

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

To view a recording of this meeting, please click here: <https://youtu.be/KMFLpCQbQCU>

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

Ref:	Agenda Item:	Action
FPC 2026/02/1.1	<u>Welcome, Introductions & Apologies</u> Kirsty Williams (KW), the UHB Chair, welcomed everyone to the meeting in English and Welsh. Apologies for absence were noted.	
FPC 2026/02/1.2	<u>Declarations of Interest</u> No declarations of interest were raised.	
FPC 2026/02/1.3	<u>Minutes of the Finance and Performance Meeting held on 21st January 2026</u> The minutes of the meeting held on 21 st January 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 21 st January 2026 were held as a true and accurate record of the meeting.	
FPC 2026/02/1.4	<u>Actions following the Finance & Performance Meeting on 21st January 2026</u> The Action Log following the meeting held on the 21 st January 2026 was received and discussed. The Finance and Performance Committee resolved that: A) The Action Log for the Finance and Performance Committee was noted.	
FPC	<u>Chairs Action since previous meeting</u>	

2026/02/1.5	There were no Chair's Actions taken since the last meeting	
FPC 2026/02/2.1	<p data-bbox="217 197 1037 224">Financial Report – Month 10 Position (including savings tracker)</p> <p data-bbox="217 255 1436 313">Andrew Gough (AG), the Deputy Director of Finance (Strategic), provided the following summary of the report to the Committee:</p> <ul style="list-style-type: none"> <li data-bbox="268 349 606 376">• Health Board Position: <ul style="list-style-type: none"> <li data-bbox="363 380 1404 497">○ The Health Board reported a deficit of £47.411m at Month 10 – this was £0.551m above the Month 10 planned deficit of £46.860m. The £0.5m deficit against the plan was broken down as a savings programme surplus of £0.584m, and an operational deficit of £1.135m. <li data-bbox="363 501 1436 591">○ The Health Board had a full savings programme in place for the past three months. They identified £32.7m worth of schemes against the £32m target – all these schemes were now green and fully delivering with no slippage. <li data-bbox="363 595 1404 654">○ It was anticipated that given the current trajectories, the Month 10 £0.551m deficit would be recovered, enabling the organisation to deliver the planned £56.2m deficit. <li data-bbox="268 689 507 716">• Key Variances: <ul style="list-style-type: none"> <li data-bbox="363 721 1404 779">○ The table in the report summarised the in-month and cumulative performance of the Health Board by its major expenditure groups, which was also split by Clinical Board. <li data-bbox="363 784 1372 842">○ With the savings plan now fully de-risked, it remained essential to continue driving recurrent savings and reducing operational pressures still in place. <li data-bbox="268 878 606 904">• Operational Pressures: <ul style="list-style-type: none"> <li data-bbox="363 909 1436 1025">○ The main issues were mental health out of area placements (22 patients at Month 10), contract underperformance in Critical Care and Cardiac services, and a £2.1m shortfall from the unfunded National Insurance (NI) increase. Non-recurrent measures had helped in-year, but long-term solutions were needed for 2026-27. <li data-bbox="363 1030 1436 1111">○ There had also been favourable movements including vaccine price savings, reduced winter plan costs, additional radiology research income, and strong workforce controls, which had all supported confidence in delivering the £56.2m planned deficit. <li data-bbox="363 1115 1420 1173">○ Welsh Government (WG) had confirmed funding for additional Welsh Risk Pool costs, though on a non-recurrent basis, meaning this pressure would return in 2026-27. <li data-bbox="268 1209 507 1236">• Key Variances: <ul style="list-style-type: none"> <li data-bbox="363 1240 1372 1299">○ Pages 11 and 12 of the report compared cumulative spend in 2025-26 to 2024-25 across staff groups and key non-pay areas. <li data-bbox="363 1303 1436 1393">○ Workforce controls had reduced 262 full time equivalents since April 2025, and this reduction had continued even after vacancy management was handed back to Clinical Boards, putting the Health Board in a stronger position for 2026-27. <li data-bbox="363 1397 1420 1487">○ Non-pay growth was mainly in secondary care medicines and prescribing, continuing healthcare, and commissioned services, with several now becoming structural pressures that would need to be addressed in the 2026-27 plan. <li data-bbox="268 1523 427 1550">• Savings: <ul style="list-style-type: none"> <li data-bbox="363 1554 1404 1612">○ An analysis of the savings position was received - a total of £32.7m of schemes had been identified, and all were delivering and rated green. <li data-bbox="268 1648 395 1675">• Risks: <ul style="list-style-type: none"> <li data-bbox="363 1680 1436 1760">○ WG had set a £9.1m target control deficit, but with a £56.2m deficit, they were not on track to meet that. Although this year's £32m savings programme was delivering, there remained a £5.5m shortfall, which must be addressed into 2026-27. <li data-bbox="363 1765 1372 1854">○ Recurrent operational pressures of £7.8m would also carry forward into 2026-27, adding to the challenge. Work continued with Clinical Boards through performance reviews to reduce these pressures and resolve persistent issues. <li data-bbox="363 1859 1388 1917">○ The remaining risks noted that the Health Board continued to remain within its cash limit. <li data-bbox="268 1953 555 1980">• Underlying Deficit: <ul style="list-style-type: none"> <li data-bbox="363 1984 1356 2065">○ Without addressing the recurrent savings shortfall and the recurrent operational pressures carried into 2026-27, the underlying deficit would increase by £13.3m, resulting in a £69.6m deficit going into next year. 	

