Minutes of the Public Finance & Performance Committee Meeting
16th September 2026
Via MS Teams

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Chair:		
Rhian Thomas	RT	Independent Member – Capital, Estates & Facilities
Present:		
Kirsty Williams	KW	CAV UHB Chair
Lorna McCourt	LM	Independent Member – Trade Union
Clive Curtis	CC	Independent Member - Community
David Edwards	DE	Independent Member – Digital
Judi Rhys	JR	Independent Member – Third Sector
Rachna Upadhya	RU	Independent Member – General
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
In Attendance:		
Chris Bown	CB	Interim Chief Executive
Adam Roberts	AR	Executive Director of Strategic Planning
Catherine Wood	CW	Deputy Chief Operating Officer
Matt Phillips	MP	Director of Corporate Governance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Mike Bond	MB	Director of Operations – Urgent & Emergency Care
Robert Mahoney	RM	Deputy Director of Finance
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Observers:		
Obi Hassan	OH	PWC
Iain Alexander	IA	PWC
Apologies:		
Steve Riley	SR	Independent Member – University
Catherine Phillips	CPH	Executive Director of Finance
Paul Bostock	PB	Chief Operating Officer
Ceri Phillips	CP	CAV UHB Vice Chair

Ref:	Agenda Item:	Action
FPC 16.09/1.1	**Welcome, Introductions & Apologies** Rhian Thomas (RT) Committee Chair welcomed everybody to the meeting in English and in Welsh.	
FPC 16.09/1.2	**Declarations of Interest** No declarations of interest were raised.	
FPC 16.09/1.3	**Minutes of the Finance and Performance Meeting held on 22nd July 2026** The minutes of the meeting held on 22nd July 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 22nd July 2026 were held as a true and accurate record of the meeting.	

FPC 16.09/1.4	**Actions following the Finance & Performance Meeting on 22nd July 2026** RT introduced the action log review and noted several actions missing from the current papers, including heatwave impact, cancer demand management update, and Welsh Government (WG) funding updates. Catherine Wood (CW) – Deputy Chief Operating Officer updated on the following points: • **June heatwave impact update (action log item)** It was noted system-wide operational impact, workforce effects, and BCI declaration, and outlines debrief learning and recovery lessons • **Cancer demand management position statement (action log item)** It was confirmed the report was circulated to NHS P&I and summarises feedback and intent to include in next committee pack • **Welsh Government development funding update (action log item)** It was noted uncertainty on detail but confirms spend occurred on non-recurrent solutions and cannot yet provide a full breakdown **Action - to provide October committee updates on heatwave impact analysis, cancer demand management statement, and Welsh Government funding/development spend update.** **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 16.09/1.5	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 16.09/2.1	**Financial Report – Month 5 Position (including savings tracker)** The DDF highlighted the following points regarding the Financial Report: • A year-to-date deficit of £43.1m compared with a planned deficit of £36.1m, resulting in a £7.1m adverse variance. • The variance was mainly driven by a £9.6m shortfall in planned savings, partially offset by a £2.5m operational surplus. • The main issue is not general overspend but the pace and certainty of savings delivery. • A slight improvement in month 5, with slower deterioration driven by income improvements, some savings delivery, and reduced cost pressures, while cautioning this does not change the overall scale of the challenge. The Interim Chief Executive – Chris Bown (CB) emphasised need for urgent actions to reduce the financial run rate by around £2.5m per month to stay aligned with the control total, acknowledging this may require difficult non-recurrent decisions. The Committee Chair – Rhian Thomas (RT) noted that the committee meets monthly and continues receiving assurances that savings would be de-risked by quarter two, but members are not seeing sufficient change or movement in practice. She asked for CB's observation on whether turnaround meetings and current arrangements have been effective enough to deliver the required improvement and cultural/operational shift. CB stated that the current arrangements were "not sufficient," evidenced by the fact the organisation had not achieved the planned de-risking by quarter two. He confirmed that, with PWC support, a revised and strengthened turnaround governance structure is being implemented to improve cadence, accountability, and control of financial recovery work. He indicated that executive colleagues have agreed to the new structure, which is intended to increase grip, control, and urgency around delivery of savings and recovery actions. The Independent Member for Digital – David Edwards (DE) flagged a discrepancy in the resident doctors' contract figures, noting inconsistency between sections of the report, where	

