is a combined ASD & ADHD position. Performance in July 2026 of 29.9%, shows improving variation but the target of 80% was not met. Performance is driven by ASD, where 718 of 3,362 (21.4%) patients had an ASD assessment < 26 weeks. 709 out of 1,409 (50.3%) patients had an ADHD assessment <26 weeks.

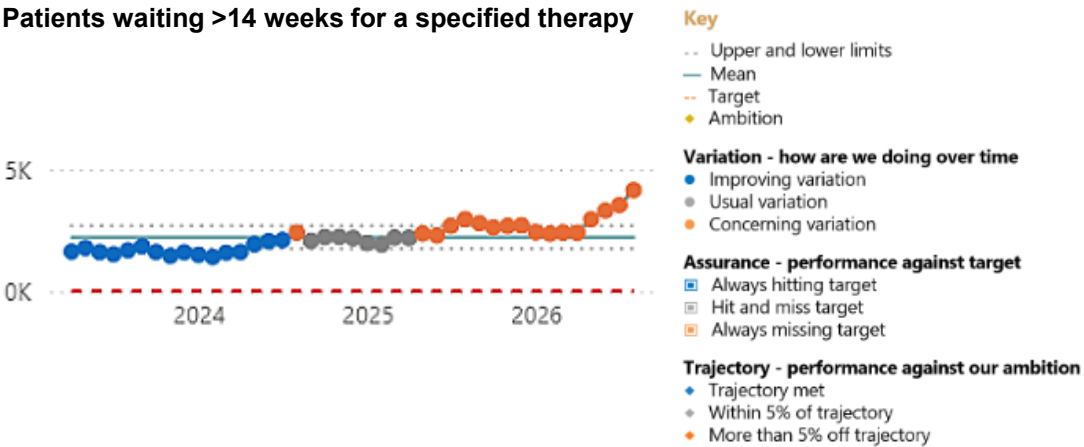
Key challenges / issues	Key actions / initiatives	Due date
Attention Deficit Hyperactivity Disorder (ADHD): There are currently 1,367 children and young people awaiting an ADHD assessment, with the longest current wait at 112 weeks and 427 individuals waiting over 52 weeks. Referrals into the service 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. In addition, clinic room availability across all sites remains a challenge. Longer-term solutions are being implemented through the Bandi appeal and the proposed reconfiguration of Puffin Ward to increase capacity.	ADHD: • Increase clinic room capacity through the Bandi appeal and the reconfiguration of Puffin Ward. • Expand core capacity by increasing access to QB testing and follow-up appointments. Currently, only one device is available across the counties, with a limited number of Healthcare Support Workers trained in its use. 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 continue to be explored. • Explore digital solutions, such as Magic Notes, to support appointments and reduce clinician administrative time. • Options paper submitted to address capacity and demand issues. ASD: • Forging closer working relationships with community services, education and local authorities in order to provide training, supervision and consultation. Current projects include a co-ordinated approach to inset day training for teachers and Additional Learning Needs Coordinators working alongside colleagues from education, Child and Adolescent Mental Health Services and school in-reach teams, particularly in schools with high referral rates. • Continued familiarisation with Beam Notes to increase confidence and competence amongst staff. • Continued development of the Patient Knows Best platform with benefits realisation project underway. • Streamlining decision making processes to reduce the time and cost of multidisciplinary (MDT) processes currently in place and reducing the delay in outcomes for children, families and carers. • Statement on the ratification of private assessments has released clinical time and empowered parents to use independent assessment documents to share information about child needs without health service oversight.	31/03/27 31/03/27 31/03/27 31/03/27 31/03/27 31/12/26 31/12/26 31/11/26
Autism Spectrum Disorder (ASD): There were 3,362 children and young people awaiting an ASD assessment in July, with 2,644 waiting longer than 26 weeks. The performance decline in month, correlates with the 2025/26 outsourcing contract coming to an end. A further contract is now in place for 2026/27 with 300 assessments to be completed by the end of November. However, outsourcing does not always reduce the longest waits due to the referral criteria excluding complex mental health needs, learning disability and particular age ranges.	Embedded improvement actions ADHD: • Explore QB Check as a digital solution to improve access to QB testing where clinically appropriate. • Continue to optimise clinic utilisation through flexible management and robust job planning. ASD: • Progression of the Patient Knows Best platform.	