- This position had been closely scrutinised by NHS Performance & Improvement (P&I) and through targeted intervention work. The drivers of the deficit would need to inform the 2026-27 plan.

- **Cash Allocations:**

- WG had confirmed strategic cash support for the £56.2m planned deficit, along with £17m in working capital. The value of unconfirmed drawing limit allocations at month 10 was £31.826m. Overall, the cash position was more positive than last month.
- The Health Board continued to exceed the 95% public sector payment target, achieving 96.3% at the end of January 2026.
- The approved capital resource limit was £59.5m for Month 10 (£14.3m discretionary funding and £42.5m for specific projects). The programme was monitored through the Capital Management Group (CMG), with no issues reported and full capital spend planned in close coordination with WG.

Paul Bostock (PB), the Chief Operating Officer, asked if the strategic cash provision was a loan.

AG responded that it was not a repayable loan; it was cash support that the Health Board did not need to pay back.

PB asked if the £56m cash support also improved their recurrent financial position, not just the bank balance.

AG responded that it did not help their position because it was cash support, not resource funding. It simply allowed them to meet payroll and pay creditors.

Judi Rhys (JR), the Independent Member – Third Sector, asked for clarification about the increase in employer NI contributions. She asked whether this had been accounted for by WG, as this was outside of the Health Board's control.

AG responded that when they set this year's plan, they assumed the increase in employer NI would be fully funded by WG. However, the funding announced did not cover the full cost, leaving all Health Boards with additional pressure. WG expected Health Boards to manage this within their existing plans, so in delivering their £56.2m position, they had to absorb this NI shortfall.

Steve Riley (SRI), the Independent Member – University, recognised the hard work from the Health Board in delivering these savings.

SRI asked whether any guidance had been provided from NHS P&I on actions to address the underlying deficit, which was due to increase again next year due to non-pay inflation outside of the Health Board's control.

AG responded that they met regularly with NHS P&I who had a clear understanding of the underlying deficit and want consistent reporting, in line with WG's view that these deficit drivers should guide how they address it. Whilst some pressures were structural, others resulted from Health Board decisions, so it was important to distinguish what they could control, what was structural/national, and what actions or models could be used to mitigate these pressures as far as possible.

Catherine Phillips (CP), the Executive Director of Finance, referred to PB's previous question, and explained that the £56.2m was not extra funding. Their plan required them to spend £56.2m more cash than they were allocated, so without this cash support, their bank balance would fall, and they would not be able to meet payroll or pay bills.