	one narrative shows a £0.8m pressure and another shows £1.2m. He identified that the £0.8m figure appears in one part of the report (narrative/page reference around page 18 / report page 7), while the £1.2m figure appears in another section (around page 20 / report page 9), raising concerns about alignment across the document. He requested clarification to ensure the financial reporting is consistent and that all figures are clearly understood, noting that even if the difference is not large, consistency is important. AG will correct the report. KW opened by welcoming newly joined observers to the meeting and introduced herself as Chair. She questioned at what point the organisation should formally revise its financial forecast, noting that the ability to deliver the planned deficit was reducing over time. She asked when it would no longer be credible to maintain the current trajectory towards the planned deficit and when a formal change should be made. She asked how the Board would be assured that financial savings could be delivered while still managing associated risks appropriately. She requested clarity on how the Board would be kept informed about risk management approaches and how assurance would be provided that quality and patient safety would not be compromised by cost-saving actions. AG indicated the organisation was not yet at the point of formally changing the financial forecast and remained working against the existing position. He stated there is still optimism that the organisation can achieve the planned deficit, but only if delivery accelerates. He highlighted that achieving the plan depends on improving the speed and certainty of savings delivery through strengthened turnaround actions. He added that the revised turnaround approach and improvements would take a couple of months to properly embed before their full impact and Assurance could be seen. CB highlighted the need to learn from the current year's process and improve planning for future cycles, including 2027–2028. He also referenced that this work is not short-term, but part of a longer-term organisational turnaround over approximately a five-year horizon. He emphasised the need to build ongoing organisational capability for turnaround, not just temporary structures The Director of Corporate Governance – Matt Phillips (MP) explained that QIA work was being led by the Executive Director of Nursing, with planned reporting routes into governance structures to ensure committee assurance. A clear "line of sight" will be created from QIA outputs into the Quality Committee so the board can be assured through that route. The turnaround/QIA interface is being actively discussed to define how it will feed into committee reporting and assurance processes. Work is ongoing to ensure lessons learned from current processes are carried forward, including how the organisation transitions from the external support model while retaining improvements and insights. The Independent Member Local Authority – Susan Lloyd-Selby (SLS) questioned what "pressing clinical boards to accelerate actions" meant in practice and asked for assurance that AMBA schemes would deliver required in-year recurring savings AG confirmed that green and amber schemes (about £24.6m) were currently delivering at full value, but the main risk sits in red pipeline schemes that need conversion or replacement to meet the savings target Obi Hassan (OH) – PWC highlighted the following points: • **Injecting realism into delivery (£102m vs £86.5m target)**: The need to ground expectations was highlighted in the current forecast position and align planning with the reality of the financial gap and delivery challenge. • **Stakeholder journey and honesty in delivery narrative**: Managing stakeholders through the process was critical and that they must be taken through the evolving position rather than maintaining static assumptions. • **Balancing risk, quality, and financial decisions**: The core challenge was balancing clinical quality and financial control, avoiding "slash and burn" approaches, and recognising that risk balancing is central to decision-making.	

- **Programme structure and prioritisation of immediate actions**: There is a need for a staged approach—immediate actions in the short term alongside a broader multi-year transformation programme (around three years).
- **Governance, capability, and risk appetite requirement**: Delivery depends on organisational risk appetite, executive sponsorship, clinical leadership engagement, and clear identification of barriers and capability needs.
- **Urgency and realism of required monthly improvement**: Significant monthly run-rate reductions are required and that expectations must be realistic about the scale and difficulty of change required.
- **Culture and trajectory change as confidence signal**: Demonstrating a shift in organisational culture and financial trajectory would be key to maintaining stakeholder confidence.

DE referenced a previous period where the organisation repeatedly forecasted a relatively stable deficit position, which later increased sharply, resulting in a loss of confidence from Welsh Government in the organisation's forecasts. He linked this experience to current concerns, stressing that without realistic forecasting and stakeholder management, there is a risk of again losing confidence from key stakeholders, including Welsh Government. He highlighted that the organisation is currently on a tight balance between maintaining credibility by sticking to the forecast and the risk of damaging trust if forecasts are not realistic or are poorly communicated.

