Minutes of the Public Finance & Performance Committee Meeting
22 October 2025
Via MS Teams

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Chair:		
Rhian Thomas	RT	Independent Member – Capital & Estates / Committee Chair
Present:		
Ceri Phillips	CP	CAV UHB Vice Chair
Rachna Uphadya	RU	Independent Member - General
Clive Curtis	CC	Independent Member - Community
Kirsty Williams	KW	UHB Chair
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
Matt Phillips	MP	Director of Corporate Governance
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Suzanne Rankin	SR	Chief Executive
Jonathan Watts	JW	Regional Planning Programme Director
Paul Bostock	PB	Chief Operating Officer
Observers:		
Suma John	SJ	Senior Nurse – Cwm Taf LHB
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Susan Lloyd-Selby	SLS	Independent Member – Local Authority
Mike Jones	MJ	Independent Member – Trade Union
David Edwards	DE	Independent Member – Digital

Ref:	Agenda Item:	Action:
FPC 17/09/1.1	**Welcome & Introduction** The Committee Chair – Rhian Thomas (RT) welcomed everyone to the meeting. She thanked the previous chair John Union for his previous leadership as chair of the committee.	
FPC 17/09/1.2	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 17/09/1.3	**Declarations of Interest** No declarations were noted. **The Finance and Performance Committee resolved that:** a) No declarations of interest were noted.	
FPC 17/09/1.4	**Minutes of the Finance and Performance Meeting held on September 2025** The minutes of the meeting held on September 2025 were received and confirmed as a true and accurate record following minor amendments. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on September 2025 were held as a true and accurate record of the meeting.	
FPC	**Actions following the Finance & Performance Meeting on September 2025**	

17/09/1.5	**The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 17/09/1.6	**Chairs Action since previous meeting** There were no Chair's Actions taken since the last meeting	
FPC 17/09/2.1	**Financial Report – Month 6 Position (including savings tracker)** The Assistant Director of Finance – Andrew Gough (AG) presented and highlighted the following: • **Headline Position**: Reported a Month 6 deficit of £31.8m, which was £3.7m over the planned deficit of £28m. The cumulative deficit included a savings programme surplus of £300k and an operational deficit of £4m. • **Savings Plan**: For the first time this year, a full savings plan was in place against the £32m target, with green and amber schemes totalling £32.6m. This included a £1m benefit from the resolution of the mental health fire case. • **Operational Pressures**: The £3.7m overspend was mainly due to operational pressures: • Mental health out-of-area placement costs were significantly above plan, with patient numbers peaking at 23 versus a plan for 7. • Underperformance in critical care and cardiology contracts. • A £2.1m shortfall due to employer NI increases. • A £1m increase in the GP out-of-hours pay settlement provision, with the final amount still uncertain. • **Forecast and Deep Dives**: If operational pressures continued, the forecast deficit would be £5m. Deep dive sessions with clinical boards closed the gap by a further £4 million, leaving a residual gap of £1m, which was expected to be addressed mainly through workforce measures like a vacancy freeze. • **Workforce Position**: Staffing numbers reduced by 137 whole-time equivalents since the start of the year, with a spike in September due to onboarding student streamliners. This was expected to reduce temporary pay costs. The vacancy freeze and executive scrutiny panel were key to closing the remaining financial gap. • **Non-Pay Pressures**: Largest growth areas were secondary care medicines, prescribing, continuing healthcare, and commissioned services. These were being closely tracked against forecasts. • **Savings Programme Risks**: Of the £32.6m savings plan, £2.4m remained amber. There was a £5m shortfall in recurrent savings, which could worsen the underlying deficit for 2026/27. • **Key Red Risks**: • Delivery of the £9.1m deficit target. • Achieving the full recurrent savings target. • Managing operational pressures. • Remaining within the cash limit. • Additional all-Wales risks: £7.4m risk pool liability and £8.3m for Band 2–3 corrective payments, both currently excluded from the plan per Welsh Government guidance. • **Cash Position**: Strategic cash support from Welsh Government will be needed to cover the planned deficit. There are £54.3m in assumed cash allocations yet to be received, including pay award funding. If unresolved, supplier payments may need to be slowed, but this is not seen as a fundamental risk based on past practice. • **Capital Resource Limit**: The capital plan totalled £37.6m, with all schemes currently on track. The Independent Member General – Rachna Upadhya (RU) asked why the £1m release from the Hafan-y-Coed fire case provision was booked in Month 6, whether this would affect reporting, and if there were any further liabilities, seeking assurance that the money was "clean" and risk-free. RT questioned why, despite the release of the £1m provision for the fire case, there was not a corresponding £1m reduction in the overspend. She observed this suggested ongoing overspending and asked AG to reiterate his confidence level in achieving the financial outcome, given this context. AG confirmed the £1m fire case provision was released, stating the case had concluded, and the benefit was included in the position with no further liabilities. He explained that previously, there was no clear plan to reach the £56.2m control total, but after conducting deep dives with clinical boards, the gap had been significantly closed, providing a more reasonable level of confidence in delivery. He emphasised that, although not 100% assured, the organisation was in a much better position than last month but cautioned that winter will bring additional challenges.	