PB responded that he feels that getting a lump sum should improve their finances, even if the deficit started building again in April.

CP responded that WG provided this support so they could meet payments, but it was not guaranteed until their year-end resources were confirmed. The underlying problem remained and returned in April.

KW thanked the team for their significant effort and continued commitment.

The Finance and Performance Committee resolved that:

- a) The reported year to date position was an overspend of £47.411m and the forecast deficit of £56.2m was noted;

	<p>b) The Month 10 operational overspend against plan of £1.135m and the £0.584m) savings surplus was noted;</p> <p>c) The progress against the in-year savings target, with £32.703m (102.2%) of green schemes identified at Month 10 against the revised £32m target was noted;</p> <p>d) Delivery of the forecast was contingent on delivery of recovery actions, and the confirmation of all expected income streams was noted;</p> <p>e) The combined recurrent savings shortfall and recurrent operational pressures of £13,4m impacting adversely on a deteriorating underlying deficit being carried into 2026/27 was noted. The underlying deficit moving into 2026/27 was currently assessed at £69.6m which was £13.4m higher than the 2025/26 forecast outturn of £56.2m. This was currently a focus of review and scrutiny.</p> <p>f) There were £105.1m of outstanding cash allocations was noted, and that WG had confirmed in writing that it would provide up to £56.2m strategic support in year.</p>	
<p>FPC 2026/02/2.2</p>	<p><u>Operational Performance Update</u></p> <p>PB provided the following summary of the report to the Committee:</p> <ul style="list-style-type: none"> • Urgent and Emergency Care – Hospital Flow and Discharge: <ul style="list-style-type: none"> ○ EU attendances in January 2026 were 6% higher than last year, but less patients had been admitted. They needed to understand what was driving the demand. ○ Ambulance holds had risen slightly but remained far better than the previous year. ○ Stroke performance needed improvement – they had held a Stroke Summit, where three priority areas had been agreed: reducing pre-hospital delays, speeding up CT and thrombolysis, and shortening rehab stays at University Hospital of Llandough (UHL). More mini summits would be held throughout the year. ○ Pathway of Care Delays – overall number of patients increased in January as expected, but the total number of bed days lost had reduced, which was positive. Compared with this time last year, this improvement was equivalent to around 75 beds. Local Authority (LA) partners had made sustained and demonstrable improvements. ○ The Health Board's biggest flow issue remained internal length of stay, particularly in medicine, where they sat in the bottom 25% nationally. A PRISM review confirmed they needed major change, and a summit was planned with physicians and consultant colleagues to share the PRISM report findings and secure consultant support for a new medical model. This would involve reallocating existing resources, but reducing length of stay could release savings and allow reinvestment. A clearer plan would be brought back to the F&P Committee in April 2026. • Planned Care, Cancer and Diagnostics: <ul style="list-style-type: none"> ○ Cancer performance improved to 59% in December, and was expected to be around 60% in January, with trajectories now being met. A full deep dive would come to the March 2026 F&P meeting. ○ Planned care remained on track to deliver the agreed 450 year-end position of patients waiting 2 years for treatment, though capacity limits meant additional funding would not speed delivery. They were on track to achieve 31,000 new outpatient appointments. ○ Diagnostic performance had plateaued due to CT downtime and extra outpatient demand. WG had acknowledged this unexpected demand, and some outsourced non-obstetric ultrasound capacity started later than planned, but by March 2026 they still expected a backlog of around 1500 patients. • Primary and Community Care: <ul style="list-style-type: none"> ○ Their district and community nurses delivered 17,000 visits in January, which was 25% more activity than EU attendances, and they supported 3500 patients at home every day. • Mental Health: <ul style="list-style-type: none"> ○ They were on track with the key measures agreed, but out-of-area placements remained a significant challenge. This was now one of the top priorities from the 36 Degrees work, with the Clinical Board reviewing the model, patient reviews, and options for repatriation. Whilst unlikely to impact this financial year, they expected improvements and reduced costs in 2026/27 • Productivity and Efficiency: 	