CB stated that CAVUHB's intention remains to deliver the £86.5m target, but highlighted it is "loaded with risks," including pressures such as winter which could affect delivery. He noted the need to manage expectations with Welsh Government and regulators by making clear that, while the target remains, it carries significant delivery uncertainty. He emphasised that risk appetite is a key factor in decision-making, particularly given constraints around workforce reduction and how savings will realistically be achieved. He also referenced that delivering the required financial position will require balancing ambition with operational constraints and difficult implementation choices.

Iain Alexander (IA) – PWC noted the following:

- **Stakeholder scrutiny & credibility**: Key stakeholders will independently assess the current monthly financial position, and this directly impacts organisational credibility.
- **Need for clear "building blocks" in recovery**: He highlighted the importance of showing a structured progression in savings delivery (moving step-by-step between different scheme levels) to demonstrate how the plan builds credibility over time.
- **Control vs external constraints (WG limits)**: He also stressed that part of stakeholder management is clearly separating what the organisation can control from what it cannot, including areas where Welsh Government policy (e.g., restrictions on redundancy approaches) may limit available options.

KW highlighted that there is a need to examine why CAVUHB continues to struggle with developing effective savings plans, particularly questioning underlying barriers preventing stronger delivery of savings plans. She questioned whether CAVUHB fully understands what has constrained the ability to build more effective savings plans over time, suggesting a need to identify structural or process-related blockers. She raised concern about benchmarking, asking whether the organisation is genuinely benchmarking its savings performance effectively against comparable organisations, given the significant time spent discussing financial shortfalls. She further suggested the organisation may not have been sufficiently ambitious or rigorous in treating savings as part of "business as usual," particularly in the context of a financially challenged system.

AG noted recurrent sustainability depends on aligning service, operational, and workforce planning to the organisation's total resource base of around £2.3bn. The core issue is decision-making trade-offs about how services are delivered within available resources, balancing timing, cost, and model change

	IA noted that NHS England operates under a "totally different funding and financial framework" compared with the current organisation context. He stated that organisations in turnaround situations typically deliver around 4–8% savings, which would equate to roughly £100m for the organisation, highlighting this as a benchmarking reference point. He concluded that the organisation is currently at a very low level of savings compared to what is seen elsewhere in turnaround organisations, reinforcing the gap to typical practice. AG noted the Capital Resource Limit at the start of September was 46.8m, with Welsh Government expected to adjust it (including for known slippage such as Parkview). The Independent Member General – Rachna Upadhya (RU) raised whether the Board has clearly defined its risk appetite across committees (finance, quality, workforce, infrastructure) and whether clear "red lines" exist for decision-making. She questioned if this has been properly quantified and embedded into how trade-offs are made, rather than only discussed at a high level MP stated that risk appetite is formally contained within the Board Assurance Framework and is presented to the Board regularly. He added that work is ongoing to better connect the Board Assurance Framework to planning and decision-making processes, with development underway through executive discussions and planning workstreams RU noted that while risk appetite is discussed across committees, it is not yet clearly translated into defined boundaries that support real decision-making and called for clearer quantification to enable decisions rather than discussion alone. She said that although risk appetite frameworks exist and are referenced (e.g., via the Board Assurance Framework), there is still a gap in how far this translates into actual decisions being taken in practice. She emphasised that more focus is now needed on execution and making difficult trade-off decisions, rather than continued discussion, particularly given the severity of the current situation and need to deliver change in practice **The Finance and Performance Committee noted that:** a) **T**he reported year to date position is an overspend of £43.1m with a planning deficit of £86.5m. b) There is an urgent need to de-risk the £86.5m deficit plan. c) At Month 05 there is an adverse variance against plan of £7.1m, driven by a £9.6m savings deficit, partially offset by an operational surplus against plan of (£2.5m). d) The core savings target of £42.5m is fully covered, although there is an associated material delivery risk linked to the £20.0m of red-rated schemes. Further work is being progressed with JCC to identify opportunities to address the additional £5.1m JCC 2% efficiency target e) That delivery of the deficit plan is contingent on delivery of a full savings programme and confirmation of all expected income streams. f) **T**here are £62.5m of outstanding resource limit allocations and that in due course the UHB expects to seek Finance Committee and Board approval to request £86.5m strategic cash support from Welsh Government to support the planned deficit.	
FPC 16.09/2.2	**Operational Performance Update** The Deputy Chief Operating Officer – Catherine Wood (CW) updated and highlighted the following points on the Operational Performance Update: • **Overview of Performance Report & SPC Charts** • Introduced the performance report and explained use of SPC charts and focus on key variation signals rather than full dataset coverage. • Confirmed the report highlights salient issues from the wider dataset. • **Urgent & Emergency Care (UEC) Performance** • Reported significant operational pressure linked to the heatwave impact and its system-wide effects. • Highlighted ambulance handover performance (W45) stability despite pressure, but rising attendances and longer length of stay in over-75s.	