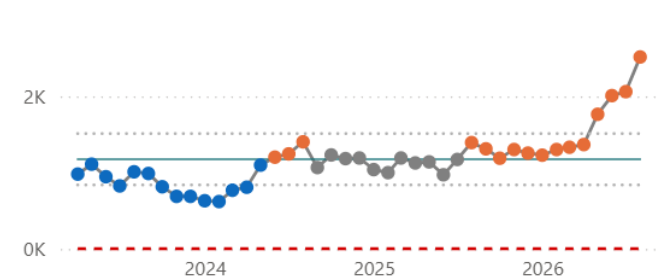
Diagnostics waits over 8 weeks (Enhanced monitoring condition and Ministerial priority)		Diagnostics	
Key challenges / issues		Key actions / initiatives	Due date
Radiology: Total breaches = 5,998 (5,964 Radiology , 34 Imaging), this is inline with the recent trajectories produced by the performance team, due to RISP go live data quality issues, and submitted to Welsh Government (WG). Activity is stable. However, base capacity does not meet the sustained demand growth. Note the impact Welsh Government funding for MRI ended 31st March 2026, reducing capacity by 540 patients per month. The Service continues to maximise internal capacity utilising insourcing where applicable for NOUS demand.		Radiology: • MRI van extended to March 2027 using core funding (vacancy lag), impact 540 patients scanned per month. • Computed Tomography (CT) van extended until September 2026 with additional funding, increasing monthly capacity for 250 urgent suspected cancer patients. • Diversification NOUS workforce pathway work underway with physiotherapy, podiatry and maternity to increase u/s capacity • Revised demand and capacity modelling work is currently being undertaken relating to Tranche 1 & 2 of Welsh Government 2026/27 Planned Care recovery funding allocation. • Opportunity to increase workforce available for u/s escalated for organisational approval	31/03/27 30/09/26 30/09/26 31/09/26 31/09/26
	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 via insourcing until end of August.	Endoscopy: • Insourcing undertaken May-August in gastrointestinal endoscopy to bridge baseline capacity deficit in-order-to-maintain the 8-week performance standard. Maintenance of zero breaches from September reliant on additional WG funding to bridge demand & capacity gap. • The service continues to maximise core capacity and management of referral demand through robust clinical vetting. • Urology to complete additional lists Aug-Sep to accommodate patients waiting over 8 weeks	31/03/27 31/09/26 31/09/26
	Cardiology: Cardiology echocardiography breaches continue to be primarily driven by longstanding shortfalls in in-house diagnostic capacity. The position has remained challenged throughout the reporting period due to ongoing workforce pressures, including the impact of both short and long-term sickness absence and maternity leave. Myocardial Perfusion Scan (MPS) waiting times remain elevated following the April 2026 system outage, which significantly increased the backlog. Recovery has been constrained by ongoing capacity limitations, and the breach position has continued to deteriorate. This remains a fragile service and is reflected on the Directorate risk register. Reliance on a single consultant presents a significant risk to service resilience, capacity, and recovery of waiting list performance.	Cardiology: • Recovery plans are being progressed to reduce the echocardiography backlog through the utilisation of additional funding initiatives and the engagement of an external provider to increase diagnostic capacity. The Service is working closely with the appointed insourcing provider to finalise delivery arrangements and confirm the level of additional activity that can be delivered. Recovery trajectories will be finalised once capacity and activity levels have been agreed. • Myocardial Perfusion Scans (MPS), the team continues to work closely with Radiology colleagues to manage risk for long-waiting patients, ensure appropriate clinical prioritisation, and maximise available capacity to support waiting list recovery.	31/09/26 31/09/26

Performance is showing concerning variation with 4,165 breaches at the end of August 2026, this highest level recorded.

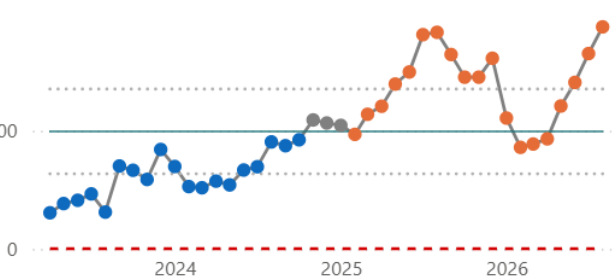
Patients waiting >14 weeks for a specified therapy