The Chief Operating Officer – Paul Bostock (PB) noted that there were plans in place and positive conversations were held with Medicine and the Surgical Clinical Board, leading to increased confidence in their management. He identified three key challenges: out of area placements in mental health (with weekly check-ins and key actions to reduce these), ITU income (which was variable), and cardiology/cardiac underperformance (where plans were in place). He stated there was a better grip and oversight of day-to-day spend, and he felt more confident than last month, though there was still a need to find £1–1.5m and manage the winter pressures.

The Executive Director of Finance – Catherine Phillips (CP) highlighted the difficulty in profiling where the benefit from actions will fall, making it hard to predict when the financial trajectory would come back on track. She noted the current overspend showed the organisation was heading toward pressure and emphasised the need to profile the impact of deep dive actions so future months could be monitored for expected improvements. She stated that this profiling work needed to be concluded and brought back to the committee to clarify how the organisation expects to return to the £56.2m control total.

RU expressed concern about upcoming winter pressures, noting they were currently an unknown for the organisation. She asked whether the deep dives conducted by clinical boards had taken winter pressures into account for months 8–11, seeking clarification on whether these factors were included in the numbers.

PB explained there was a £1.5m provision within Medicine Clinical Boards control total for winter, but the team was challenged to use only half of that money and reprofile spending to be more effective. He noted the CAV UHB had about 200 more nurses this year compared to last, which should allow the winter plan to be delivered more cost-effectively than the previous year. He acknowledged there was still some risk but expected the winter plan to be more efficient due to increased staffing. He confirmed the revised winter plan would go to Board in November.

The UHB Vice Chair – Ceri Phillips (CPH) referenced a report from the respiratory network stating that 80% of patients admitted to hospital could, with additional resources, be managed in their own homes. He suggested that clever modelling could be done to factor in this potential, which would have significant financial benefits. He also noted that the board would be under increasing pressure due to proposals from the Chief Medical Officer (CMO) to shift attention and resources away from hospitals into primary and community care.

The Chief Executive – Suanne Rankin (SR) assured that Board colleagues always receive the winter operational plan, which was reviewed at least twice prior to the winter months. She emphasised the plan covered a much wider approach to care than just hospital beds, including a COPD plan and population stratification to support care at home and avoid admissions. She mentioned ongoing work on "safe at home" and deepening community capacity, with increased emphasis on community response and preventative measures like vaccination and resilience.

PB noted the cabinet secretary was clear that we should be doing some of the work that was being done previously. There was a small cohort of high-risk patients. CAV UHB would have to make some choices and the cost of implementing / paying GPs to complete the work.

RT highlighted that several risks, such as the Welsh risk pool liability growth and the band 2 and 3 pay costs, are "Pan Wales problems" and represent significant figures for health boards already struggling to break even. She specifically asked AG to confirm whether Welsh Government (WG) was currently excluding these from the calculations and expectations for the end-of-year financial position.

AG confirmed that WG is very clear these issues (Welsh risk pool liability and band 2 to 3 pay costs) were kept outside of the plan and were not reported within the financial position, which was consistent with most health boards. He stated this was clearly documented in their monitoring returns and the Cabinet Secretary was aware of the band 2 to 3 issue. He added that there was ongoing debate and expected movement on how these risks were reported and managed as they move forward.

RU asked about the timing of potential cash allocations from WG, noting that they were already in month 6 and inquired if there was any idea when this would be received, as it would have a significant impact on their ability to pay suppliers and manage cash.