- Set out “course correction” actions: admissions avoidance, falls pathway improvements, and ward flow transformation (red-to-green, board rounds, discharge planning).
- **Diagnostics & Stroke / Hip Fracture Performance**
- Updated on SNAP tool implementation and data adjustments for stroke/thrombolysis reporting.
- Reported delayed pathways above escalation threshold but with reduced average length of stay and reduced bed days lost.
- **Clinical Coding**
- Reported major improvement in coding timeliness, increasing from 36.2% to 84.5% within 30 days.
- **Cancer Performance**
- Provided updates on single cancer pathway performance (gradual improvement from 60.9% to 64%).
- Explained rising demand and backlog impact on performance metrics.
- Highlighted skin cancer backlog as a key pressure point and outlined corrective actions to reduce waiting times.
- **Planned Care & Diagnostics (104-week waits)**
- Reported funding uncertainty and dependency on Welsh Government allocation for delivery of improvement trajectory.
- Described productivity actions including outpatient overbooking and follow-up conversion programme.
- **Mental Health Performance**
- Reported overall performance on or above trajectory, with significant improvement in out-of-area placements reducing from around 30 to 7 patients.
- **Closing Summary**
- Reinforced overall positive movement in several areas but noted ongoing system pressures and need for continued transformation.

RT highlighted a significant achievement in relation to the significant reduction in out-of-area mental health placements, describing it as a really encouraging update.

CB referred to the reduction in out-of-area mental health placements as a “great result” and questioned whether it would translate into cost savings when he said the reduction was positive but asked if it would actually lead to a measurable reduction in spending on out-of-area placements, specifically whether the financial impact could be tracked through to lower costs.

AG confirmed the ability to track out-of-area placements and stated this tracking was a key driver behind improving the month 5 financial position, linked to reducing the number of patients to around 14 and strengthening both in-month and forecast performance. He also highlighted that the improvement was not just a snapshot effect, but supported increasing confidence in continued reductions going forward, which further supported the improved financial trajectory.

SLS noted positive update that out-of-area mental health placements had reduced through the pilot and asked how the learning is being captured to ensure the improvement is sustained long term. `

CW initially explained that early thinking considered whether the rise in out of area placements reflected a systemic demand and capacity imbalance across the service (i.e., whether the system itself was structurally misaligned). She then clarified her view that it was not primarily a systemic demand/capacity issue, but instead driven more by cultural, behavioural, and process-related factors within the service. She added that sustaining improvement would depend on continuing the work to reset culture, reinforce new behaviours, and embed consistent processes so that the changes become standard practice rather than temporary fixes.

KW Highlighted that outpatient performance had been a longstanding weak area, previously worse than other regions, and noted improvement momentum as positive. Noted progress