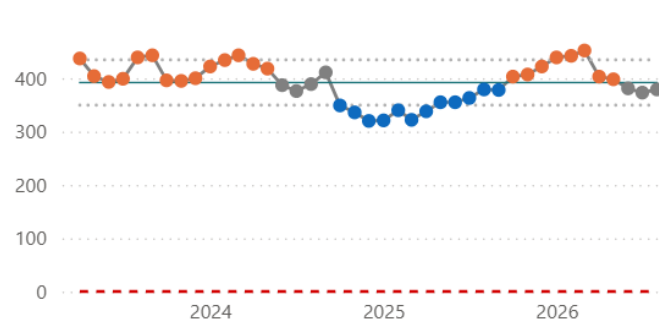
Number of patients waiting 14 weeks plus for Physiotherapy



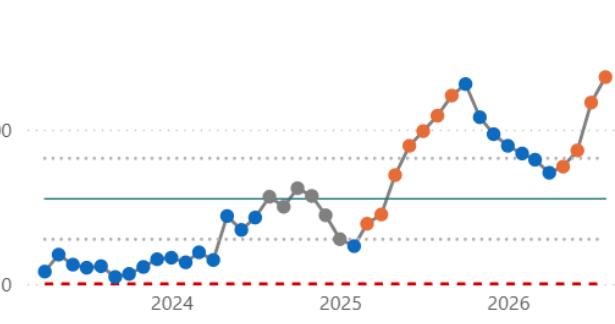
Number of patients waiting 14 weeks plus for Podiatry



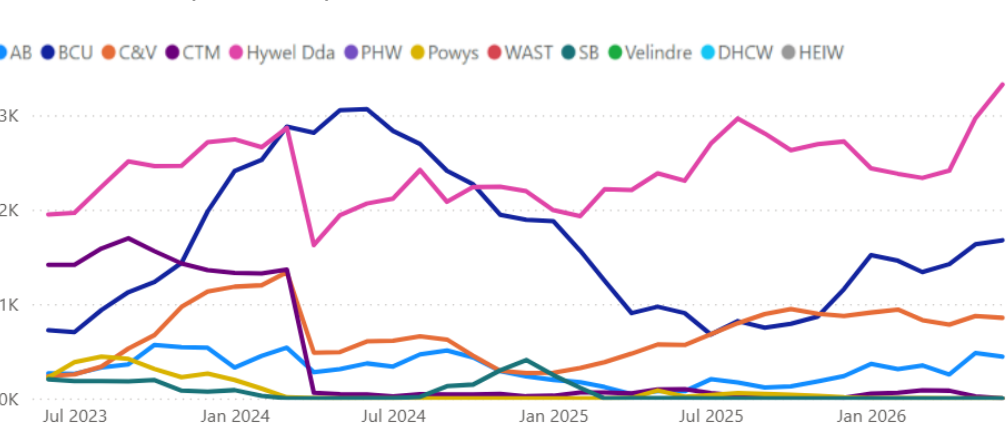
Number of patients waiting 14 weeks plus for Occupational Therapy



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



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



Therapy	Latest period	Latest actual	Variation	Assurance
All	August 2026	4,165	●	▣
Physiotherapy		2,516	●	▣
Podiatry		940	●	▣
Occupational Therapy		379	●	▣
Dietetics		268	●	▣
Art therapy		33	●	▣
Speech & Language Therapy		29	●	▣

Therapy waits over 14 weeks (continued) (Enhanced monitoring)

Key challenges / issues

Physiotherapy
96% of breaches are in Musculoskeletal (MSK). Demand continues to grow and is greater than capacity, driven by shifting work from primary and secondary care toward MSK Physiotherapy services. Demand growth is compounded by:

- Increased proportion of urgency in demand (now >50%) in MSK and community services.
- Reduced service capacity (staff leave, 3 whole time equivalent (WTE) vacancies, 1 Band 3 maternity) compounded by recent availability issues for agency/bank to backfill. The service has also not replaced 1.4 WTE vacant posts in line with financial standing instructions that were without budget.

Occupational Therapy (Paediatrics)
Overall demand has increased by around 40% and whilst the service had some additional capacity, this has reduced through July and August 2026 by 2.0 WTE and further workforce turnover planned towards the end of September 2026. As a result, we are predicting a further deterioration in performance through the next quarter to December 2026.

Podiatry
As anticipated, waiting list breaches have continued to increase. Demand has increased by around 40% in the last six years without subsequent increase in capacity, while patient complexity has increased. Podiatry is the first point of contact/triage service for Orthopaedics and Vascular services. To meet modern expectations for timely assessments and interventions, the service now includes 7 Independent Prescribers and 5 Ultra Sonographers, achieved through internal reconfiguration. A demand and capacity (D&C) review indicated that a proposed increase in 3 whole time equivalent staff is required, however, as funding has not yet been made available, the staffing gap remains unaddressed, and the waiting list will continue to increase.

