Minutes of the Public Finance & Performance Committee Meeting
18th March 2026
Via MS Teams

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Chair:		
Rhian Thomas	RT	Independent Member – Capital, Estates & Facilities
Present:		
Judi Rhys	JR	Independent Member – Third Sector
Clive Curtis	CC	Independent Member - Community
Ceri Phillips	CP	Health Board Vice Chair
David Edwards	DE	Independent Member – Digital
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
In Attendance:		
Matt Phillips	MP	Director of Corporate Governance
Catherine Phillips	CP	Executive Director of Finance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Paul Bostock	PB	Chief Operating Officer
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Rachna Upadhya	RU	Independent Member – General
Suzanne Rankin	SR	Chief Executive Officer
Kirsty Williams	KW	CAV UHB Chair

Ref:	Agenda Item:	Action
FPC 2026/03/1.1	**Welcome, Introductions & Apologies** The Chair welcomed everybody to the meeting.	
FPC 2026/03/1.2	**Declarations of Interest** No declarations of interest were raised.	
FPC 2026/03/1.3	**Minutes of the Finance and Performance Meeting held on 18th February 2026** The minutes of the meeting held on 18th February 2026 were received and confirmed as a true and accurate record. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 18th February 2026 were held as a true and accurate record of the meeting.	
FPC 2026/03/1.4	**Actions following the Finance & Performance Meeting on 18th February 2026** The Action Log following the meeting held on the 18th February 2026 was received and discussed. It was noted that all actions were on the forward plan for the meeting being held 20th May 2026. **The Finance and Performance Committee resolved that:** A) The Action Log for the Finance and Performance Committee was noted.	
FPC 2026/03/1.5	**Chairs Action since previous meeting**	

	There were no Chair's Actions taken since the last meeting	
FPC 2026/03/2.1	**Financial Report – Month 11 Position (including savings tracker)** Andrew Gough (AG), the Deputy Director of Finance (Strategic), provided the following summary of the report to the Committee: • Reported a month 11 deficit of £51.6m, which is £95k over the planned deficit of £51.5m, indicating the position is back on plan and stable. • Expressed confidence in hitting the year-end control total deficit of £56.2m, with no significant changes expected in the final month. • Savings programme is overachieving by £600k against a £32m target, but there is an operational deficit of £700k offsetting this surplus. • Key operational pressures include: • Mental health out-of-area placement costs (noted a reduction from 23 to 9 patients in month 11). • Underperformance in specialist contracts (critical care and cardiac services). • National Insurance employers uplift pressure. • Benefits contributing to the position: o Vaccine price savings. o Effective winter plan management. o Additional radiology research income. o Reduction in substantive headcount by 285 staff since the start of the year. o Lowest overtime levels and near eradication of agency spend. • £32.7m of savings schemes are now green, but £5.4m are non-recurrent, increasing the challenge for 26-27. • Underlying deficit for 26-27 projected at £68.7m due to non-recurrent savings and operational pressures, compared to £56.2 million if all savings were recurrent. • Cash allocations: Able to draw down cash support for the £56.2m deficit and require £17m in working cash support. Outstanding cash allocations of £23.4m were not expected to be an issue. • Public sector payments compliance target of 95% achieved, with 96.3% at end of February. • Capital resource limit is £62.5m, with no forecast variance; capital plan is finalised and on track. • Overall, the report is described as "holding steady," with confidence in meeting the year-end forecast. Rhian Thomas (RT) the Independent Member – Capital Estates & Facilties / Committee Chair asked AG to clarify if the additional £17m of working cash support related to expenditure costs incurred in 24-25 but paid out in 25-26. She requested a clear explanation of the nature of the additional cash support. AG Explained that the £17m working cash support was due to the difference in balances between debtors and creditors, and the movement in these throughout the year, not specifically tied to expenditure costs incurred in 24-25 and paid in 25-26. He confirmed that this cash support will not cause pressure this year following correspondence with Welsh Government (WG). **The Finance and Performance Committee resolved that:** a) The reported year to date position is an overspend of £51.642m and the forecast deficit of £56.2m was noted. b) The month 11 operational overspend against plan of £0.712m and the (£0.617m) savings surplus was noted. c) The progress was noted against the in year savings target, with £32.674m (102.2%) of green schemes identified at Month 11 against the revised £32m target. d) That delivery of the forecast is contingent on delivery of recovery actions and the confirmation of all expected income streams was noted. e) The combined recurrent savings shortfall and recurrent operational pressures of 12.3m impacting adversely on a deteriorating underlying deficit being carried into 2026/27 was noted. The underlying deficit moving into 2026/27 is currently assessed at £68.5m which is £12.3m higher that the 2025/26 forecast outturn of £56.2m. This is currently a focus of review and scrutiny. f) There are £87.551m of outstanding cash allocations and that Welsh Government has confirmed in writing that it will provide up to £56.2m strategic support in year was noted.	
FPC 2026/03/2.2	**Operational Performance Update**	