AG stated there was no firm timing on when the cash position would be settled but noted that last year the cash situation was resolved between months 8–10. He mentioned they would likely submit an Accountable Officer letter in the next month requesting strategic cash support, and expected the pay award funding to come in over the next couple of months.

The Finance and Performance Committee resolved that:

	a) The reported year to date position is an overspend of £31.843m and the forecast deficit of £56.2m was noted. b) The month 6 operational overspend against plan of £4.035m and the (£0.308m) savings surplus was noted c) The progress against the savings target, with £32.617m (101.9%) of green and amber schemes identified at Month 6 against the revised £32m target was noted. d) The delivery of the forecast is predicated on delivery of recovery actions, and the confirmation of all expected income streams was noted. e) The £4.995m recurrent savings shortfall impacting adversely on a deteriorating underlying deficit being carried into 2026/27 was noted. f) There is a potential £127.5m cash shortfall at year end before outstanding cash allocations and strategic support are confirmed by Welsh Government was noted.	
FPC 17/09/2.2	**Operational Performance Update** PB presented on the Operational Performance Update and highlighted the following: • **Urgent and Emergency Care** • September performance was as expected, with demand approx 3.6% above forecast (forecast was 4%). • Ambulance delays dropped considerably with the new 45-minute standard, though sustaining this was challenging. • Focus for winter: improve 12-hour emergency unit waits and maintain the 45-minute ambulance handover standard. • Efforts continued to find alternatives to emergency unit attendance, such as better use of medical assessment units. • **Out of Hospital Care** • In September, 2,750 patients attended urgent primary care centres, and 914 were triaged, reducing pressure on GPs and minor injury units. • General practice demand remained high, with increased use of digital options. • **Stroke Performance** • Improvements seen in time to ward and thrombolysis rates. • Ongoing issues with the emergency unit CT scanner which caused delays. • **Pathways of Care Delays** • Delays hadn't reduced after the summer peak, especially in Mental Health, with complex, long delays. Working with local authorities to address this, as it was a concern heading into winter. • **Planned Care and Diagnostics** • Additional WG funding helped clear backlogs. • Cancer performance remained in the 60% range despite a 10% increase in demand; hotspots in skin and urology were being addressed with new capacity and pathway improvements. • Endoscopy and non-obstetric ultrasound wait times improved, with additional capacity expected to bring endoscopy waits to 8 weeks by year-end. • **104-Week Waits** • At the end of Q2, just under 1,000 patients were waiting over two years, the best position in years. • Target for Q3 was around 600; not expected to reach zero due to spinal surgery and paediatric respiratory hotspots. • WG was aware and comfortable with this, focusing on reducing the total waiting list. • **52-Week Outpatients** • Supported by HBS (national insourcing company), with 2,500 appointments completed so far. • Some challenges in fulfilling specialty requirements but working closely with WG and other health boards. • **Primary Care** • Some GP practices were struggling with demand; one is at high-level escalation and being supported. • Ongoing contract discussions with WG; uncertainty remains, but enhanced community services were being delivered as planned. • **Mental Health** • Neurodevelopment services for children remained a major issue due to lack of capacity. • Funding reallocation from adult to children's services was not fully possible, so waiting list issues persist. • **Summary** • Overall, performance was largely on track with plans, with known challenges in Mental Health and some specialties.	