Dietetics
Paediatric breaches present 96% of nutrition and dietetic breaches, the longest wait now 77 weeks. This is an increasing trajectory from May 2026 (142) to August 2026 (255) and is due to high demand vs capacity in this service and long-term sickness absence. Approval in place for 1.6 WTE agency extension to support stabilisation until 31/03/27.
Community breaches have increased by 10 in August 2026, with D&C work being finalised.

Key actions / initiatives

Actions below attempt to reduce breaches where possible (impact is not expected to significantly reduce breach numbers therefore impact is not stated) but without the required investment in additional posts, the 2026/27 agreed forecast is a minimum of 3,229 breaches by March 2027.

Physiotherapy

- Second MSK form validation process to start 01/08/26, a refinement of process following pilot.
- A review of community prioritisation criteria aligned to clinical risk matrix is currently being undertaken, with initial pilot complete in Carmarthenshire, analysis in progress.
- Three projects being developed through Enabling Quality Improvement in Practice (EQIiP) program. 1) development of agnostic condition management classes; 2) patient activation and chronicity risk stratification as part of self referral processes; 3) pilot of new model for telemedicine assessment in MSK.

Occupational Therapy (Paediatrics)

- Development of Paediatric Sensory Workshop to support universal and targeted offer. Implementation review and further refinement in progress.
- Development of triage process to improve access and reduce delays and inappropriate referrals.
- A review of referral pathways and activity criteria within the Carmarthenshire Integrated Service to establish a clear distinction between Health and Social Care activity, demand and waiting lists.

Podiatry

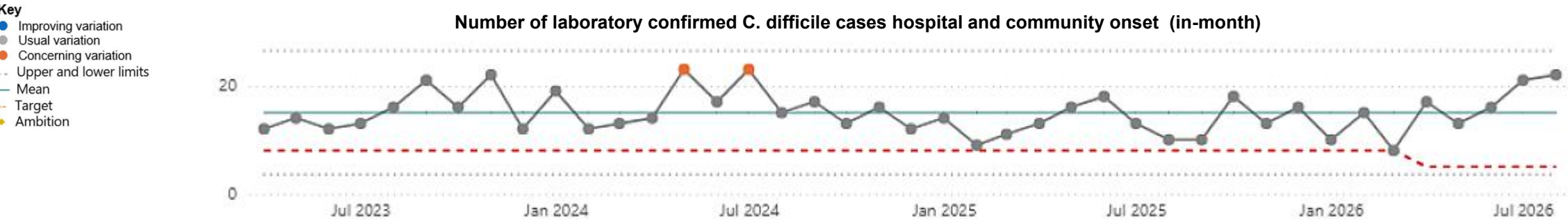
- Consultant Podiatrist post in development. This will improve treatment flow, governance and waiting times.

Dietetics

- Paediatric - reviewing referral criteria and scoping implementing e-referrals to reduce admin required for triage allowing more efficiency in clinical time
- Community - Contingency measures in place include revised prioritisation tools and triage criteria to ensure essential and critical patients prioritised.

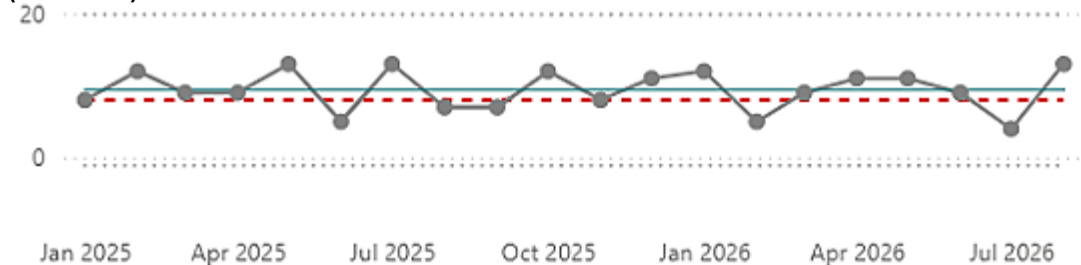
Embedded improvement actions

Podiatry: In depth D&C review indicated that service was efficient, all staff on 10 session template booked by office with electronic rota and strong discharge and eligibility procedures in place. Significant skill mixing undertaken. Service review undertaken to strengthen management structure and maximise efficiency.