	through overbooking initiatives, estimating this could help address a large backlog of missed appointments (around 75,000 additional slots needed to meet targets). She referenced clear Welsh Government expectations for outpatient transformation and sought assurance the organisation would fully implement these requirements. CW confirmed many elements of the WG outpatient expectations were already being implemented, including "see on symptoms," patient-initiated follow-ups, and overbooking clinics with high DNA rates (expected to create ~7,000 additional appointments). She stated there is general movement toward full implementation, but it must be done incrementally due to operational and clinical constraints and concerns raised by clinicians about patient safety and workflow disruption. Indicated that full implementation will require a structured, phased plan and strong clinical engagement, likely over a multi-year horizon, supported by clinical leadership roles and operational planning. KW asked when CAVUHB will receive the outpatient transformation plan and how it will be ensured that it is clinically led, with clinicians fully signed up to delivery and expectations aligned with Welsh Government direction. CW explained that the plan is expected to be developed as a ~2-year programme aligned with WG expectations and broader system timelines. Clinical leadership will be embedded through executive clinical colleagues supporting communication, delivery, and operational design. A planned care clinical lead is being appointed to work alongside operational teams and support clinical engagement and implementation. The approach combines executive clinical leadership and operational clinical leadership to ensure phased implementation and clinician involvement, recognising the scale of change required. SLS highlighted the ENT clinic's approach as a positive example, noting they have already implemented "see on symptoms" type changes and are actively improving outpatient flow by booking additional patients into each clinic session. She referenced clear improvements in waiting times and strong patient communication and acceptance of the changes introduced in ENT services. She concluded that ENT is operating as an exemplar within the organisation and that the learning from this clinic should be shared across other clinical boards to spread best practice. RT highlighted that coding staffing levels have been a longstanding challenge, stating that clinical coding resourcing has been "notoriously challenging over the last few years and beyond" when introducing a question on coding workforce pressures. CW noted that in relation to clinical coding, the performance "speaks for itself", pointing to the significant improvement in coding timeliness and compliance as evidence of progress She explained that the main challenge in this area has been retaining and recruiting specialist coding staff, despite the importance of the function She stated the service has shifted toward "growing our own" workforce model, including creating internal progression routes, rotation opportunities, and developing staff within the service to improve sustainability. CB stated that clinical coding is a widespread issue and highlighted that future improvement should rely on technology rather than traditional manual approaches. He explained that coding processes are well suited to be supported by AI and automation. He noted that the way coding is currently done will change significantly over the coming years, with a shift toward more modern solutions. He emphasised the need to move toward a technological solution rather than outdated approaches. **The Committee resolved that:** a) The position against key organisational indicators for 2026-27 and the update against the Operational Plan programmes were noted.	
FPC 16.09/2.3	**UEC Hospital Flow & Discharge** RT stated that the UEC Hospital Flow and Discharge paper had not been received in time and was therefore removed from the current agenda and deferred to the next meeting.	

	The Director of Operations for Urgent & Emergency Crae – Mike Bond (MB) highlighted the following points: • **Reliable daily routine / ward flow focus** • Described work to standardise ward routines to improve patient flow and reduce delays, including early discharge planning and consistent daily routines across wards. • Highlighted introduction of criteria-led discharges and earlier planning for patient discharge, including structured weekday discharge processes. • **Monday A&E pressure** • Noted Mondays experience 10–15% higher A&E attendances compared with other days, creating system pressure and reinforcing the need for improved flow and weekend discharge patterns. • **Targeted intervention link** • Referenced a targeted intervention aiming for around 33% of discharges before midday, with current performance around 28% in medicine services. • **Pathway delays and partner work** • Described work with partners to address pathway-of-care delays and improve system flow, including reviewing ward-level processes and escalation issues. • **Days lost / performance trajectory** • Stated that despite pressures, days lost were broadly on trajectory and that the system was seeing some stabilisation alongside ongoing improvement work. • **Scaling across wards + system delivery** • Explained the approach is being rolled out across 6 pilot wards initially, with intent to scale across all wards (over 40 in total), supported by structured transformation work. • **Shaping Change support** • Confirmed the Shaping Change team (with Ruth Jordan's team) is supporting implementation and scaling of the flow improvement programme. • **Escalation / SLT reference** • Mike Bond did **not reference SLT** in relation to taking this work forward. • He stated instead that he would be sharing the UEC plan and next steps in **SLP (not SLT)** on Thursday prior to further governance discussions. **Action – MB to bring formal UEC hospital flow & discharge paper to next meeting and scale ward flow model across all wards.** **The Committee resolved that:** a) The UEC Hospital Flow & Discharged would be added to the agenda for October.	
FPC 16.09/2.4	**Diagnostic Deep Dive** CW highlighted the following: a) **Context & challenge framing**: She thanked Sarah Lloyd for compiling the report and noted it reflected a highly detailed view of diagnostics with major concerns around the scale of demand and difficulty in consistently interpreting system movement and variation. b) **Overall demand growth & pressure**: She highlighted significant growth across diagnostic modalities, particularly where demand is increasing faster than capacity. c) **CT demand increase**: Cancer pathway demand increased by ~34.9%, alongside urgent demand growth of ~37%, showing strong pressure across both urgent and cancer pathways. d) **MRI demand increase**: Cancer demand rose by ~34% and urgent demand by ~75%, indicating a marked shift in case mix and urgency profile. e) **System impact of demand shift**: Catherine explained that prioritisation of urgent/cancer cases is impacting lower-acuity pathways, increasing waits for routine diagnostics. f) **Professional alignment**: She noted the demand pattern aligns with Royal College of Radiologists expectations and national trends. g) **Activity increases but insufficient**: Endoscopy activity increased significantly (around 63%), but still not keeping pace with rising demand. h) **Workforce constraints**: She highlighted shortages and pressures in key diagnostic areas including endoscopy, echo, and musculoskeletal ultrasound services.	