Paul Bostock (PB) – Chief Operating Officer provided the following summary of the report to the Committee:

- February 2026 was challenging, with increased acuity and near business continuity incident; contained within Medicine Clinical Board by reallocating staff and opening extra capacity.
- Avoided corridor care but used treatment rooms as last resort due to high demand.
- Effect demand for services was 4.5% higher than last year, mostly in minor A&E stream.
- Slight improvement in 12-hour EU waiting times; ambulance holds worsened but average ambulance wait was 36 minutes, best in NHS Wales.
- UHB managed 13% of all Welsh EU attendances; 75% of ambulance handovers within 45 minutes over last 12 months.
- Stroke performance dipped; focus on reducing pre-hospital delays, EU delays, and rehab unit length of stay, with follow-up meeting planned.
- Delayed pathways of care reduced again; average delay for discharge-ready patients is 31 days (physical health), 109 days (mental health).
- Top 20 longest hospital stays being reviewed as tail of delays WAs growing; credit given to adult social care for reducing bed days lost.
- Planned care: commitment to have <400 patients waiting over two years by end of March, and none over three years; would be approx. 370, mainly in spinal, complex general surgery, and ophthalmology.
- Pressure from WG to eradicate >2-year waits by end of Q1, but not able to commit yet.
- Diagnostics backlog started year with 14,700+ patients waiting >8 weeks; expected to be ~1,000 but will end year at ~6,300 due to unexpected outpatient push, contract delays, and equipment breakdown.
- Endoscopy remained biggest issue; 17 sessions/week short of recurrent capacity, with no line of sight on revenue to fund this.
- Risk that endoscopy backlog will grow again in April, working on right-sizing options for planned care and diagnostics in annual plan.
- Mental health, primary care, and continuing care performing reasonably well, but focus was on diagnostics and cancer.

Judi Rhys (JR) – the Independent Member Third Sector noted issues with CT scanners leading to loss of approx. 400 procedures and asked if this was due to the machines being old, needing replacement, or insufficient numbers.

PB noted the CT scanner in EU was the busiest in NHS Wales, not particularly old (about four years), but breaks down due to high usage; when it fails, all work is moved to general radiology, impacting planned care and schedules. Infrastructure issues also affect MRI scanners, such as breakdowns due to leaks, causing further disruption.

Susan Lloyd Selby (SLS) – Independent Member Local Authority Noted the positive progress in reducing delayed transfers of care and highlighted that allocation of a named social worker for medical wards is critical, but this support can break down if patients are transferred between hospitals. She questioned whether more could be done to ensure social worker support remains consistent for patients across the hospital estate. Raised concerns about moving bottlenecks, specifically the risk that investing in more outpatient appointments could shift the bottleneck further up the line (now seen in Diagnostics). She asked if, once the Diagnostics bottleneck is resolved, there is planning for potential pressures elsewhere in the system.

Ceri Phillips (CPH) – the UHB Vice Chair mentioned a meeting last Friday with the neurodevelopmental team, referencing the growth in referrals and waiting times. He noted the team had identified actions to address the problem, with one improvement being for primary care to take on more management of patients, as currently, once people become patients, they must come into the hospital for assessment and medication titration. He observed a reluctance from primary care to undertake some of this work and wondered if conversations are taking place to address this issue.

PB stated that everyone agrees the current model is not right and there is a need nationally to change the pathways of care, moving from a medical model to a needs assessment model. He emphasized the importance of agreeing on the right pathway of care and resourcing it appropriately, whether by moving things around or doing the right thing, but was unsure if the pathway is fully established yet. He noted there is willingness to do something different, but roles need to be clarified, especially regarding primary care's involvement. He pointed out that this area is not a target that is measured, so it does not get the same focus and priority as others, but the team is working on it.