In August 2026 there were 22 confirmed cases and the chart is showing usual variation.

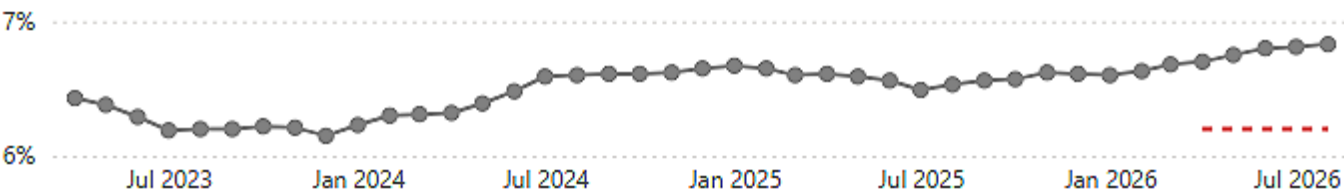
Key challenges / issues	Key actions / initiatives	Due date
- Hospital onset infections of C. difficile cases are increasing and remain above target. Several community onset infections have been classified as "community onset, healthcare associated", meaning cases are linked to recent healthcare exposure. 1 Outbreak and 3 Periods of Increased Incidence for C. difficile have been reported between July and August. - The Welsh Health Circular Antimicrobial 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. Current year-to-date figures indicate a 29% deterioration on the reduction target of 2024/25 (20 cases). - 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 remain below the expected standards and further assurance is required for post discharge cleaning across the Health Board. - Compliance Gaps: Lapses in bare below the elbow standards across staff groups. - Mandatory Training: Level 2 Infection Prevention Control E-learning compliance at 86.78%-an improvement	- ePMA rollout will support antimicrobial stewardship, intravenous to oral switch for medication will also be revisited alongside this. - Review of cases for August to assess locations, themes and any cleaning implication that could have contributed to the infection. - Targeted training for wards with Periods of Increased Incidence relating to hand hygiene and cleaning.	01/10/26 30/09/26 30/09/26
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 Level 2 infection prevention and control Training, Aseptic non-touch technique compliance and assessor training offered to clinical areas from infection prevention as well as Fit-testing compliance.		



In August 2026 there were 13 confirmed cases, and the chart is showing usual variation.

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 2026/27 the HB would need to achieve 54 cases or less to meet the improvement goal. Current year-to-date figures indicate a 45% deterioration on the reduction target of 2024/25 (9 cases). • Most cases occur in the 80–89 age group. With an increase in cases seen in July and August likely linked to the prolonged hot weather. • Non-compliance observed bare-below-the-elbow practices across all staff groups.	E. coli: • Undertake monthly reviews of all hospital-onset E. coli BSIs to identify avoidable urinary tract infection and catheter-related factors, with learning shared through Clinical Care Groups. • Hand hygiene validation and observational audits conducted based on senior nurse monthly audits • Targeted hand hygiene validation audits for areas with Hospital Onset infection	30/09/26 30/09/26 30/09/26
S. aureus • Hospital and community onset MSSA BSI cases have remained broadly stable over the reporting period, fluctuating between 1 and 5 cases per month. • The Welsh Health Circular Antimicrobial Resistance and Healthcare Associated Infections 2025 to 2027 sets an improvement goal: for Methicillin-susceptible Staphylococcus (MSSA): a decrease of at least 20% compared to the 2024/25 baseline counts for all Health Boards for MSSA for hospital and community onset. Current year-to-date figures indicate a 6.4% improvement on the reduction target of 2024/25 (3 cases). • Health Board aseptic non-touch technique compliance for E-learning is at 85.62%.	S. aureus • Hand hygiene validation and observational audits conducted based on senior nurse monthly audits • Targeted hand hygiene validation audits for areas with Hospital Onset infection • August Infection to be discussed at the Healthcare Associated Infections Group meeting for each site to gain and share learning	30/09/26 30/09/26 30/09/26

% staff sickness rate (12 months rolling)



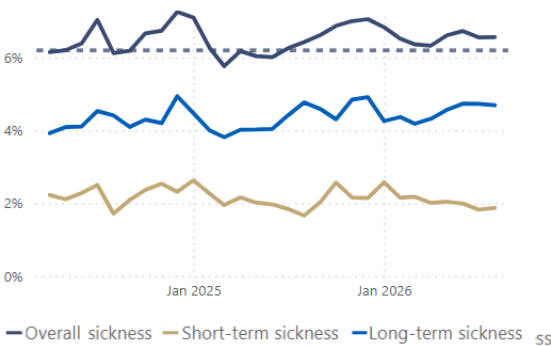
Rolling 12-month staff sickness percentage rate comparisons for August:

- August 2024: 6.60%
- August 2025: 6.53%
- **August 2026: 6.83%**

2026-2027 Rolling 12-month target = 6.2%

% staff sickness rate (in month)

August 2026 (in month) = 6.56%
Short-term sickness = 1.87%
Long-term sickness = 4.69%



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

Team	Staff	R12m	In-month
Health Protection – Immunisation Team	67	14.4%	22.2%
GGH - Domestic Services	134	13.6%	17.2%
Sunderland Ward	75	14.5%	13.6%
WGH - Domestic Services	139	11.1%	12.7%

Key challenges / issues

Sickness absence across the Health Board remains a significant workforce challenge.

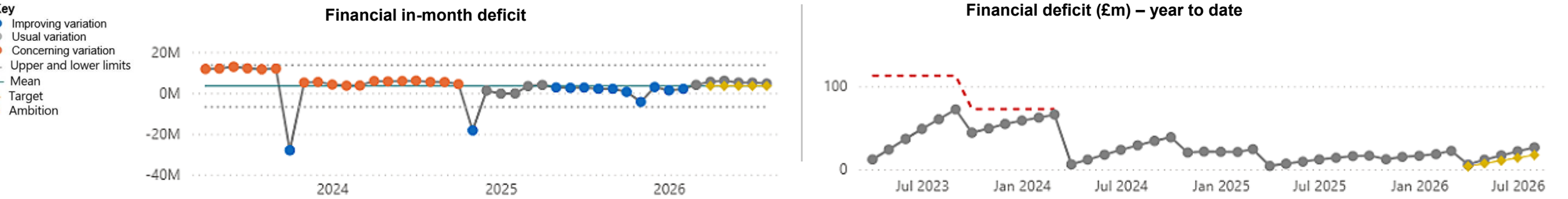
The data indicates that high absence is concentrated within operational, patient-facing services, particularly Estates and Facilities, Public Health, Community and Integrated Medicine, Mental Health and Learning Disabilities, and Planned and Specialist Care. This suggests ongoing challenges relating to workforce wellbeing, workload pressures, and the management of long-term absence.

Analysis of absence reasons demonstrates that mental health-related absence remains the most significant challenge, accounting for over one-third of all sickness absence days lost. Musculoskeletal conditions, gastrointestinal illness, injuries and back problems remain the next largest contributors. The continuing dominance of stress, anxiety and depression as the primary cause of absence highlights the importance of ongoing investment in staff wellbeing, early intervention, psychological support and proactive attendance management. While increasing musculoskeletal absence suggests a need for sustained focus on workplace health, manual handling, ergonomics and preventative interventions.

Embedded improvement actions

Targeted support for sickness absence

- The Absence Grip and Control Programme is being implemented across Clinical Care Groups, with a focus on strengthening management oversight of long-term sickness absence and progressing return to work, redeployment and case resolution plans.
- Workforce and Occupational Health teams continue to provide targeted support to managers, ensuring timely interventions, effective case management and consistent application of the Attendance Management Policy.
- Data quality and reporting improvements are being embedded to support more accurate sickness absence monitoring and enable focused interventions in hotspot areas.
- Service-level reviews continue to identify key drivers of absence, particularly mental health and musculoskeletal conditions, informing targeted wellbeing and prevention initiatives.
- Preparations for the autumn and winter period are underway, including targeted flu vaccination promotion and workforce wellbeing initiatives to support attendance and workforce resilience.