i) **Infrastructure failures**: Repeated equipment and infrastructure issues affecting CT, MRI, and endoscopy capacity were identified as a major constraint.
j) **Mitigation approach (short-term)**: Reliance on non-recurrent Welsh Government funding and productivity/efficiency measures was described as currently supporting performance but not sustainable.
k) **Impact of non-recurrent solutions**: Without mitigation, backlog would be significantly higher (~17.5k patients), but current trajectory brings it down to ~3.5k, though still not at desired level.
l) **Next phase of work**: Catherine set out a further deep-dive phase to quantify what would be required to sustainably meet demand, including workforce, infrastructure, and funding implications.
m) **Future decision point**: She confirmed this work will support a strategic board-level decision on whether to fully baseline diagnostic activity or continue mixed non-recurrent approaches.

CB stated that non-recurrent solutions are not a satisfactory long-term approach and highlighted the need to understand the gap between required capacity and current provision to meet demand He emphasised the need for a clearer understanding of the true ongoing cost of meeting demand sustainably, rather than relying on short-term or one-off interventions. He noted that at some stage a decision will be required on making the system sustainable, and that this requires facing up to the financial cost involved. He reinforced that without this understanding, services risk continuing cycles of temporary fixes rather than addressing underlying demand pressures

AR explained that the organisation is on an ongoing improvement journey, with priority given to areas where demand–capacity modelling shows the clearest gaps and risks. He noted that current analysis suggests some services may appear over-resourced, but this is linked to variation in productivity and performance levels rather than a simple staffing excess. He added that improving system-wide performance may require redistributing resources between services, shifting capacity from higher-performing or potentially over-resourced areas to those with greater shortfalls.

CW stated that without mitigating actions and non-recurrent solutions, the system would be facing around 17,500 patients waiting over 8 weeks by year-end, highlighting the scale of avoided backlog due to current interventions.

OH asked whether there is a detailed breakdown of demand drivers and specifically whether analysis exists on screening mechanisms and what is driving the increase in diagnostic demand

CW explained the paper describes significant demand growth and changing demand shape across diagnostics. She noted that while demand patterns align with national expectations, there is uncertainty about the exact level at which this should translate into practice. She would share the paper following the meeting.

RT noted that across services the organisation is managing not only existing demand but also ongoing growth in almost all service areas, and asked what operational work is being done to understand and manage this increasing flow.

CW explained there is currently no single systematic organisation-wide view of demand drivers, but the response is being managed through multiple operational levers including triangulating demand trends, using clinical pathway tools (e.g., health pathways and referral guidance), and reviewing whether all demand is appropriate or could be redirected. She also highlighted actions such as diagnostic stewardship work to better understand test utilisation, and operational productivity measures like overbooking outpatient clinics where DNA rates are high (to increase capacity), alongside wider pathway redesign and prioritisation of urgent and cancer demand, which is reshaping how capacity is allocated across services.