CPH noted that there are various entry points for assessment, including people going online to get their assessment and then expecting immediate action. He mentioned a growth area in university students seeking diagnosis and management and wondered to what extent universities can help with diagnosis

	and management going forward. He stated it was pleasing to see work being done to define the pathway and improve treatment and care. PB mentioned that the conversion rate for neurodivergent children waiting for assessment is about 80% **The Committee resolved that:** a) The year-to-date position against key organisational performance indicators for 2025-26 and the update against the Operational Plan programmes was noted.	
FPC 2026/03/2.3	**Cancer Deep Dive** PB gave an update on the cancer deep dive and noted the following: • 30% increase in referrals to the single cancer pathway since 2021; conversion rate of referrals to confirmed cancer remained at 15–17%, indicating referrals are appropriate. • Performance on the 75% single cancer pathway standard has fluctuated, with recent months in the mid-50% range; no health board in Wales has ever delivered the 75% standard. • More patients with confirmed cancer are being treated each month than before, with step changes visible in the data. • Unpredicted demand growth and population increase in Cardiff and Vale are impacting cancer services. • Increase in skin cancer referrals led to two new consultant appointments; capacity issues have affected performance. • Competing demands for capacity (emergency admissions, planned care, diagnostics, theatres) sometimes limit ability to deliver timely cancer care. • Specific bottlenecks: breast service lost key staff, urology pathway changes temporarily affected performance, and bowel screening Wales requires 9 endoscopy sessions per week, straining capacity. • Endoscopy capacity is divided among bowel screening, surveillance, single cancer pathway, polyp patients, and routine diagnostics; routine colonoscopies have been deprioritised. • Patients from bowel screening Wales often join the cancer pathway late, affecting timely treatment. • Backlog is coming down; patients are being treated in turn, and bottlenecks are understood. • Reasons for breaches in the 62-day standard vary by specialty: breast (not enough seen within 14 days), colorectal (bowel screening delays), skin (volume and first outpatient delays), urology (biopsy pathway). • Milestones are being reinstated: aiming for 85% seen by day 14, 85% diagnosed by day 28, to help deliver 75% treated by day 62. • Expect recovery to mid-60% performance by March and aim for 75% by September, contingent on holding milestones and creating more capacity. • Cancer is prioritized as time-critical care, but there is more national focus on 104-week waits than cancer performance. • Associate Medical Director for Cancer role was disestablished; recruitment underway for a Clinical Director. • High turnover in cancer tracker team; need to make roles more attractive and secure more organisational development support. • Committed to delivering the standard, with ongoing competition for capacity and a need for more transformational planning. JR asked about the interface with Bowel Screening Wales, seeking clarity on what CAVUHB can do to improve the issue, and whether the health board is beholden to Bowel Screening Wales or can influence the situation. She raised the future potential of AI to help with breast radiology issues and questioned whether the shortage of breast radiologists is a UK-wide problem or specific to Cardiff and Vale. She asked about the upper GI issue, specifically why the capsule sponge innovation was not being accelerated in NHS Wales, given its evidence and potential benefits. PB responded with the following points: • Bowel Screening Wales commissions CAVUHB to provide 9 endoscopy sessions per week; the issue is not with Bowel Screening Wales but with the health board's ability to fulfill this requirement due to competing demands on endoscopists. • Ongoing conversations about radiologists, including a recent discussion with the Clinical Director for breast services about recruiting radiologists who can also do general work; he was unsure if there is a national shortage, suggesting the need for a regional solution.	

- A couple of nurses attended the ask Suzanne session to discuss the capsule sponge innovation, indicating willingness to accelerate its adoption and promising to check for any holdbacks.

SLS highlighted demographic trends, noting the Vale's aging population and Cardiff's growth in the under-5 population, and asked whether CAVUHB is incorporating these trends into future planning and considering the resource implications for medium to long-term service provision.

The COO described attending an integrated session co-chaired by Ceri, where local authorities presented their plans for population growth and housing, prompting him to question whether CAVUHB was sufficiently linked into these plans. He acknowledged that the health board needs to improve and better join up its work with local authorities, admitting to playing catch up from an operational perspective and not fully understanding how all the pieces fit together.

Catherine Phillip (CP), the Executive Director of Finance explained that CAVUHB is catching up in various ways, currently focusing on understanding existing opportunities and conducting a stock take to assess their position. She emphasised the need to proactively address major housing developments and align health and social care needs with local authority plans, noting that the organization is two years into this process and expects it will take a couple more years to fully align and develop integrated plans.