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 £60.9m, with required mitigating actions of £19.9m to be finalised, to achieve the reported end of year forecast position of £41.0m. Total savings delivery are £30.5m, leaving a savings delivery gap of £12.3m against the savings target.	Mid Year Forecast Assessment - The reported deficit, which currently remains the same as the Annual Plan at £41.0m, is being reviewed throughout September. If there is no material improvement, or robust plans, the forecast will likely alter.	07/10/26
The in-month financial position is a deficit of £4.6m, which is an adverse variance against the £3.4m deficit plan. This is driven by a core operational overspend of £0.6m, and a £0.6m under identification of savings, with £3.0m savings identified against the savings target of £3.6m.	Dental Allocation Underspend Risk - Welsh Government has confirmed that forecast dental funding underspends at quarter three (Q3) will be recovered. Immediate review of the dental financial position and delivery plans is required to maximise utilisation of the ring-fenced allocation and mitigate potential funding recovery.	31/11/26
The in-month core operational overspend of £0.6m largely relates to drugs price and concessions increase in line with May Prescribing Audit Report £1.0m, Continuing Healthcare packages increase £0.5m, Theatres and Radiology outsourcing of activity and consumables expenditure £0.3m, Digital initiative programmes contract expenditure £0.2m, offset by General Medical Services supplementary services underspend £(0.9)m and Dental contracts handback £(0.5)m.	Identification and delivery of robust savings plans - Whilst there has been a significant shift in the identification and conversion of underspends, there remains an identification gap to achieve the plan. There is an inequity across services with some over-delivering against target, and others under-delivering.	Overdue
	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. Month 5 deteriorating the end of year position further by £0.7m.	15/12/26
	Update presented to the August Finance and Performance Committee, Committee to advise the Board on the challenges faced in delivering savings at the detriment of performance, the Committee asked for a further update be presented in December.	