KW raised that primary care (GMS) colleagues may be under significant pressure when managing referrals, particularly where public awareness and expectations influence what

	patients believe should happen in their care. She noted that patients or the public may sometimes expect investigations or referrals that are not clinically appropriate, creating difficult conversations for GPs and placing them in challenging decision-making positions. She sought assurance that the organisation is actively working with primary care colleagues to support them in these decisions and help manage these pressures through appropriate pathways and guidance. CW noted that Cardiff and Vale has the highest adoption and utilisation of healthcare pathways in Wales, describing them as an online library/resource supporting primary care referral decisions. She explained that primary care colleagues use these pathways to seek advice, guidance, and sometimes avoid unnecessary referrals or admissions. referenced a formal primary and secondary care interface group chaired by David Fluck, with LMC involvement, where these issues are discussed and the interface is described as working in both directions. She noted that the group has active/robust discussions on such issues, and highlighted that changes (e.g., skin pathway improvements in secondary care) would have consequential impacts into primary care pathways. **Action – CW to develop phased implementation plan for Welsh Government outpatient reforms with clinical engagement and operational delivery approach.** **Action – CW & AR to develop a fully costed diagnostic demand & capacity plan (including recurrent funding requirements) for return to committee (target end of Q3).** **The Committee noted that:** a) The deterioration in diagnostic waiting-time performance since March 2026. b) The recurrent demand-capacity deficits across Radiology, Endoscopy and Cardiology. c) The Welsh Government diagnostic recovery funding request. d) The integrated diagnostic recovery programme was endorsed. e) The principal risks to delivery. f) Support monthly trajectory, performance and recovery assurance reporting via the Productivity and Efficiency Board.	
FPC 16.09/2.5	**Grip & Control** AG highlighted the following points on Grip & Control: • **Overall assessment of controls** Confirmed the organisation has a substantial underlying financial control framework already in place, including core financial, procurement, workforce and reporting controls, but these are not applied consistently across all areas. • **Core issue identified** Emphasised the key gap is not the absence of policies, but the difference between having controls in place and ensuring they are effective and consistently used in practice. • **Nature of the weakness** Highlighted that the main problem is inconsistent application, weak escalation of exceptions, and lack of assurance that corrective action reliably changes outcomes. • **Root cause framing** Described the issue as an operational discipline and follow-through problem rather than a structural or policy deficit. • **Integration into turnaround approach** Stated that grip and control actions will be embedded into the wider integrated improvement plan rather than managed as a standalone finance action list, ensuring organisational ownership beyond finance. • **Ownership and accountability** Confirmed responsibility for delivery will sit with relevant executive directors and operational leadership, with finance providing challenge, support and assurance. • **Success criteria / expectations** Set expectation that success will be measured by whether actions are delivered, exceptions trigger intervention, and interventions lead to measurable behavioural and performance change.	

	• **Future assurance approach** Noted that progress will be revisited through reassessment cycles over the coming months to confirm whether improvements are embedded and effective. SLS raised that issues reported through People & Culture include some unexpected gap. She highlighted that there is no single organisation-wide policy covering the use of temporary staffing. She requested clarity on how issues identified in P&C are properly escalated and "read across" to other relevant committees AG Confirmed that actions linked to the grip and control plan will have designated executive/operational owners. These owners are expected to ensure reporting and escalation into the appropriate committees as part of delivery MP noted that governance and performance management structures should ensure issues are routed to the right committees, including P&C, through integrated reporting. AR added that revised senior leadership forums will improve awareness of key performance and control issues, supporting better cross-organisational visibility. **Action – AG to confirm delivery timescales and provide completion evidence for all grip & control actions.** **Action – AR to embed grip & control actions within the integrated improvement plan and ensure committee read-across (take this off-line).** **The Committee noted that:** a) The final Grip and Control self-assessment and the areas of relative strength and weakness identified; b) The actions already underway and the further improvements required; c) Delivery will be led by the relevant Executive Directors, supported by their deputies and nominated operational leads; d) Executive Directors and deputies were required to confirm delivery timescales and completion evidence for each action; e) The development of a consolidated Grip and Control Improvement Plan was to be endorsed and: f) Progress was required, overdue actions and material exceptions to be reported through the Finance and Performance Committee and relevant executive governance arrangements.	
	Monthly Monitoring Return	
FPC 16.09/5.0	**Any Other Business** No further business was raised.	
FPC 16.09/6.0	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 21st October 2026 via MS Teams**	