SLS highlighted that both local authorities have a statutory duty to produce local development plans, which are currently out for consultation. She noted these plans are very detailed regarding projected population growth and locations. Susan raised the key concern from residents about what these developments mean for health provision and questioned how already overstretched health services, especially primary care, will cope with the anticipated growth.

CPH stated that the Regional Partnership Board (RPB) has a role in this work and emphasised the need to move away from relying on the hospital to the same extent, highlighting the importance of determining where treatment and care can be provided for different population groups as growth areas are considered.

PB mentioned that some of this work is playing catch up, especially regarding annual discussions with WG about allocation and population growth. He speculated that perhaps they are a year behind, needing to prove growth before requesting funding, and imagined the process is not as seamless as desired.

Robert Mahoney (RM) – the Deputy Director of Finance (Operational) explained they previously did work on this, including planning around CAVUHB and creating a modelling agent to feed into the consultation, which estimated demand on acute and primary care services in areas of major development. He clarified there is no population growth factor in health allocations and no further allocation; funding is weighted between health boards in Wales, so population projections have no impact on funding. He noted population increase may involve people moving from high-density areas, and actual population growth has been more modest than previously forecast, with displacement rather than net addition.

David Edwards (DE) – Independent Member for Digital stated demographics were important but asked about better screening, improvements in treatments, and how these factors could have a bigger impact on demand and costs, potentially changing the shape of demand in a more dynamic and less predictable way than demographics alone.

PB noted screening programmes are well proven to save lives by identifying cancer sooner, which generally leads to more cost-effective treatment and better patient outcomes. He described screening (breast, bowel, cervical, and upcoming lung screening) as a cost-effective way to identify cancer at an earlier stage and initiate treatment.

DE mentioned that treatments are changing, costs are also changing dynamically, and new treatments are coming online all the time, which affects funding and the dynamics of what needs to be done.

PB stated that advances in diagnosis are already happening in breast cancer, making it more difficult to deliver the 62-day standard due to additional pathology and gene testing. He suggested the 62 day standard may be a blunt instrument but emphasised the need to deliver it before challenging it, and highlighted the importance of looking ahead at how to organise for future developments.

	JR commented that there were exciting developments such as genomics that are very expensive but will transform cancer services and emphasised that since 4 in 10 cancers can be prevented, the prevention agenda must not be neglected. **The Committee resolved that:** a) The Committee noted the content of the report.	
FPC 2026/03/3.1	**Items for Approval / Ratification** **Newborn screening justification case** CP explained that the space at UHW was vacated by Cardiff University, and the pathology service would like to move into this purpose-built space. The business case is expected to be favourably received by WG, would allow the service to open, and will be managed by Public Health Wales on the CAVUHB site. The case had been to the Capital Management Group, will go to the Board meeting and Value and Benefits Realisation Group, and there was a keenness to secure capital approval. PB thanked CP for explaining the revenue aspect, noted that this is the only lab in Wales that does this testing, and emphasised that the work cannot proceed unless the revenue is signed off by Public Health Wales. CP stated that the operational Senior Responsible Officer (SRO), Sarah Lloyd, and her team, including the finance business partner, were confident about this work and have the revenue source to back up the capital. **The Committee resolved that:** **a)** The paper and contents of the attached Executive Summary for the Business Justification Case for the UHB to deliver additional All Wales New Born Screening at UHW was noted. b) The Business Justification Case was supported to proceed through the agreed governance process, allowing submission of the document to be submitted to Welsh Government for scrutiny and to seek capital funding approval of £1.21m **c)** The project will not proceed until the UHB receive written confirmation of the revenue support for the delivery of the additional services was noted. d) The procurement undertaken to select the preferred supply chain partner and relevant advisors to deliver the project was noted. It was recommended that the Board approve the following appointments which will be subject to Welsh Government approval of the BJC. I. The intention to award the construction contract to ET&S Construction Ltd at a value of £0.744m inclusive of VAT under the NEC4 Option A contract. II. The intention to award Gleeds Management Services the commission to provide Project Management and Cost Advisor services at a cost of £0.062m inclusive of VAT under the SBS Framework contract.	
FPC 2026/03/4.1	**Monthly Monitoring Return – Month 10** The monthly monitoring return for month 10 was noted. **The Committee resolved that:** a) The monthly monitoring return for month 10 was noted.	
FPC 2026/03/5.0	**Any Other Business** *No further business was raised.*	
FPC 2026/03/7.0	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 22nd April 2026 via MS Teams**	