IPAR key metrics by type

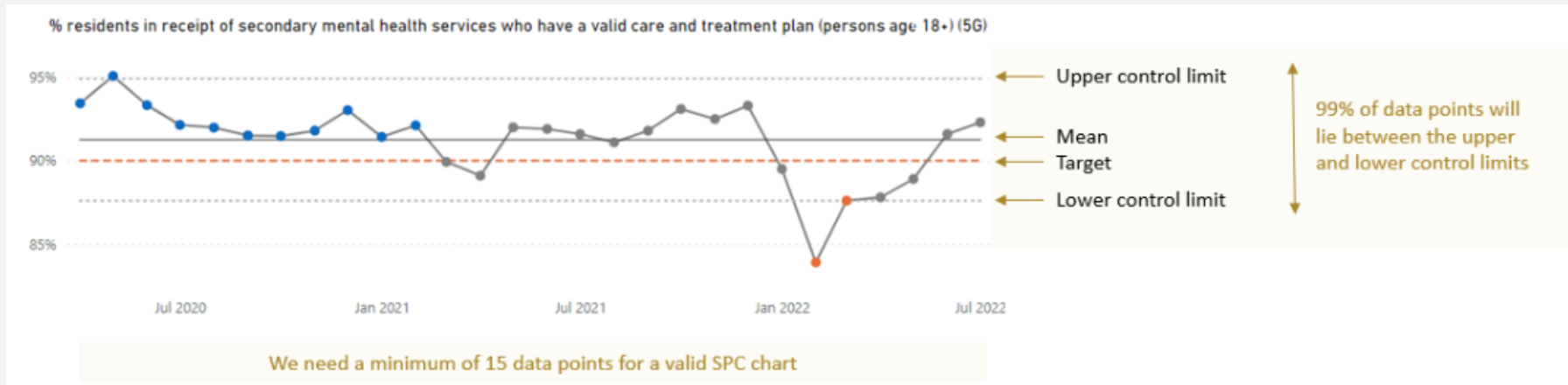
July 2026

Metric ID	Metric name	Annual plan	Enhanced monitoring	Local	Ministerial priority	Performance framework	Targeted intervention
27	C. difficile: Number of confirmed cases (in-month)	Y	-	-	-	Y	Y
51	Coding: % clinically coded - 1 month post discharge	Y	-	-	Y	Y	-
80	Pts waiting 8 wks+ for specified diagnostic	Y	Y	-	Y	Y	-
87	Ambulance handovers > 1 hour Hywel Dda	Y	-	Y	-	-	Y
88	% patients spending <4 hours in A&E/MIU Hywel Dda	-	-	-	-	Y	-
89	Patients spending > 12 hours in A&E/MIU Hywel Dda	Y	-	-	Y	Y	Y
150	Financial in month deficit	Y	-	Y	-	-	Y
155	% sickness absence rate of staff	Y	-	-	-	Y	-
275	% adult psychological therapy waits <26 weeks	-	-	-	-	Y	-
276	% child neurodevelopment assess waits <26 weeks	-	-	-	-	Y	-
277	% pts on single cancer pathway within 62 days	Y	Y	-	Y	Y	-
303	Follow-up appts - delayed >100%	-	Y	-	-	Y	-
320	% MH assess within 28 days (age 0-17)	-	Y	-	-	Y	-
321	% MH assess within 28 days (age 18+)	-	Y	-	-	Y	-
322	% therapy interven post LPMHSS assess (age 0-17)	-	Y	-	-	Y	-
323	% therapy interven post LPMHSS assess (age 18+)	-	Y	-	-	Y	-
433	Patients waiting 104 weeks+ RTT	Y	Y	-	Y	Y	-
443	Waits over 52 weeks: new outpatient appointment	Y	Y	Y	-	-	-
449	Pts 12yrs+ with diabetes receiving all 8 NICE care processes	-	-	Y	Y	-	-
483	Ambulance handover > 4 hours Hywel Dda	-	-	Y	-	-	-
501	Patients waiting over 52 weeks RTT	Y	-	Y	-	-	-
504	% uptake of flu vacc - 65+ years	Y	-	-	-	Y	-
515	Number of Pathways of Care delayed discharges	Y	-	Y	Y	-	Y
525	% of children who are up to date with scheduled vaccinations by age 5	Y	-	-	Y	Y	-
542	% of children receiving HPV by age 15	Y	-	-	Y	Y	-
545	Pts waiting 14 wks+ for specified therapy (Exc. Audiology)	Y	Y	-	-	Y	-
559	Median time ambulance arrest category calls	-	-	-	-	Y	-
560	Median time ambulance emergency category calls	-	-	-	-	Y	-
561	Ambulance handover > 45 minutes Hywel Dda	-	-	-	Y	Y	-
566	% R1 eyecare patients waiting within 25% delay to target date	-	-	-	-	Y	Y
571	% uptake of RSV vacc - 75+ years	-	-	-	-	Y	-
575	Patients waiting 26 weeks+ new outpatient	-	Y	-	-	Y	-
580	E.coli BSI: Number of hospital onset cases (in-month)	Y	-	-	-	Y	Y
581	S. aureus (MSSA) BSI: Number of hospital onset cases (in-month)	Y	-	-	-	Y	Y
588	Total days delayed for Pathways of Care delayed discharges	Y	-	Y	Y	-	-

Why use SPC charts?

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

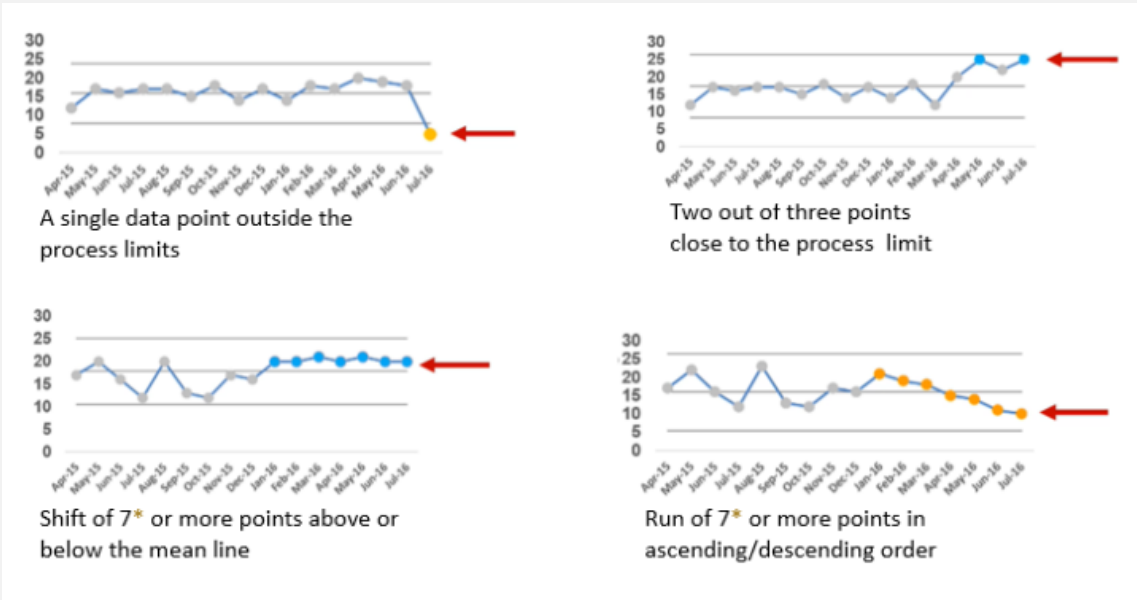
Anatomy of a SPC chart



Rules for special variation within SPC charts

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

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



* A 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		