- The efficiency metrics needed refreshing, as progress on Did Not Attends (DNAs), See on Symptoms (SOS), and Patient Initiated FU (PIFU) pathways had stalled due to the intense focus on delivering the 104 position and managing outpatient subcontracting, which had demanded significant time and resource.
- As this work concludes, they would reset the planned care programme for next year, and intended to bring back the refreshed plan, including productivity and efficiency priorities, to April 2026's F&P Committee.
- The same applied to theatres, where they planned to relaunch the efficiency programme from Q1 once the Theatres Together work was fully embedded.

Rachna Upadhyia (RU), the Independent Member – General, asked whether they could quantify the financial impact of continued 12-hour waits and discharge delays, and how they ensured health inequalities were addressed within operational performance.

Additionally, RU asked for Mental health, what the cost different was per patient per day for out-of-area placements compared with in-area care.

In terms of financial impact, PB responded that there was no direct financial penalty for 12-hour waits, the impact was mainly on patient safety and experience. The financial effect came from needing to open escalation or winter capacity, which carried an additional cost. The pressure was already built into the plan (around £1m) and managed, but essentially, they were keeping beds open that they would not need if length of stay were reduced.

Regarding the cost difference between in-area and out-of-area placements, PB responded that he did not have the exact number per patient, but that out-of-area placements would cost the Health Board around £3m this year. It was extremely expensive, in addition to the distress caused for patients and families. Whilst a small number of out-of-area placements may occasionally be unavoidable, having around 20 was not sustainable.

Around health inequalities, PB answered that the patients who needed their care more often did not access it, especially in their most deprived clusters. When they did attend, the Health Board provided equitable care, but they weren't consistently reaching those with the greatest need. This was also reflected in issues like stroke, where long delays before seeking help could significantly worsen outcomes. PB would return to the Committee with a clearer response.

RU asked to receive a more detailed update at a future meeting on how they addressed health inequalities within operational performance, and how they can better reach patients.

David Fluck (DF), the Executive Medical Director, agreed that health inequalities must remain a key focus, and that the Clinical Services Plan (CSP) was designed to address this.

KW noted that when the CSP and operational redesign come to the Board, a key test of their acceptability will be whether they genuinely improve health inequalities.

JR commented that once they know what has driven the rise in EU attendances, it would be useful to explore whether it linked to health inequalities, and people using the EU because they believed it was their only option.

JR asked for confirmation on whether they were working with the Stroke Association and relevant third-sector partners, as they were key links into the community.

To check involvement with the Stroke Association and the third sector and update the Committee – ACTION.

Regarding community and palliative care, JR noted they saw high levels of activity outside of hospital, but the graph demonstrated that they were still some distance from the 80% target, especially for weekend provision. JR suggested it would be useful to understand this at a future Committee.

PB responded that they had a partnership agreement with Macmillan, who had lent around £4m to help establish enhanced end-of-life and palliative care services. If they could demonstrate the benefits, they would have at least 30 beds worth of fewer patients in the acute hospital in their end-of-life stage.

Provide an update to Committee Members on the palliative care work being undertaken – ACTION.