	SR asked if the agreed trajectories for 104-week waits this year were in writing from NHS, expressing concern about having formal documentation given the Cabinet Secretary's commitment to achieving zero 104-week waits. PB confirmed the agreed trajectories for 104-week waits were not in writing; he mentioned a recent conversation with WG about the required funding and that a formal request was sent, with a response pending. CPH stated he recently met with the Cabinet Secretary, who asked when zero 104-week waits would be achieved. He explained that CAV UHB was not in that position and noted the Cabinet Secretary reiterated this in a follow-up letter. He expressed hope that, following PB's conversation with WG, the Cabinet Secretary would be aware of the current position. He added the importance of using district nurse contact data to understand and reduce pressures on A&E by avoiding hospital admissions through community interventions. PB agreed to take as an action - the suggestion to revisit district nurse contact data to help understand and reduce A&E pressures. **Action – PB to take forward the action to resurrect district nurse contact data to provide insight into community interventions that avoid hospital admissions.** RT asked PB to contextualise the insourcing contract challenges, specifically whether WG was taking the lead on resolving these issues or if there was a clear accountable person or entity managing them. PB explained that WG was funding the insourcing contracts, each HB has an allocation of money and outpatient appointments, and there was additional funding for subsequent diagnostic interventions that might be required. **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 17/09/2.3	**Annual Plan** The Head of Strategic Plan – Jonathan Watts (JW) presented the quarter two report on the delivery of the Health Board's 2025/26 plan, which contains close to 200 actions spanning the organisation and highlighted the following: • the challenge of documenting progress on all actions in an accessible way and explained the report draws on existing data resources and reports already produced by the Health Board. • The report uses a tracking system to show, by strategic portfolio, the status of actions at quarter two. • A more mature approach to planning was needed, suggesting the organisation should be smarter about which actions are included in future, focusing on those that provide direct assurance to the Board and stakeholders. • Some actions are open-ended and hard to close, which contributes to the prediction that 30% of actions may remain outstanding at year end. More work is needed in quarter three to clarify the intent and progress of these actions. • Plan monitoring and plan development should be aligned, and that not all outstanding actions will simply roll over into the next year; instead, they will be reviewed and potentially recast. • Work is underway to develop an outcomes framework so that actions lead to measurable improvements, especially in patient experience. • Whilst the plan was comprehensive and includes good news stories, there is a need to focus on outcomes and strategic alignment as the planning process matures. RT remarked that 200 actions are significant volume of metrics to track. She found the document helpful, noting it provides a narrative that contextualises the numbers and statistics, making it arguably more useful than the PowerPoint pack that comes with the integrated performance report. She asked how the team could sharpen their thinking on the "so what" aspect of what is being monitored and measured, especially as they move into the next year. She expressed that she took a lot of assurance from the points Jonathan made. She asked where the work was heading next, both for the rest of the year and into the next financial year, and what lessons were being taken forward to optimise the approach. She also invited CPH to add to the questioning if they had a similar or related query. CPH stated that the Health Board has a strategy around shaping its future direction and noted that the 200 actions do not all necessarily align with the required direction of travel. He suggested that the plan should factor in alignment with strategic goals, emphasising that each year the organisation needs to get	

	closer to those goals. He highlighted the importance of developing an outcomes framework, so that actions have a measurable impact on patient outcomes and population health, rather than just activity. JW shared that there have been good discussions with the Exec team and it is now clear that next year's plan should focus on a fewer number of actions, suggesting closer to about 50, to ensure targeted efforts and clear line of sight into what is important. He noted there is an ambition for next year to commit to an annual plan, as previously tested with the board, and that the plan must demonstrate the required level of assurance around recovery and trajectory. He emphasised the need to make transformational changes, signalling what that transformation journey will look like over the next 12 months, and ensuring clear alignment between a more succinct set of actions and the organisation's strategic objectives. He stated that the plan should balance annual priorities with the longer-term transformation journey, making sure the actions answer the "so what" question and support both immediate and strategic goals. CP highlighted that building a quality management system was a major strategic goal for the quality team to drive progress toward the 2027 and 2035 bellwether measures. She noted the organisation is constrained by the annual plan, which only allows for a limited amount of progress in a 12-month window, but the plan was built by considering what progress was needed by 2027, especially in areas like infrastructure conditions surveys, site master planning, and digital enablement. She observed that there is a lot of detail in the 200 actions, with a balance between strategic initiatives and day-to-day improvement work, and that the number of actions is probably on the high side. She stated that as the organisation moves from annual plans to IMTPs, the approach should be to work back from 2035 to each annual planning cycle, and that the work for exec directors in the next few months is to identify the major pieces of work and milestones needed to reach 2027 and then 2035. She concluded that the focus should be on determining the right balance between current activities and shifting the strategic direction, learning from the current approach, and ensuring confidence that progress is moving in the right direction. . **The Committee resolved that:** a) The progress highlighted in the Q2 Annual Plan Report was noted.	
FPC 17/09/3.1	**Business Case for Information & Support** No Items. **The Committee resolved that:** a) There were no business cases to approve.	
FPC 17/09/4.1	**Monthly Monitoring Return – Month 5** The monthly monitoring return for month 5 was noted. **The Committee resolved that:** a) The monthly monitoring return for month 5 was noted.	
FPC 17/09/5	**Any Other Business** No further business was raised. **The Committee resolved that:** a) Any other business was noted.	
FPC 18/06/013	**Review & Close** To note the date, time and venue of the next Committee meeting: **Wednesday 19th November 2025 via MS Teams**	