	<p>JR asked for assurance that the high DNA rate would be addressed, as it represented significant inefficiency.</p> <p>PB agreed with JR's comments. He noted they had the clinical tools and templates to manage follow-ups properly, but they needed better consultant engagement and improved internal processes. Many DNAs occurred because patients were aware of appointments or did not need them, and they had also been overbooking clinics, which created confusion and inefficiency.</p> <p>SRI informed the Committee that he had visited the Ely district nursing hub and saw excellent work, but there were structural issues (mainly limited IT access, as not all staff had access to a computer). Increased community pressure from hospital discharge targets also affected capacity, so staffing and system improvements were needed.</p> <p>SRI noted that seven-day working required a whole system approach, including weekend diagnostics. He asked whether there were UK exemplars that medical teams could visit to learn from.</p> <p>PB responded that this was about continuity of care and keeping patients' pathways moving; increased discharges were a bonus, not the goal. They needed to discuss what was needed to support seven-day continuity, and it was likely less extensive than some suggested.</p> <p>DF noted that the real issue was continuity – they often had seven-day services without consistent handover or communication, especially when patients were discharged. Weekend discharges were extremely low for a 1500-bed organisation, which was unacceptable. High-performing organisations discharged at weekends at similar levels to weekdays, because illness and recovery did not stop. The key step was getting clinicians to recognise the problem.</p> <p>Clive Curtis (CC), the Independent Member – Community, explained that effective engagement with the community and third sector was key around health inequalities, although the Stakeholder Reference Group (SRG) was on hold. He asked what interim arrangements could be put in place to maintain meaningful engagement, as they reshaped their engagement model.</p> <p>Matt Phillips (MP), the Director of Corporate Governance, responded that a meeting was scheduled with some of the Executives to capture learning from the Executive Director of AHPs, Health Scientists and Community Services Development's coproduction work, and consider how this transitioned into the SRG. This discussion was scheduled to be brought to a future Board meeting.</p> <p>KW highlighted that the important issues addressed in this meeting (e.g. length of stay, out-of-area mental health placements, and palliative care) were not just about performance, but about quality and patient experience.</p> <p>The Committee resolved that:</p> <ol style="list-style-type: none"> a) The year-to-date position against key organisational performance indicators for 2025-26 and the update against the Operational Plan programmes was noted. 	
<p>FPC 2026/02/2.3</p>	<p><u>Board Assurance Framework – Research & Development</u></p> <p>DF presented the slides to the Committee, and highlighted the following:</p> <ul style="list-style-type: none"> • Research & Development (R&D) sat within <i>Shaping our Future Generations</i> and was a core component of Cardiff Health Partners (CHP), alongside other foundational contributions. • R&D was a key enabler of clinical services and population health plans, supporting care transformation in the short and long-term. • Evidence showed that research-active organisations achieved better patient outcomes, experience and mortality, and fostered a culture of continuous improvement. Research brought wider benefits, including workforce attraction, early adoption of innovation, economic impact, and preparation for future healthcare delivery. The proximity to a university strengthened research impact through collaboration and cross-fertilisation. • Research activity included hosted research (commercial and non-commercial studies led externally), and sponsored research (internally designed and grant-funded studies). • Patient recruitment had varied year on year, peaking in 2021-22 (COVID-related trials), with scope to increase participation going forward. • Two core ambitions for R&D – 1) position research centrally within the organisation; and 2) operate a professional, sustainable model with a clear understanding of costs, income, and benefits. • Current commercial research income was fragmented, but proposals were being developed by Health and Care Research Wales to improve coordination and transparency. 	

- Proposed funding model – costs built into grants and sponsorship; and income split to support delivery, R&D capacity building (including CHP), specialty research groups, and corporate overhead. The aim was to support researchers in a more coordinated and collegiate way whilst maintaining academic control.
- A new CAV Research Strategy was in development, aligned with wider organisational strategies, focusing on:
 - Fostering a research culture
 - Aligning research structures with clinical services
 - A robust financial model for reinvestment
 - Workforce development
 - Partnership working
 - Recognising and articulating the impact of research
- Current priority research areas included:
 - Advanced therapies (including cancer and partnership with Velindre)
 - Population health
 - Paediatrics (linked to CHP)
 - Genomics and cancer research

DF explained that understanding the organisation's research position was essential to understanding its contribution to CHP, and highlighted the below:

- CHP is a strategic partnership between the Health Board, Cardiff University, and Velindre, aligned with UK Academic Health Partnerships.
- The partnership was not exclusive and would expand over time, with future memberships and agreements to be determined.
- CHP brought together complementary resources, expertise and talent across partners, extending beyond clinical trials to:
 - Translational research (lab to bedside)
 - Service organisation and management
 - Education and workforce development
- The partnership responded to significant population health challenges including lower life expectancy, high levels of ill health, and marked health inequalities linked to deprivation, smoking, and economic inactivity.
- CHP aimed to stimulate innovation, improve population health, reduce inequities, and support delivery of clinical services and population health plans.
- CHP also supported economic growth and regeneration across Cardiff and Vale through attracting and developing talent, working with industry, enabling translational research, building a future-ready workforce, and strengthening regional collaboration.
- Initial priority areas included next-generation cancer care and advanced therapies (with Cardiff University and Velindre), brain therapies, and precision medicine and genomics.
- A CHP prospectus had been developed which outlined intended outcomes to 2035, including improved economic prosperity and reduced health inequalities.
- CHP was a central element to the organisation's strategic approach to transforming clinical care, not an additional or peripheral activity.

JR referred to the growth in commercial income, largely from pharmaceutical investment, and asked if there were examples of this commercial activity expanding through partnership with others (such as WG).

DF responded that CHP provided the opportunity to strengthen relationships with industry by combining the different expertise and resources of each partner. Existing relationships were already supporting product development. There was scope to develop further these partnerships in Wales, positioning the region as an attractive centre for industry whilst ensuring collaboration focused on innovations that benefit patients.

RU noted that whilst the growth in commercial income was positive, £4m remained small in pharmaceutical terms. She asked whether they were fully recovering the costs of running these trials, and where they currently sat within the commercial pricing framework. RU also asked whether there was scope to increase income, even with existing trial activity.

	<p>DF responded that whilst £4m was a significant sum, the opportunity was much greater given their co-location with Cardiff University and their population base. This required strong industry relationships, clear planning, and a proven track record of delivery. Some areas, such as brain therapies, offered significant commercial advantage due to specialist expertise, but it was essential that costs were fully understood and that delivery was timely to remain attractive to industry partners.</p> <p>RU asked whether these payments were made upfront, or whether they were contingent on meeting specific clinical trial milestones.</p> <p>DF responded that the Joint Research Office (JRO) was established with agreed delivery timelines, helping to build reliability and attract further partners. Funding was often contingent on meeting recruitment targets, so failure to deliver could reduce income despite incurred costs. This reinforced the need to manage research on a professional, financially robust basis. Work was ongoing to clarify contractual arrangements within partnerships, ensuring that risks and benefits were clearly defined.</p> <p>SRI explained that CHP would strengthen the bi-directional flow between clinicians, researchers, and industry. Work was underway to map resources and demonstrate cost recovery and potential surplus. There was scope to increase commercial income, and the JRO was key to this. Progress was being made on partnership agreements, and the programme was moving in the right direction.</p> <p>Robert Mahoney (RM), the Deputy Director of Finance (Operational), reassured the Committee that consistency of offer and ease of access were key to attracting pharmaceutical partners, and the JRO provided vital support. Centralised support would help grow commercial income. Additionally, pharmaceutical trials provided significant benefit through the supply of free, cutting-edge drugs, which represented a substantial contribution.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) The alignment of Research to the Future Generations strategic portfolio was noted; b) The ongoing development of the new R&D strategy and Research finance policy once they were finalised and submitted to Board for review was supported. 	
<p>FPC 2026/02/3.1</p>	<p><u>Items for Approval / Ratification</u></p> <p><i>No items.</i></p>	
<p>FPC 2026/02/4.1</p>	<p><u>Monthly Monitoring Return – Month 9</u></p> <p>The monthly monitoring return for month 9 was noted.</p> <p>The Committee resolved that:</p> <ul style="list-style-type: none"> a) The monthly monitoring return for month 9 was noted. 	
<p>FPC 2026/02/5.0</p>	<p><u>Any Other Business</u></p> <p><i>No further business was raised.</i></p>	
<p>FPC 2026/02/7.0</p>	<p><u>Review & Close</u></p> <p>To note the date, time and venue of the next Committee meeting: Wednesday 18th March 2026 via MS Teams</p>	